SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	**11J/0262**
Service	At Scale Urgent Community Response (UCR)
Commissioner Lead	PCC
Provider Lead	Dorset Healthcare
Period	*01/04/2021 to 31/03/2023*
Date of Review	*01/04/2022*

1. Population Needs

1.1 National/local context and evidence base

From 1st April 2022, Urgent Community Response (UCR) is nationally mandated, to provide a 2-hour crisis response to support people in their own homes, including care homes, to avoid hospital admission. This response should be available from a multiagency team, have a single point of access, and link closely with the Integrated Urgent Care Service (IUC) and 111/999.

Criteria for the 2-hour response include:

- An acute physical presentation (e.g., a respiratory or urinary tract infection)
- A new short-term physical care need (e.g., following a non-injurious fall or reduced mobility)
- An acute episode of mental ill-health. This includes those experiencing acute confusion (delirium) or an exacerbation of behavioural and psychological symptoms of dementia
- Palliative care and end of life care needs
- When a carer becomes acutely unwell and the person being cared for is unable to remain at home safely

In July 2021 a proof of concept for UCR 2-hour response launched in the Bournemouth and Christchurch area. The model provided a cluster wide 2-hour response via a vehicle staffed by 1 x Band 7 Advanced Nurse Practitioner/ECP and 1 x Band B6 therapist. The aim was to avoid unnecessary conveyance and admissions though a rapid UCR assessment/ immediate response and co-ordination of on-going services where required.

Referrals into the cluster wide service came via the countywide Single Point of Access team (SPoA) and/or community teams/GPs direct to the cluster hub, where a clinical discussion took place with the duty clinician prior to acceptance and UCR clock start.

The UCR proof of concept was a new and additional service to meet national requirements, but built upon the existing foundation of;

- Bournemouth Intermediate Care and Christchurch ICRT for assessment, treatment, and provision of equipment, therapy involvement, short term care and ongoing support
- Bournemouth and Christchurch community nursing teams for nursing interventions and support of end for life care.
- Dorset's Integrated Urgent Care Service and Single Point of Access

Provision of an urgent response car with a medical and therapy holistic approach to care, assessment and treatment of physical, psychological, environmental and social aspects of the patients' needs to enable them to remain safely at home has determined a clear model for

UCR to be delivered at scale across Dorset.

The following data was collected and reported;

- Number of UCR completed
- Referral source e.g. Primary care111/999
- Time taken
- Skills mix- Banding and profession
- Referral reason
- Outcome of visit

Data over a 12-week period during the proof-of-concept phase has shown;

- 78% of patients avoided conveyance into hospital
- The remaining 22% were appropriately admitted for conditions such as sepsis, fractured neck of femur or required acute medical intervention
- A third of patients seen were non injurious falls
- Referrals into the service were low, indicating a need to proactively 'pull' patients from the IUC CAS queue, emergency departments, and Category 3 and 4 SWAST presentations as well as receiving referrals from GPs and other sources

Learning from the proof-of-concept phase has shown that whilst an initial UCR response from an ACP/paramedic is vital in meeting urgent patient need. It is essential that this is supported by a robust and responsive multidisciplinary intermediate care service, including both nursing and therapy.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	✓
Domain 2	**Enhancing quality of life for people with long-term conditions**	✓
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	✓
Domain 4	**Ensuring people have a positive experience of care**	✓
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	✓

2.2 Local defined outcomes

- Enable people to live healthy independent lives for as long as possible in their own homes, or place they call home.
- Reduce the need for escalation of care to non-home settings
- Facilitate timely return to their usual place of residence following temporary escalations of care to non-home settings
- Support the collaborative working required to deliver the requirements of the hospital discharge service policy and operating model
- Ensure patients, where appropriate, are referred for ongoing care needs identified

3. Scope

3.1 Aims and objectives of service

- Working collaboratively with relevant stakeholders (PCNs, Local Authority, VCSE etc), to develop a plan for delivery of the Ageing Well Programme outcomes which meets the needs of the population, this includes a local 2-hour Urgent Community

Response.

- To ensure membership and attendance in Governance Meetings, to have oversight and joint decision making for the Ageing Well Programme and intrinsically linked services. Joint decision making must include changes to workforce and staff movement to support other services, applicable to workforce associated to the Ageing Well Programme.

- Provide a 2-hour response as described in line with B0651 Urgent Community Response 2-hour and 2-day, Standards Guidance and in addition provide UCR rapid response nursing and therapy to support patients following an intervention for a minimum of 1 day and up to 7 days.

3.2 Service description/care pathway

Urgent Community Response (2 hour response)

County wide roll out of an Urgent Community Response with an ACP/Paramedic and therapy assistant in a roaming car;

- Four response vehicles to be provided – each with an Advanced Community Practitioner or paramedic and a therapy assistant, vehicles to be dispatched centrally to enable flexible coverage to meet need
- A responsive and flexible service to be provided
- A proactive approach to case finding will be in operation, to look at a specific cohort of patients such as falls, cat 3 & 4
- Triage from the IUC hub will cover the county, but cars will be located, despatched and flexibly moved to meet demand in the East (2), West and North of the county.

Rapid response nursing and therapy resource to provide support to Urgent Community Response and virtual ward management of patients

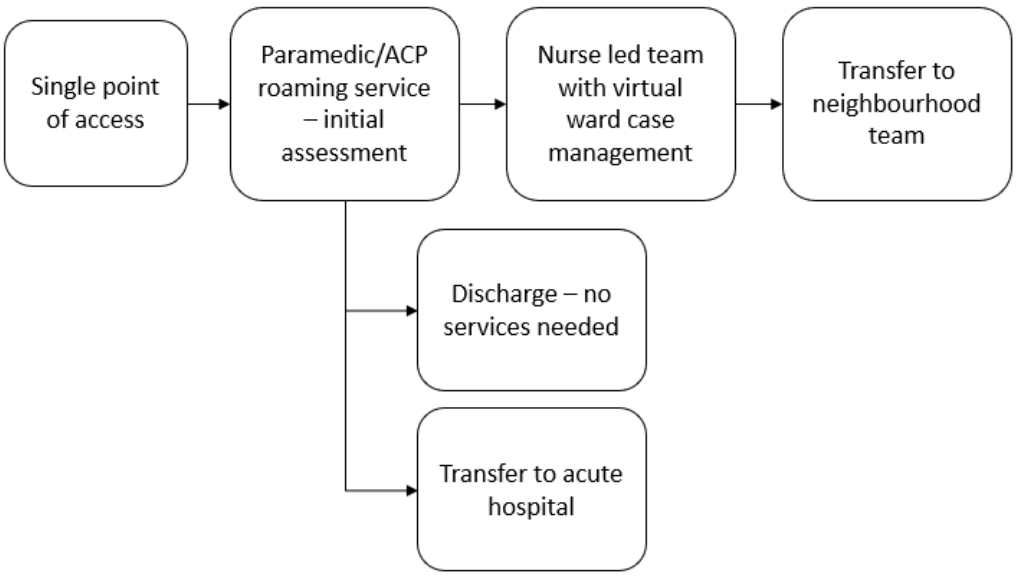
It was identified that the key to success of an Urgent Community Response in keeping a patient who is frail and unwell at home is not just an initial assessment, but a robust and responsive urgent therapy and nursing response, with the flexibility to pick up quickly from the UCR initial visit and provide intensive virtual ward support to enable a patient's acute needs to be managed at home.

Therefore, provision of an urgent multidisciplinary response team as part of UCR will address this initial acute phase. Teams to be nurse led with the following interventions provided;

- Nursing assessment and holistic management
- End of life care/case management
- Wound care
- IV therapy
- Pressure care
- Venepuncture
- Symptom management
- Case management and supporting provision of short-term care

Teams have rapid access to therapy, short term care and a range of resources to support the initial acute phase of intervention.

Service Flow Chart:



3.3 Population Covered

Adults living in Dorset and registered with a Dorset GP. Patients in their usual place of residence, to include care/nursing homes, with an urgent care need.
Does not include children.

3.4 Acceptance criteria

Patients experiencing:

- An acute physical presentation (e.g., a respiratory or urinary tract infection)
- A new short-term physical care need (e.g., following a non-injurious fall or reduced mobility)
- An acute episode of mental ill-health. This includes those experiencing acute confusion (delirium) or an exacerbation of behavioural and psychological symptoms of dementia
- Palliative care and end of life care needs
- When a carer becomes acutely unwell and the person being cared for is unable to remain at home safely

3.5 Interdependence with other services/providers

This service links in to PCN/Neighbourhood level Ageing Well services and must link in with local PCN/neighbourhood plans.

Interdependencies with the following providers:
Primary Care Networks
Acute Trusts
SWAST
VCSE providers
Local Authority

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

B0651-urgent-community-response-2-hour-and-2-days-standards-guidance-may-2021

4.3 Applicable local standards

Funding allocations to be reviewed annually against submitted plan, any underspend against the plan to be recovered at year end.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4A-C)

5.2 Applicable CQUIN goals (See Schedule 3E)

6. Location of Provider Premises

The Provider's Premises are located at:
N/A

7. Individual Service User Placement

N/A

8. Applicable Personalised Care Requirements

8.1 Applicable requirements, by reference to Schedule 2M where appropriate

N/A for 2-hour Response