Commissioning a new delivery model for unscheduled care in London
For the purposes of the Healthcare for London unscheduled care project, the following working definition has been used:

- Unscheduled care is any unplanned contact with the NHS by a person requiring or seeking help, care or advice. It follows that such demand can occur at any time, and that services must be available to meet this demand 24 hours a day.
- Unscheduled care includes urgent care and emergency care.
In 2006, Professor (now Lord) Darzi carried out a review of London’s health services, involving clinical experts, patients and the public. His recommendations were published in July 2007 in the report: Healthcare for London: A Framework for Action; setting out the reasons why London’s health service needs to change.

Led by the London Commissioning Group (LCG), a Healthcare for London programme office was subsequently established to begin work on six early priority workstreams; and to co-ordinate a London-wide public consultation on the ideas and principles proposed in A Framework for Action. Consulting the Capital was undertaken by all 31 primary care trusts (PCTs) in London and Surrey PCT between November 2007 and March 2008, and received over 5,000 responses from individuals and organisations.

A joint committee of PCTs (constituting one representative from each PCT board) met in public in June 2008 to agree a set of recommendations based on the results of the consultation. It made decisions on taking the Healthcare for London proposals forward, with an emphasis on quality, safety, outcomes and patient experience.

Key decisions were:
- Consolidation of acute specialist care: stroke, trauma, complex emergency surgery, specialist children’s services;
- Primary and community care: improved access, enhanced integration, broader range of services;
- Implementation of the polyclinic service model. (The nature, location and precise services will be subject to appropriate local consultation.)
- New models of care: maternity, children, mental health, end-of-life care and long-term conditions;
- Focus on (and investment in) health improvement and health inequalities.

Unscheduled care is one of the six early priority project workstreams; and has been informed by the results of Consulting the Capital.
1.1 Unscheduled care: project scope and work to date

The first phase of the unscheduled care project (between February and September 2008) was designed to:
• improve understanding of current unscheduled care arrangements in the capital;
• explore how unscheduled care could be improved by commissioning the models of care and delivery proposed in Healthcare for London: A Framework for Action alongside other identified improvement opportunities.

Healthcare for London’s approach included an in-depth examination of unscheduled care systems in six PCTs across London, involving significant stakeholder engagement.

This was complemented by additional pan-London analysis; a review of key policy and literature; discussions with other stakeholders; and a review of Consulting the Capital responses.

A strong case for change was identified:
• Earlier intervention and support could prevent people choosing to enter (or defaulting to) the unscheduled care system to have their needs met;
• Access to care needs to improve and be more responsive to patients’ needs and expectations;
• The system needs to be less complex and easier for patients (and staff) to understand and use;
• Standards and quality could be more consistent and improved across the spectrum of care in community and hospital services.
• Improving the way that the unscheduled care system works as a whole will improve care and patient experience and make better use of resources; the system should be designed around patients not organisational boundaries or institutions.
This Healthcare for London guidance for London’s primary care trusts (PCTs) is designed to support the development of unscheduled care commissioning and commissioning strategy plans (CSPs) in London. It sets out a new delivery model for unscheduled care that has been developed through the Healthcare for London unscheduled care project.

The model takes a tiered approach which encompasses three broad responses to patients’ unscheduled care needs: rapid/moderate, urgent and emergency.

The range of service models within local unscheduled care systems should be broadly consistent. One size does not fit all, but there are many common features in the delivery model which should be present in every system. There also needs to be far greater uniformity in the terminology used to describe access points and the associated services they provide. This should improve navigation and reduce confusion for the public, contribute to equity of access, and deliver greater consistency of standards across London.

The London Commissioning Group has endorsed this delivery model as the framework for unscheduled care commissioning in London. To ensure opportunities for improvements are realised, every PCT should agree a five-year unscheduled care strategy which sets out key milestones to implementation. The 2008 commissioning strategy plans should reflect this. To be effective, local plans need to demonstrate how an integrated service will be enabled.

### 1.2 Future focus

The next stage of the unscheduled care project (between October and December 2008) will include the following activity:

- Developing a commissioning toolkit for unscheduled care to support PCTs in commissioning the new delivery model; and in promoting a consistent approach across London.
  
  The unscheduled care project commissioning group will advise on content and oversee development of the toolkit to ensure it focuses on areas that will be of greatest assistance to PCTs;

- Scoping a pilot project to test and evaluate a single point of telephone access (for non-emergency) in one area of London;

- Further work on enablers to support the delivery model;

- Continuing to ensure alignment with other Healthcare for London initiatives.
This Healthcare for London guidance for London’s primary care trusts (PCTs) is designed to support development of unscheduled care commissioning and commissioning strategy plans (CSPs) in London. It sets out a new delivery model for unscheduled care which has been developed through the Healthcare for London unscheduled care project.

Healthcare for London: A Framework for Action highlighted that every year millions of Londoners have non-life-threatening short-term illnesses or health problems for which they need prompt and convenient treatment or advice. A much smaller number of Londoners suffer from serious illness or have a major injury which requires swift access to highly-skilled, specialist care to give them the best chance of survival and recovery. To meet all of these needs, the NHS in London must improve access to timely and appropriate care, information and advice across the 24-hour period.

The first phase of the unscheduled care project (between February and September 2008) was designed to:

- improve understanding of current unscheduled care arrangements in the capital;
- explore how unscheduled care could be improved by commissioning the models of care and delivery proposed in Healthcare for London: A Framework for Action alongside other identified improvement opportunities.
The project's approach included an in-depth examination of unscheduled care systems in six PCTs across London. This work involved significant stakeholder engagement, including with patients and the public. It was complemented by additional pan-London analysis; a review of key policy and literature; discussions with other stakeholders; and a review of Consulting the Capital responses.

A summary of the case for change based on this work is presented in this document. A more detailed paper on the case for change, which sets out and references key findings from the project, will be published on the Healthcare for London website: www.healthcareforlondon.nhs.uk.

In response to the case for change, Healthcare for London has developed a new delivery model for unscheduled care in the capital. The core objective is to ensure that when someone has an unscheduled care need, he or she (or a parent or carer) knows how to get help, and receives prompt and rigorous assessment in a consistent way, followed by the right care, in the right place, at the right time. It requires all the different elements of unscheduled care to function as a whole system. Achieving this would significantly improve patient experience and outcomes.

The delivery model has been shared and developed with clinical stakeholders, patients and the public, and commissioners – and received broad support. Further engagement will be needed to support implementation.

The London Commissioning Group (LCG) has endorsed the delivery model as the framework within which unscheduled care systems should be developed and commissioned across London.

The unscheduled care project will undertake further work to develop and refine the delivery model and to support PCTs in commissioning it. This will include the development of a commissioning toolkit for unscheduled care, guided by the project's commissioning group.

It is recognised that for many PCTs and partner organisations, many aspects of the delivery model are not new, and reflect their current direction of travel and commissioning plans. The delivery model should, however, support greater consistency in the approach to commissioning unscheduled care across London and the development of clearer pathways of care which will help patients and the public to understand and navigate the system.
The case for change

The unscheduled care project identified the following five key areas:

- More can be done to prevent people choosing to enter (or defaulting to) the unscheduled care system to have their needs met
- Access to care needs to improve and be more responsive to patients’ needs and expectations
- The system needs to be less complex and easier to understand and navigate for patients and staff
- Standards and quality can be more consistent and improved across the spectrum of care in community and hospital services
- Improving the way the system works as a whole will improve care and patient experience and make better use of resources
### What needs to improve

- There needs to be a greater focus on supporting self-management and promoting independence.
- A&E attendances and admissions continue to rise – London has the highest rates in England and many could be avoided.
- Earlier resolution of patients’ needs may reduce repeat attendance and improve patient experience.
- Better access to scheduled care would prevent unscheduled care services being used as an alternative.
- There needs to be stronger and ongoing interaction with the voluntary sector, homeless organisations, care homes, hospices and prisons.

### Implications for the delivery model

- Support for self-management and access to tools which enable this, such as the NHS Direct website, need to expand.
- Community provision needs to expand to increase delivery of pre-emptive care (especially for older people, and people with long-term conditions) and home support through integrated multi-disciplinary health- and social care teams working across organisational boundaries.
- Better integration between community services and social care to provide rapid assessment and support would prevent patients moving further into the unscheduled care system.
- Acute assessment services should be developed to ensure prompt access to enhanced assessment and decision-making skills; and to prevent admission or facilitate early discharge wherever possible. This needs to be supported by 24/7 access to diagnostics. The needs of older people and children require a particular focus.
- Triage/assessment skills and protocols need to be developed more broadly to improve case management and tracking; critically this needs to be supported by better information capture and timely flow.
- More capacity is required in primary care services and at more convenient times for patients.
- A&E attendances and admissions continue to rise – London has the highest rates in England and many could be avoided.
- Earlier resolution of patients’ needs may reduce repeat attendance and improve patient experience.
- Better access to scheduled care would prevent unscheduled care services being used as an alternative.
- There needs to be stronger and ongoing interaction with the voluntary sector, homeless organisations, care homes, hospices and prisons.
3.2 Access to care needs to improve and be more responsive to patients’ needs and expectations

<table>
<thead>
<tr>
<th>What needs to improve</th>
<th>Implications for the delivery model</th>
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<tbody>
<tr>
<td>Accessibility and availability of urgent care needs to improve to meet the needs of people attending A&amp;E with primary and urgent care needs. There needs to be more consistency in provision and equity of access.</td>
<td><strong>Urgent Care Centres (UCCs)</strong> should be established to deal with undifferentiated primary care and urgent care caseload at the front of A&amp;E departments in hospitals. The UCCs should be integrated with the emergency department and operate within a common framework of standards and governance. UCCs should provide multi-disciplinary care, with GPs, nurses, midwives, emergency care practitioners, mental health practitioners and social care staff; and develop a strong interface with community services. Access to the same range of urgent care services is also required in the community to address inequalities in access, offer choice and meet rising demand.</td>
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<td>GP and other primary care services need to be available and accessible at times more convenient to patients.</td>
<td>The role and function of walk-in centres (WiCs) and minor injury units (MIUs) should be reviewed. These could be developed into UCCs, subject to local need and capacity and demand across the system.</td>
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<td>The number of people not registered with a GP needs to be reduced.</td>
<td>An increase in access points and new ways of delivering care are needed. This is recognised in developments already underway (such as polyclinic proposals and GP-led health centres). These should be supported; and further expansion, or acceleration, may be needed. Evaluation of newly-commissioned capacity is required for unscheduled and scheduled care in primary care services and within routine weekday hours and extended hours.</td>
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<td>Up to 50% of people currently conveyed to hospital by the London Ambulance Service could be treated at the scene or in community settings.</td>
<td>A primary care access/GP registration function (or direct access to it) is required at every walk-in access point to support the non-registered population to access universal primary care services.</td>
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<td>Better access to diagnostics in local settings would speed up care, reduce steps in the patient journey and cut down on duplication of episodes of care.</td>
<td>Clinically appropriate and cost-effective pathways supported by associated protocols need to be developed and staff appropriately trained to establish see and treat, including conveyance to community sites such as polyclinics.</td>
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<td>Pharmacies are an under-used resource and offer potential for local and very accessible care and advice.</td>
<td>There needs to be faster and extended access to diagnostic tests and prompt return of results in and out of hospital settings (within four hours). These need to be easily accessible to a wide range of primary care services. Access to diagnostics needs to be matched to the needs of related services; access to the most frequently required tests should be available 24/7.</td>
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<td>Quicker access to social care (including equipment, telecare and personal care) both pre- and post A&amp;E attendance.</td>
<td>Pharmacies need to be firmly integrated into unscheduled care systems. Enhanced availability of dispensing facilities (24/7) is needed to improve access to prescription medicines. There should be wide roll-out of the minor ailments scheme, medicines management linked to admission prevention/discharge, plus self-care advice.</td>
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<td>Access to community equipment, such as mobility aids; or to support administration of medication (12-18 hour response for common items); and telecare (24/7) (for example, remote monitoring via alarms or sensors to enable independent living), needs to be expanded.</td>
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<td>A system needs to be developed in which frontline professionals can ‘order’ immediate basic care packages.</td>
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### 3.3 The system needs to be less complex and easier to understand and navigate for patients and staff

**What needs to improve**

- Clear, easily accessible information about all services is needed to support patients, carers and the public in making informed choices about accessing care; and to be directed to the access point that best meets assessed need as promptly as possible. A source of advice is also needed for staff to support patients and carers to navigate the system.

- There should be greater emphasis on development and promotion of telephone advice.

- Better mechanisms are required to ensure people have the information they need, when they need it.

- Demand can be better managed at first point of access, whether face-to-face or by telephone.

**Implications for the delivery model**

- More consistency in service design and terminology is required to facilitate patient and staff understanding of the range and scope of services offered.

- A single point of 24/7 telephone access for urgent care and advice. This would enable integrated processes and achieve a consistent and co-ordinated response across call handling operations (a virtual response hub) – potentially incorporating social care teams. The system should be capable of incorporating local knowledge and context. A capacity management system could enable provision of high-quality real-time information to support the system. Over time, it could be enhanced by direct booking capability to access points along the unscheduled care pathway. A three-digit telephone number for London is not possible outside a national solution. An easily-remembered alternative (such as six digits) could be explored. Testing the feasibility of underpinning technical infrastructure and processes will be a necessary first step.

- Telephone clinics in GP surgeries should be evaluated and expanded if indicated benefits are demonstrated (such as more convenience for patients, patient satisfaction, and better use of clinician time).

- Triage and assessment capability needs to be available at every access point, with clear protocols for onward referral if this is assessed as a requirement. Transfer and transport arrangements will need to be improved to support patients triaged from one access point to another.
3.4 Standards and quality can be more consistent and improved across the spectrum of care in community and hospital services

**What needs to improve**

- Outcomes for some seriously ill patients can be improved if the specialised services and treatment required are concentrated on fewer sites.
- Increasing specialisation (and in some cases, relatively low volumes) in emergency surgery means that high-quality services cannot be sustained around the clock at all current sites.
- The current configuration of children’s inpatient services is not safely sustainable.
- All services should comply with minimum standards regardless of where and when care is accessed.
- Quality of care and patient experience would be enhanced by improved data capture, data sharing and timely flow across access points and services.
- There need to be flexible governance arrangements that can stretch across the whole pathway.
- Facilities need to be clean and well-maintained and patients should be treated with dignity.

**Implications for the delivery model**

- London should develop a trauma system based on trauma networks to deliver quality care across the whole pathway (pre-hospital care, hospital care, rehabilitation).
- Hyper-acute units should be established for interventional stroke care, with specialist multi-disciplinary teams able to provide CT scans 24/7, appropriate neuroscience expertise and early intensive therapy. Care should be provided in the context of the whole pathway, including rehabilitation.
- Emergency surgery should be provided in fewer centres with higher volumes; this could potentially involve maintaining medicine and emergency departments without 24-hour on-site surgery.
- Emergency care for children should be provided in fewer centres with higher volumes. This could involve establishing paediatric assessment units on some sites co-located with urgent care centres and A&Es.
- Ambulance by-pass protocols will need to be put in place to support development of specialised services and there will be an increase in hospital transfers and the need for associated development of expert transfer teams.
- Improved IT connectivity is needed to underpin service delivery and performance.
- Development of specialised services will necessitate development of robust networking arrangements with clarity about roles and functions and strong clinical leadership.
- Facilities need to be well-designed and staff trained appropriately. Outcome measures should encompass these criteria.
3.5 Improving the way the system works as a whole will improve care, patient experience and make better use of resources

### What needs to improve

- The unscheduled care system is fragmented with potential duplication and poor utilisation of services delivered by different organisations.
- Staff roles and skill mix need to be developed to enhance opportunities, capacity and flexibility.
- Greater recognition is required of the fact that a significant number of people access unscheduled care with mental health problems and alcohol and substance misuse. An improved response is needed for vulnerable people, including those with disabilities or in a confused state (either temporarily or longer term).
- A response is needed to the increase in unscheduled maternity care reported across London trusts.
- Demand and capacity are not as well aligned and managed as they could be.
- Resources could be used more effectively across the system; where appropriate, seeing patients in less acute settings has clear cost advantages.
- There need to be flexible governance arrangements that can stretch across the whole pathway.

### Implications for the delivery model

- Greater integration and consistency is needed to bring primary, secondary and social care processes and working arrangements closer together; challenges that will need to be addressed include working across boundaries, effectiveness and compatibility of IT systems and funding mechanisms. There should be an integrated approach to training and education, including staff rotations between access points.
- A system-wide view of opening times is needed to match and reflect peaks and troughs in demand, and the system should be supported by a single point of telephone access. Differences in volume ratio mean that a small shift in activity from GPs/primary care will have a significant impact on other parts of the system, including costs. Robust and consistent processes are needed to benchmark quality and costs across the whole system, supported by better, more consistent, data sets.
- The right balance needs to be struck between prevention, access and navigation; and the optimal configuration of services needs to be considered. For example, co-location of UCCs and out-of-hours services can improve integration and simplify access.
- A whole-system and extended service model must include mental health, substance misuse, and maternity care – and be more responsive to the needs of vulnerable people, such as patients in a confused state; or people with disabilities and complex needs.
- Consistent terms for services are needed to overcome the current confusion that exists around roles and functions.
A new delivery model for unscheduled care

Principles

The delivery model that has been developed for unscheduled care across London is underpinned by the following eight principles:

- The approach to care should be shaped around patients’ and carers’ needs and expectations. For example, patients and the public have highlighted cleanliness and dignity as particularly important, and these need to be considered when commissioning services;
- Developments should aim to reduce inequalities in access and improve choice, patient experience and outcomes – and these should be continuously assessed;
- Services should be delivered within a whole-systems model which includes prevention and self-care;
- Collaborative working arrangements, common protocols and processes and consistent standards across different access points are essential features of an effective system;
- Patients/carers should expect 24/7 consistent and rigorous assessment of the urgency of their need and an appropriate and prompt response – the system needs to ensure there is timely access to appropriate clinical expertise for assessments to be done;
- The response should support patients and carers to access the most appropriate service to meet their assessed need within a suitable timeframe – and follow through to conclusion;
- Care should be delivered in community settings close to home wherever possible – and at home whenever appropriate;
- Some care can only be provided in hospitals; specialised care should be concentrated in fewer centres than now to improve standards and outcomes.
4.1 The pathway of care

The diagram below illustrates the pathway of care we are aiming to achieve.

- **Need for care identified**: By self, By carer, By professional, By other method

- **Need assessed**: By telephone, By face-to-face

- **Right response initiated**: Emergency response, Urgent response, Rapid/moderate response

- **Follow through to closure**: Episode complete, Planned follow-up, Ongoing care

Service contacted by phone or face-to-face – information easily available via London/local campaigns

Information and patient data captured and shared as necessary – patients give details only once

Information recorded and flows with the patient – need resolved at first contact wherever possible

Information flows with patient – always copied to GP (patients without GP can easily be registered)
4.2 A tiered approach within a whole-systems model

**Emergency response**
- Some specialised services in fewer hospitals
- Access to all types of care 24/7
  - Some sites could operate less than 24/7 as part of a network arrangement;
  - Specialised services would be provided in designated centres only

**Urgent response**
- In hospitals and some community settings
  - e.g. urgent care centres, polyclinics
- Access to all types of care 24/7
  - Some sites could operate less than 24/7 subject to local needs

**Rapid/moderate response**
- Mostly community-based
  - e.g. home*, polyclinics, with some hospitals in-reach
- Access to all types of care 12/24 (minimum) and some 18/24

**Integrated health- and social care system supported by:**
- Consistent standards, common processes, shared protocols
- Integrated IT infrastructure, real-time data capture and timely flow
- Integrated capacity management
- Single point of (telephone) access for non-emergency care
- Integrated workforce training, education and rotations across the system
- Operational and strategic networks
- Community-wide view on opening times to match demand capacity

*Home includes care home and specialist supported accommodation
The delivery model described in this document is a tiered approach encompassing three broad responses to patients’ unscheduled care needs: rapid/moderate, urgent and emergency. Most services, as now, would be community-based. Regardless of location, services should function as a single system, supported by shared processes and infrastructure.

Figure 4.2 illustrates key services that should be available within each tier of response; where services should be provided; and when services should be available. The range of service models within local unscheduled care systems should be broadly consistent. One size does not fit all, but there are many common features which should be present in every system. There needs to be far greater uniformity in the terminology used to describe access points and the associated services they provide. This should improve navigation and reduce confusion for the public, contribute to equity of access and deliver greater consistency of standards.
Whole-system working

Key features
Greater integration across the whole system achieved by:

- Consistent standards, common and coherent processes, shared protocols;
- Consistent definitions and terms;
- Integrated IT infrastructure, real-time data capture and timely flow;
- Single point of (telephone) access;
- Integrated capacity management;
- Integrated workforce training and education; rotations across the system;
- Community-wide view on opening times to match demand and capacity;
- Development of effective networks with clarity of roles encompassing operational and strategic functions.

Integrated health- and social care system supported by:

- Consistent standards, common processes, shared protocols
- Integrated IT infrastructure, real-time data capture and timely flow
- Integrated capacity management
- Single point of (telephone) access for non-emergency care
- Integrated workforce training, education and rotations across the system
- Operational and strategic networks
- Community-wide view on opening times to match demand capacity

It is essential that people are enabled to make an informed choice about the access point which could best meet their need, or perceived need, through provision of clear, accessible information about services and how to get to them. This applies to both the public and staff.

A whole-system approach should minimise the number of steps in the process between initial contact with a service, assessment, and resolution of presenting need.

In developing the whole-system approach, the particular needs of older people and children/young people need to be recognised. Appropriate recognition of mental health issues is also essential.

There is significant potential to improve access through a more joined-up and strategic approach to how the system works as a whole. This will improve the integration and co-ordination of services between access points and the transfer of patient information across these access points.
Rapid/moderate response

Key features

- Increased access to primary care services for scheduled and unscheduled care, progressing the development of GP-led health centres, polyclinics (including increase in GP numbers, increasing role for nurses and therapists, increasing use of telephone consultation and advice, and some extended hours);

- Increased number of access points offering walk-in services for registered and unregistered patients – for scheduled and unscheduled care. (For example, through polyclinics);

- Prompt and extended access to the most frequently required diagnostics (ECGs, X-rays, blood tests) and speedy return of results (within four hours);

- Expanded (by size and scope), integrated health- and social care teams, available beyond 9am-5pm and at weekends – with clear referral protocols and rapid access, increasing roles for nurses and therapists;

- More pharmacies providing care treatment and advice with a greater range of services and increased dispensing facilities.

General practice environments can and do cope with the majority of unscheduled care. For patients, improving access to GPs means more convenient opening hours and extended hours at evenings and weekends. Prompt and extended access to diagnostic tests and results is also essential.

Integrated health- and social care teams should be available to provide pre-emptive care and to respond quickly to prevent needs escalating, also operating extended hours.

This tier of the system should provide a primary and community care response for scheduled and unscheduled care needs with some access points available between 8am and 8pm, including walk-in services for unregistered patients and with enhanced facilities available. Some services will need to be available beyond these hours, including access to community equipment where the aim should be a 12 to 18-hour response for common items; and telecare, which should be available 24/7.

Pathways and incentives should be developed that support case completion at the earliest point in the patient journey. A broader range of integrated community teams (in terms of service scope and operating hours) should be available.

The capacity and capability of pharmacies, already a significant part of unscheduled care and advice, should be developed further. Increasingly, the response to rapid/moderate unscheduled care needs will be delivered through a polyclinic model.

*Home includes care home and specialist supported accommodation
In hospitals and some community settings
- e.g. urgent care centres, polyclinics

Access to all types of care 24/7
- Some sites could operate less than 24/7 subject to local needs

Key features
- Urgent care centres at the front end of every emergency department. These should be staffed by multidisciplinary teams including GPs, nurses, emergency care practitioners, as well as staff skilled in dealing with maternity, substance misuse and mental health problems; together with an equivalent range of community-based urgent care services networked to UCCs;
- Out-of-hours services, ideally co-located with UCCs;
- Urgent care by telephone (24/7) – providing an integrated and consistent response;
- Acute assessment services co-located with every emergency department, including specialist assessments and teams for older people;
- Paediatric assessment units co-located with UCCs;
- Prompt and extended access to diagnostics (24/7) and dispensing (potentially 24/7);
- Integrated (health- and social care) rapid response teams (the same teams providing a routine/moderate response);
- Clinically appropriate pathways to enable paramedics/emergency care practitioners to treat at the scene or take patients by ambulance to non-hospital providers;
- Crisis resolution; home treatment and acute mental health liaison services.

This tier of the system needs to provide a wider range of more appropriate community responses to patients who have urgent needs; providing them – and their carers – with better local sensitivity from community provision (including social care).

A key feature of the services to be provided in this tier is the commissioning of urgent care centres at the front end of A&E departments to provide an improved and focused response to people who attend with primary and urgent care needs. UCCs should be integrated with emergency departments and operate within a common framework of standards and governance. To address issues of equity and choice, and to meet rising demand, access to the same range of urgent care services should be available in the community.
Urgent care services in hospital and community settings should function as part of a networked model with common protocols and standards.

Other key features of the urgent care response include prompt and extended access to diagnostics and dispensing (24/7 recommended for both); clinically appropriate pathways to enable ambulance crews with enhanced training to assess and treat at the scene, or convey patients to non-hospital providers; and urgent care, advice and navigation by telephone.

**Urgent care services**

- **To effectively meet the needs of people currently attending A&E with primary and urgent care needs,** urgent care centres (UCCs) should be commissioned as the front end of A&E departments. Urgent care centres should provide multidisciplinary care using GPs, nurses, midwives, emergency care practitioners, mental health practitioners and social care staff.
- **UCCs need to be effectively integrated with the emergency department.** Further work is needed to develop the detail of a service specification and delivery model options; where UCCs are at the front end of A&E departments, patients who self-refer will present to the UCC for initial streaming and assessment – and be triaged into A&E if assessed to be appropriate.
- **In this model, the A&E department would become more akin to the US model of an ‘emergency room’ or ‘emergency department’.** Where patients arrive by ambulance, the initial streaming decision will be made by the ambulance crew, in accordance with agreed protocols, as to whether the patient should be brought directly to the emergency department or taken to the UCC.
- **The way UCCs are integrated with emergency departments may vary depending on local circumstances, but they will be expected to operate to common standards and governance arrangements to ensure a seamless and consistent service is provided to patients 24/7.**
- **A key role is envisaged for emergency medicine consultants in supporting UCCs; and there is expected to be opportunity for some staff to work in both the UCC and emergency department, including training rotations for junior staff.**
- **UCCs at the front of A&E departments may be part of a hospital-based polyclinic.** Where the UCC is not part of a hospital-based polyclinic it is expected that it would be networked with urgent care services in community-based polyclinics (see below).
- **Enhancing urgent care in the community – through polyclinic centres – should reduce inequalities through better access, and help to address rising demand.** Urgent care in community settings should provide access to the same range of services as UCCs on hospital sites, including extended access to diagnostics and dispensing, and the ability to transfer patients to emergency departments where necessary.
- **Urgent care services in the community are expected to be provided through polyclinic centres and operate for a minimum of 12 hours a day, seven days a week, 365 days a year.** Longer operating hours may need to be considered subject to local need.

- **Urgent care services in hospital and community settings should function as part of a networked model with common protocols and standards.**
• All urgent care services (whether provided through a hospital-based UCC or a polyclinic centre) should provide a consistent service and operate to the same standards. A common offering to patients that is consistently delivered will make services easier to access and understand. Close working relationships between hospital-based UCCs and urgent care services in community settings will need to be enabled. These should include ambulance services. Mechanisms should be established to ensure consistency of approach, such as staff rotations and joint training, and the development of protocols.

• All urgent care services (wherever located) should ensure patients receive a consistent and rigorous assessment of the urgency of their need – and an appropriate and prompt response. The particular clinical discipline of the professionals that do the streaming and triage will not be important as long as these protocols are carried out consistently and rapidly by professionals with appropriate competencies.

• All urgent care services should have facilities that enable patients to register with GP practices. They should have strong links with providers that deliver services in the community to enable ongoing and integrated care.

• Where feasible, ambulance stations and staff may be co-located with UCCs, or polyclinic centres. This would enable emergency care practitioners and paramedics to use the UCC, or polyclinic centre, as their base for travelling out to provide see and treat services to urgent care callers.

• It is anticipated that a number of existing services will be integrated with UCCs or the urgent care services provided by polyclinic centres. GP out-of-hours services could be co-located with, or be part of, a UCC or polyclinic centre, to improve integration and simplify access. Out-of-hours services would still be expected to provide appropriate domiciliary visits (for end-of-life care, for example). Existing walk-in-centres and minor injury units could also be developed into, or replaced by, UCCs or polyclinic centres.

• A more detailed service specification for UCCs will be developed as part of the next stage of the Healthcare for London unscheduled care project to support PCTs in commissioning UCCs.

Appropriate clinical governance arrangements for UCCs and urgent care services provided in the community will also be considered. It is strongly recommended that all services offering unscheduled care, including urgent care services in community settings, should be networked to an emergency department for professional support, clinical supervision, training and advice on standard-setting and outcome measurement.
Emergency response

Key features
- A&E services, some designated as specialist centres. For example, for primary angioplasty, stroke, and major trauma;
- Consolidation of emergency surgery in fewer centres;
- Consolidation of emergency services for children in fewer centres;
- Acute assessment services available to support every emergency department – including specialist assessments and teams for older people with access to 24/7 diagnostics;
- 24/7 access to acute medical service/senior clinical decision-makers;
- 24/7 access to surgical opinion;
- Emergency ambulance services operating pre-hospital care and bypass protocols for some emergency responses;
- Crisis resolution and home treatment; and acute mental health liaison services;
- Consistent assessment and response at all access points;
- Ability to provide an effective first line emergency response.

In an emergency, a fast, co-ordinated response and rapid access to senior clinical decision-makers improves outcomes. A consistent service needs to be available around the clock. The benefits of specialised centres are shaping the way that some services are configured. Centralised expertise will result in new pathways being commissioned. For example, in some emergencies patients will bypass the nearest local hospital, and be taken by highly trained paramedics straight to specialist centres. This will require redesign of A&E pathways in some hospitals. This potentially includes maintaining medicine without 24-hour on-site surgery. Possible models have been identified for this; A&E services at local hospitals without emergency surgery would need to have emergency doctors able to resuscitate, intubate and ventilate patients who may then need to be transferred for emergency surgery. Clear protocols would also be needed to support the care for, and transfer of, patients between sites, as necessary. There is a need to develop expert transfer teams for very ill patients.
4.3 Commissioning implications

- **Local partnerships for planning and delivery**
  Successful implementation of this delivery model will require a co-ordinated commissioning approach across health- and social care, covering primary, community, ambulance, acute, mental health and social care services.
  This could be led at borough or sector level, as agreed locally among PCTs; either option will require a very strong interface between relevant borough and sector functions. PCTs will need to work closely with local authorities on the commissioning and delivery of their local strategy; and further work is needed to ensure local authorities are able to invest in alternatives to acute care where appropriate. PCTs also need to consider the integration at the primary/secondary care interface, particularly across borough boundaries where flows to acute trusts are shared.

- **Patient and public priorities**
  The delivery model described in this guidance reflects the majority of areas that patients and the public have identified as important to them in the delivery of unscheduled care.
  However, the model does not specifically focus on cleanliness, dignity, or security – which patients and the public have identified as key success criteria. They are mentioned here to inform commissioning of specific services locally.

- **Cost**
  The cost of implementing the delivery model will vary from one PCT to another depending on existing arrangements. It is anticipated that there will be changes to the A&E tariff in 2009/10; and the unscheduled care project team intends to undertake some initial work exploring the implications of the new tariff for the delivery model.
  Whilst cost and affordability are identified as a risk, the project has also identified opportunities for efficiencies and more effective use of resources within the system which present ways to mitigate this risk. These include minimising hospital attendance and admissions by focusing on the urgent care needs of older people, management of long-term conditions, and ambulatory care sensitive conditions.
  The commissioning toolkit being developed through the next stage of the unscheduled care project will include some guidance for PCTs in assessing and quantifying the costs and benefits of the delivery model.
  (For more detail, see section 5 of this document: Next steps)
Consistency
It is recognised that the delivery model set out in this paper reflects the direction of travel for many PCTs’ strategies. However, the stage of strategy development for unscheduled care varies across London, and the approach can be inconsistent. Whilst acknowledging that one size does not fit all, the model sets the expectation of common features and a consistent approach – in particular to improve access and understanding for patients and the public.

To realise opportunities for improvement, every PCT should agree a five-year unscheduled care strategy which sets out key milestones to implementation. The project’s findings suggest that to be effective, plans should be able to demonstrate how integration will be achieved.

Integration, information and access
PCT strategies should reflect locally-agreed priorities. To inform local planning, the diagnostic work carried out through the unscheduled care project identified a number of areas where early focus may be helpful:

- Developing arrangements for urgent care, including plans to respond to the urgent care needs of older people;
- Continuing to improve access to GP and primary services so that unscheduled care is embedded within strategies for out-of-hospital care and reflected in local approaches to primary care, including polyclinics;
- Improving the availability and accessibility of information about local services for patients and the public (and staff) to help them navigate the system better;
- Improving the quality and use of patient information to strengthen pathways of care and support performance. (For example, greater focus on repeat attendances);
- Focus on management of long-term conditions and ambulatory care sensitive conditions.
In its next phase, the unscheduled care project will focus on delivering the following key activities and products:

- **A commissioning toolkit for unscheduled care**
  A commissioning toolkit will be developed to support PCTs in commissioning the new delivery model and promote a consistent approach across London. The unscheduled care project commissioning group will provide advice on the content of the toolkit based on what they expect will be of greatest benefit to PCTs to be developed on a pan-London basis.

  The toolkit is likely to be issued on a modular basis, with the first module produced in early 2009. The content of the initial guidance is expected to include:

  - Case studies of good practice for commissioning services. This component will be aimed at reducing demand for unscheduled care and enabling rapid discharge following unscheduled care admissions – including guidance on achieving greater integration with social care;
  - A core service specification for an urgent care centre (UCC) informed by existing models in London and elsewhere;
  - Guidance on governance arrangements for urgent care service provision across primary care and secondary care;
  - Service standards, outcome measures and guidance on benchmarking to support commissioning of unscheduled care services;
  - Guidance on assessing and quantifying the costs and benefits of the delivery model informed by an initial assessment of the implications of the new A&E tariff.

  Future modules will need to include guidance and tools for improving understanding about, and simplifying access to, the system. This will include considering the information needs of patients and staff; and will need to be informed by the services specification for UCCs and the urgent care services that are provided in the community – for instance, through polyclinics.

- **An evaluation approach for the new delivery model**
  It will be important to put mechanisms in place to capture and disseminate learning about different models of care, commissioning approaches and the impact they have as commissioning strategies are implemented.

  In the case of urgent care services the evaluation approach will need to be aligned with the evaluation framework being developed for polyclinics.
Assessment of enablers to support the delivery model

To support delivery, the project will examine the implications of the model on the following key enablers in more depth:

Workforce
A number of workforce challenges will need to be addressed to enable delivery – and to develop the more integrated and flexible workforce envisaged for the future: one that is able to work across care settings;

Information and information technology
Access points need to be joined up more effectively with IT solutions to ensure patients receive seamless and co-ordinated care;

Transport
The development of more points of access for urgent care in community settings has the potential to increase the requirement for patients to be transferred, following assessment, for definitive care.

Scoping a pilot for a single point of telephone access for non-emergency care
The project will scope a pilot for an integrated call-handling system to support a single point of telephone access for non-emergency care.
The scope of providers would include NHS Direct, the London Ambulance Service and out-of-hours service providers. The work will explore the implications and benefits of establishing a single point of contact telephone number for urgent care in the capital.

Ensuring alignment with other Healthcare for London initiatives
The unscheduled care delivery model is consistent with the models of care and pathways that have been developed to date by Healthcare for London across its other five priority areas: polyclinics, local hospital, stroke, major trauma and diabetes.
The project will ensure that developments and plans for unscheduled care remain in alignment with these initiatives. The project will also work closely with new Healthcare for London workstreams exploring service delivery models and pathways for maternity care, children and young people, and mental health.
To find out more about Healthcare for London visit
www.healthcareforlondon.nhs.uk