STANDARD OPERATING PROCEDURE
URGENT COMMUNITY RESPONSE SERVICE

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VALIDITY – All local SOPS should be accessed via the Trust intranet

CHANGE RECORD

Version	Date	Change details
1.0	*Sept 2022*	*New SOP. Approved at Community Services Clinical Network Group (15 September 2022).*
1.1	*June 2024*	*Reviewed. Updated forms and leaftlets and process maps. Approved at Community Services Clinical Network Group (20 June 2024).*

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1. INTRODUCTION

Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need assessment and intervention, can get fast access to a range of health and social care professionals. This includes access to physiotherapy and occupational therapy, medication prescribing/pharmacy reviews and help with staying well-fed and hydrated.

In 2021/22, providers, commissioners and systems have taken important actions to improve the capacity and responsiveness of existing UCR services to deliver care within two hours. In line with national roll-out of the two-hour standard by April 2022, integrated care systems (ICS) should provide a consistent service at scale, from 8am to 8pm, seven days a week (at a minimum) across the full geography of each ICS.

2. PURPOSE & SCOPE

This Standard Operating Procedure explains the process to follow for Humber community services in Scarborough. Ryedale, Whitby and Pocklington, it has been developed in order to provide guidance and clarity for clinical teams within HTFT services regarding the requirement to respond to Urgent community response referrals within set timescales in line with agreed commissioning requirements. It will also support partners in understanding the scope of service. This SOP should be read in conjunction with the established pathway between Humber NHS FT and YAS & the more recently instigated SOP for YAS Low Acuity Call PUSH Model which was established to directly receive referrals from the ambulance stack where clinically appropriate. These pathways were developed in collaboration with Yorkshire Ambulance Services (YAS) and each SOP provides further information regarding scope and parameters for preventing avoidable admission. These are available via links in this SOP.

This document should be shared as part of the induction process for new starters or temporary workers involved in any of the above aspects, to ensure consistent compliance with the systems and processes. It does not replace professional judgement which must be used at all times when managing referrals and patient intervention. This SOP does not include process for urgent nursing intervention for patients who are already known to and being actively managed by Community Nursing Teams.

3. DUTIES AND RESPONSIBILITIES

Service Managers, Modern Matrons and appropriate clinical/ professional leads will ensure dissemination and implementation of the policy within the sphere of their responsibility. They should also ensure staff are supported in attending relevant training and that time is dedicated to the provision and uptake of training and sign off competencies.

Matrons/Service managers//Ward Managers have responsibility for ensuring the quality of clinical interventions and record keeping by their staff, and monitoring compliance with this policy and procedure through the supervision process.

All relevant clinical staff and Customer Access staff will familiarise themselves and follow the agreed SOP and associated guidance. They will use approved documentation on SystmOne as per policy and Standard Operating Procedures. They will make their line managers aware of barriers to implementation and completion.

4. PROCEDURE

- Available 7 days per week 08:00-20:00. Referral cut off time 18.00.
- Urgent Community response available for patients with immediate need to prevent hospital admission
- Patients must be registered with a Scarborough and Ryedale / Whitby Coast and Moors PCN or Pocklington GP practice (incl. temporary registration) to access services
- The identified health or social care need requires urgent treatment or support and can be safely delivered in the home setting
- Referrals to support discharge from hospital should be made via the hospital discharge service for intermediate care.

4.1. Inclusion and Exclusion Criteria

Inclusion

- New or acute problem (e.g., infection)
- Exacerbation of chronic condition where it can be safely treated out of hospital, but its functional consequences may mean the individual is at risk of hospital admission.
- Serious illness where treatment at home is in keeping with the persons wishes as part of a pre agreed treatment escalation plan - such as palliative care crisis
- Breakdown of unpaid carer arrangements which causes an immediate health risk to an individual e.g., main carer admitted to hospital or carer stress causing breakdown in ability to provide safe health and care support.
- Local authorities have a responsibility to respond to people experiencing a social care crisis
- Common conditions covered falls, decompensation of frailty, reduced function / deconditioning, EOL crisis support, equipment provision to reduce risk of hospital admission, unpaid carer breakdown which may lead to a health care crisis.

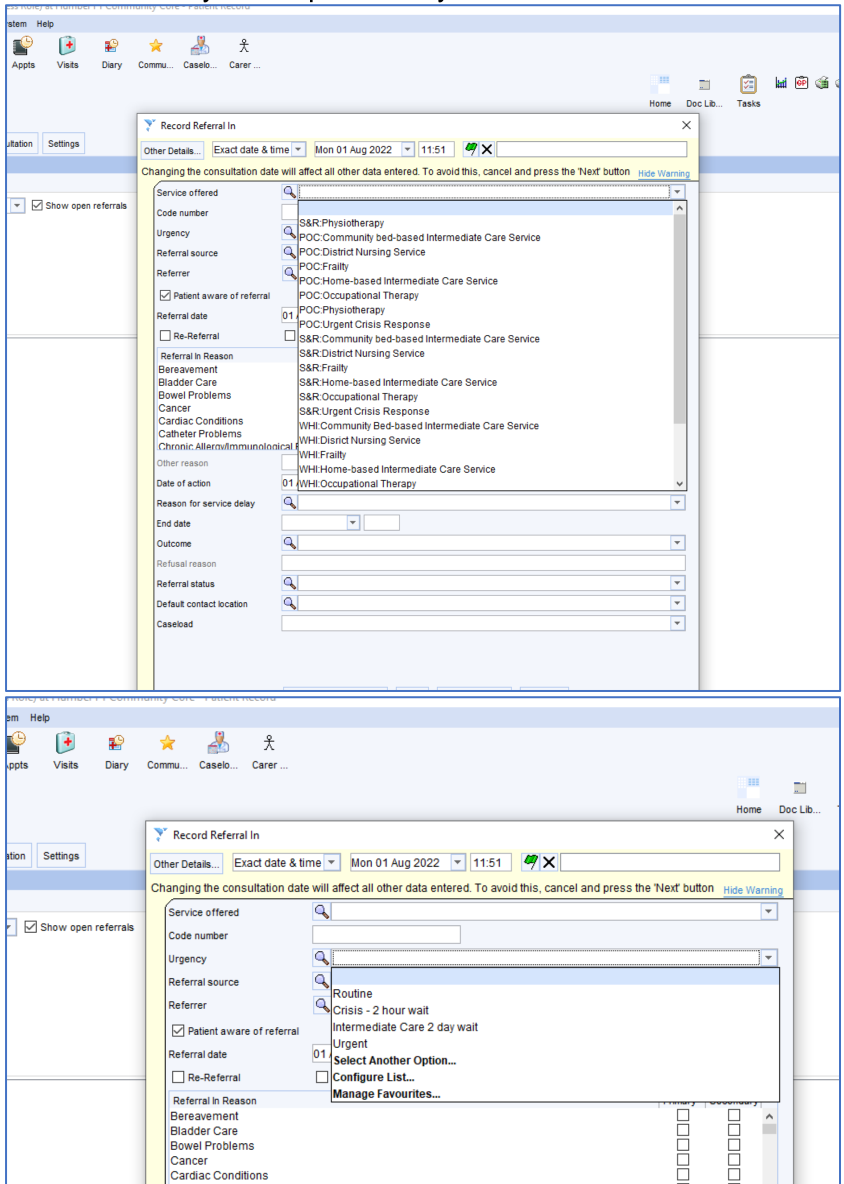
Exclusion

- Patient under 18 years old
- Patients not registered with a qualifying GP practice
- All presentations requiring a specialist or acute pathway, or not suitable for community care,
- Acutely unwell or injured requiring emergency care /intervention in an acute hospital bed
- Experiencing a mental health crisis and requiring referral / assessment by a specialist mental health team
- Needs acute / complex diagnostics and clinical intervention for patient safety in hospital
- Patients admitted to an acute setting – these referrals come to intermediate care via Hospital discharge service
- Overnight care and support needs (overnight nursing visits are available as clinically indicated across Scarborough, Ryedale and Whitby but not in the Pocklington locality)

4.2. Process

S1 referral detail required.
Referrals are created by the Single Point of Contact with the Service offered **- Urgent Crisis Response** and referral priority of **Crisis – 2 hour wait**

For each locality this is prefixed by S&R / WHI / POC



Clinical triage is undertaken by the Band 6 clinical co-ordinator in conjunction with service criteria to establish an understanding of the patients current presentation inclusive of individual social assets. The clinical co Ordinator will ensure all relevant information has been gathered and liaise with other agencies prior to contacting the clinician to allocate the visit and will fully document the triage undertaken on Sysm1 including completion of the Therapy and UCR Triage Template. The triage activity undertaken must ideally include clinical contact with the patient/carer or relative, be recorded as being completed by telephone and linked to the UCR referral.

Where the contact is with the carer or relative or other professional this should be saved as **PROXY.** Where triage ascertains that a UCR response is not required the UCR referral is ended and where applicable a referral created by the clinical co-ordinator for an alternative HTFT community service such as District Nursing, Community Therapy etc. Alternatively, where timely intervention is needed through intermediate care services in order to promote a home first approach referrals may be created with the following service offered:

Service offered **Home-based Intermediate Care Service** and referral priority of **Intermediate Care – 2 day wait**

Service offered **Community Bed -based Intermediate Care Service** and referral priority of **Intermediate Care – 2 day wait** (Not currently available in the Whitby locality)

4.3. Initial Assessment for UCR referrals

This is undertaken and documented in line with the Community Services Assessment and Documentation SOP22-007 Patients should be provided with the UCR information leaflet which provides them with contact details for the service and also helps manage expectations of service delivery. Discharge planning should commence at initial contact and timely onward referral made to social services/other agencies completed as indicated.

4.4. Appropriate delegation of care to unregistered staff

The UCR service includes band 3 Community Support Practitioners (CSPs) and band 4 Associate Practitioners who play a vital role in supporting patients to remain at home and rebuild confidence and ability. It is the responsibility of the assessing clinician to formulate robust care plans for delegation of duties and these must be recorded on Sysm1 . Any tasks which are deemed to be appropriate for delegation to CSPs must be in line with HTFT SOP for Delegation to Non Registrants available via the intranet

4.5. Responding to Falls in the Community

HTFT work in partnership with YAS to implement and support a PUSH model for referrals in to the service. A summary for the pathways is in figure 1. For further details please see this document link:

YAS Low-Acuity Call Push Model SOP

YAS

- YAS recieve call that is deemeds as low acuity and they believe meets UCR criteria. YAs navigators contacts Humber UCR via SPO

SPOC

- SPOC take demographic details of the patient and open referral on S1. Call then transferred to clinical co ordinator, if unable to transfer call then a message will be taken by SPOC.

clinical coordinator

- clinical co ordinator applies UCR triage criteria and agrees to accept or decline the referral within 30 minutes of recieving the referral. if the referral is accpeted responsibilty for contact with the patient is with Humber FT, if declined this remains with YAS.

clinical coordinator

- clinical coordinator makes contact with the patient - if the patient is within the remit for UCR service (see inclusion / exclsuoin criteria) then contact made as clinically appropriate.

clinical coordinator

- if the patient is out of scope for UCR criteria then the referral should be passed back to YAS via the clinical navigator number 03331300545. The S1 referral should then be closed and accomanying documentation completed.

clinical coordinator

- If, after a referral is accepted by the UCR team, the patient cannot be contacted by the Humber UCR clinician after two attempts with at least two minutes in between, this job **CANNOT** be closed by Humber UCR team and needs to go back to Yorkshire Ambulance Service on Clinical navigator number: **0333 130 0545**. The S1 referral should then be closed and accomanying documentation completed.

clinician

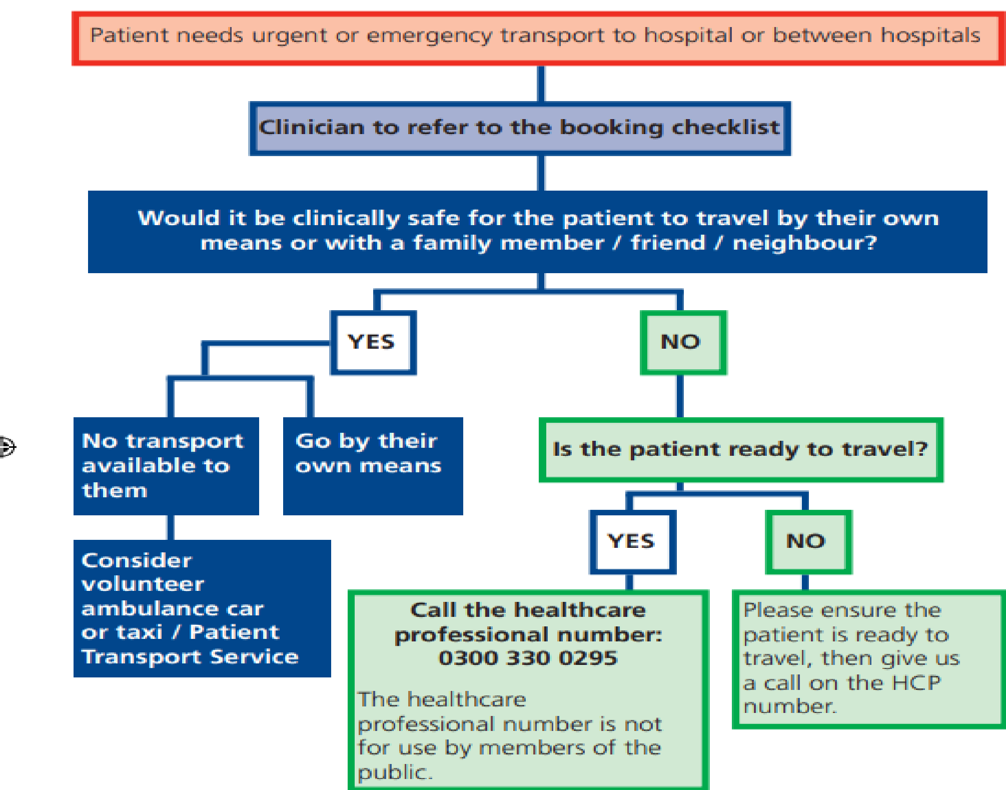
- If on further remote or face-to-face clinical assessment by the UCR service an ambulance response is deemed necessary (Urgent) but not an emergency, a call back will be made to YAS EOC by Humber UCR service (Clinical navigator number: **0333 130 0545**. Clinical responsibility for the patient remains with Humber UCR until transfer of care back to EOC is complete. The incident will then be inserted back to its original place on the CAD system queue (‘stack’), and this would not affect the despatch priority of the incident. The S1 referral should then be closed and accomanying documentation completed.

clinican

- If on further remote or face-to-face clinical assessment Humber UCR service requires an Emergency ambulance a call back will be made to YAS HCP number: **0300 3300295.**

4.6. Escalation for review in acute services

It is recognised that on assessment at times the patient may require escalation to acute services such as SDEC / A and E. If this is required the following process should be followed.



Booking checklist

Before calling, please consider whether your patient could make their own way to hospital or may be eligible for the Patient Transport Service. If not, please ensure the patient is ready to travel and that you have the following information:

Vital signs measurement or NEWS2* score		Patient's mobility (walking /wheelchair/stretcher/ incubator – including type)	
Summary of patient's condition		Provide details of any patient infections	
Name of authorising HCP		Advise if there are any family or clinical escorts	
Contact details of authorising HCP or deputy		If the patient requires medication en route, is it ready to transport?	
Location the patient needs collecting from		Could the patient travel with others as part of a multi-occupancy transfer?	
Destination (inc. ward/clinic)		Probability of clinical deterioration	
Patient's full name		Special requirements/ instructions	
Patient's NHS number		Anything else you think we need to know	

[Yorkshire Ambulance - Helpful Guide for HCPs - Foldable Leaflet for Professional Printing]

The patient should be provided with an SBARD handover and a copy should also be uploaded to S1 as per guidance set out in the Clinical digital photography.

4.7. Safety Huddle

A daily safety huddle will take place for staff in localities in line with the safety huddle SOP and any concerns should be escalated via this forum to senior members of staff.

4.8. Delays in Transfer of Care

Criteria for UCR services for patients in crisis with care needs only stipulates that support should be provided for up to 48 hours with onward care being delivered by local authority or palliative care services as indicated. Delays in the transfer of care from HTFT to these services after 48 hours should be captured on datix and via the DTOC spreadsheet held by in the UCR teams channel. Patients referred into UCR whom have Intermediate Care needs will be supported by services until rehabilitation potential is achieved. Delays in transfer of care for ongoing social care needs should also be submitted on datix and via the DTOC spreadsheet held by in the UCR teams channel

5. MONITORING COMPLIANCE AND EFFECTIVENESS

To ensure robust governance monitoring of clinical response time is captured with monthly performance reports and on exception reporting where response has not met target.

Quality and safety is monitored through monthly documentation audit and regular, individual clinical supervision with members of the UCR Service, and exception reporting from the clinical system (SystmOne).

Escalation of any concerns regarding service delivery / clinical risk would occur from team / clinical lead to therapy lead / service manager and then via relevant forums and groups specific to the issue identified see additional documents.

6. REFERENCES

Health Care Professionals' Area | Yorkshire Ambulance Service (yas.nhs.uk)

NHS England » Urgent community response services

Community - Delegation of Care to Non Registrants SOP21-027.pdf (humber.nhs.uk)

Community - Safety Huddle SOP21-028.pdf (humber.nhs.uk)

Community - Clinical Digital Photography SOP.pdf (humber.nhs.uk)

Community Services Assessment and Documentation SOP22-007

B1406-community-health-services-two-hour-urgent-community-response-standard.pdf (england.nhs.uk)

Appendix A - Urgent Community Response Guidance

- Adults over the age of 18 who are experiencing a physical health crisis which can be defined as a sudden deterioration in their health / wellbeing.
- This health or social care need requires urgent treatment or support within 2 hours and can be safely delivered in the home setting.

Inclusion Criteria - Health

- new or acute problem (eg infection)
- exacerbation of chronic condition where it can be safely treated out of hospital, but its functional consequences may mean the individual is at risk of hospital admission.
- serious illness where treatment at home is in keeping with the persons wishes as part of a pre agreed treatment escalation plan - such as palliative care crisis

Inclusion Criteria- Social

- breakdown of unpaid carer arrangements which causes an immediate health risk to an individual eg main carer admitted to hospital or carer stress causing breakdown in ability to provide safe health and care support.
- local authorities have a responsibility to respond to people experiencing a social care crisis

Exclusion Criteria

- acutely unwell or injured requiring emergency care /intervention in an acute hospital bed
- experiencing a mental health crisis and requiring referral / assessment by a specialist mental health team
- needs acute / complex diagnositcs and clinical intervention for patient safety in hospital

Referral Sources

Common conditions covered (not exhaustive)

Falls - With no apparent serious injury, including to the head, back, hip or evidence of any fracture and if there has been no loss of consciousness however care/support is required within two hours to prevent hospital admission. Lifting equipment and manual handling aids should be available to UCR teams to help a person who has fallen and needs support to get up from the floor.

Decompensation of frailty - A frailty-related condition which may result in loss of strength, speed, energy, activity, muscle mass, resilience to minor health strains and subsequent loss of independence/function including decompensation caused by a short-term stressor event, such as a urinary tract infection.

Reduced function/ deconditioning/ reduced mobility - The person may have a gradual change in functional ability or ability to manage at home and with activities of daily living. Mobility loss can also be sudden, leading to an acute need

Palliative/end-of-life crisis support – If core palliative/end-of-life care services are not available to respond, a two-hour UCR service will help maintain a person close to the end of their life at home, offering symptom control/pain relief in line with a person's wishes.

Urgent equipment provision to support a person experiencing a crisis/at risk of hospital admission- Assessment & provision of equipment to make a person safe and optimises functional ability to support prevention of admission. A person should be made safe and ongoing care provided where appropriate by reablement or rehabilitation services.

Confusion/delirium - Increased or new confusion, acute worsening of dementia and/or delirium (excluding sepsis requiring hospital admission). The patient should be assessed, and physical health needs managed to establish the cause (e.g., UTI, cellulitis, pneumonia) so that their needs are managed safety at home.

Urgent catheter care Where a person has a blocked catheter and/or pain from a catheterrelated issue and is at risk of harm and has a very high risk of admission to hospital.

Urgent support for diabetes Examples of this include urgent injections and where the person has experienced a hypoglycaemic episode (now resolved) or where blood sugar management is a concern, and the person is at risk of hospital admission as a result (excluding sepsis requiring hospital admission hyperglycaemia / ketoacidosis)

Unpaid carer breakdown which, if not resolved, will result in a healthcare crisis for the person they care for

Provide healthcare where a carer who meets a person's healthcare needs is no longer able to do this and the person, they care for now requires a two-hour UCR.

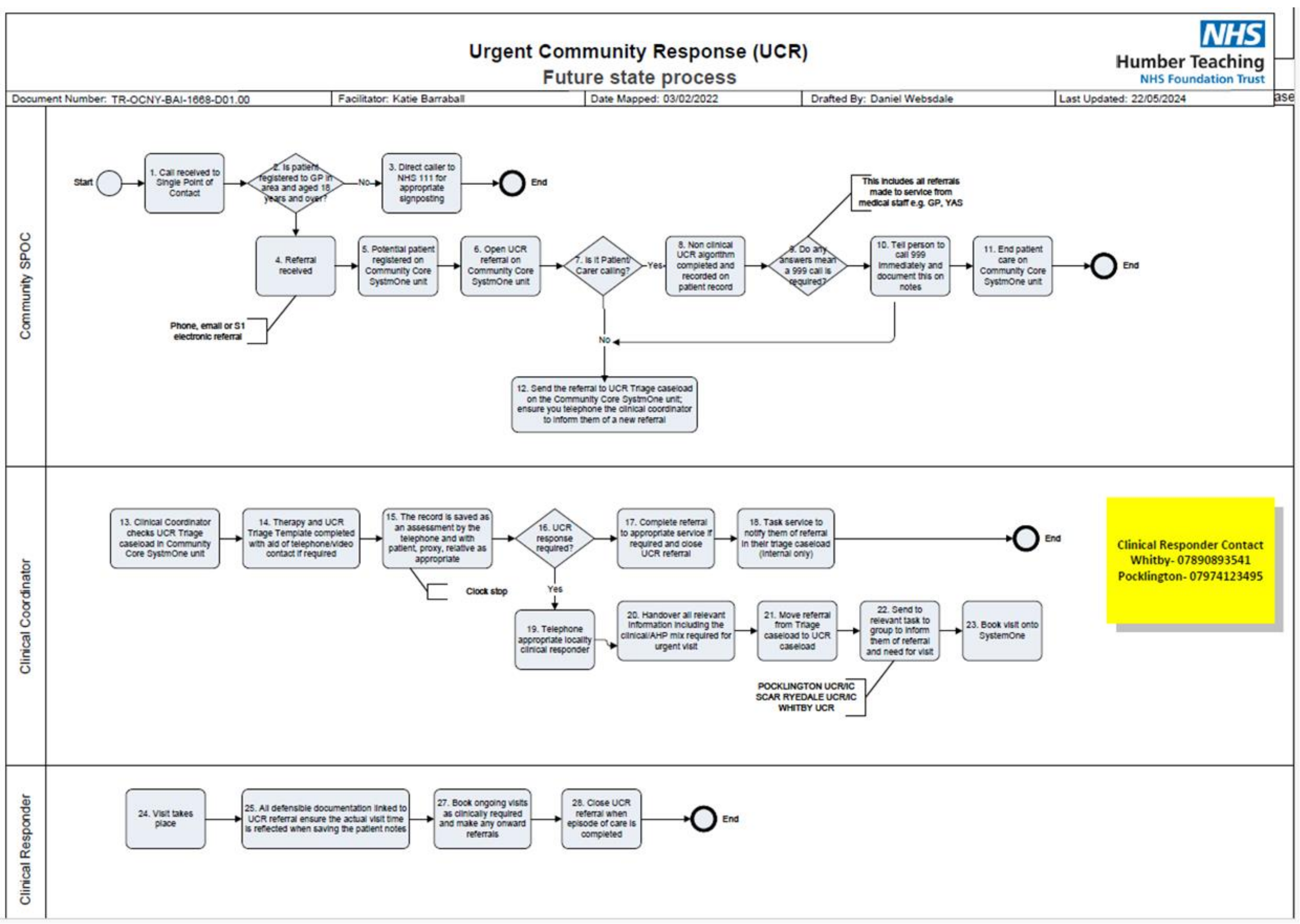
Where two-hour UCR teams identify social care needs rather than healthcare needs – for example, where carer stress means a carer is unable to provide safe care or where either the carer or cared for person is experiencing abuse or neglect – they should:

• make an urgent referral to the relevant service where the two-hour UCR team does not have Care Act 2014 responsibilities

• work jointly with local authorities or care providers.

B1406-community-health-services-two-hour-urgent-community-response-standard.pdf (england.nhs.uk)

Appendix B - UCR Interim Future State Process



Appendix C - Patient Transfer Information Form

Patient Name: ____ **NHS no** ______________________

S	**Situation** Reason for transfer	
B	**Background** Relevant PMH and medication –(please send meds with patient). Include NOK / Carer details.	
A	**Assessment** Include observations and NEWS score / detail of environment	
R	**Recommendation** **Patient / family understanding of situation / need for escalation** **Discharge Planning:** any outstanding assessments / equipment requirements for discharge already identified / ongoing services / functional level required for discharge	

Clinician name __________________________________ ***Date*** ________________________

SPOC: 01653 609609, Email: hnf-tr.csspoc@nhs.net

Appendix D - One Page Professionals Document

Scarborough and Ryedale Urgent community response (UCR) including Whitby and Pocklington Single Points of Contact UCR

NHS
Humber Teaching
NHS Foundation Trust

Clinical Pathways

Availability and Assessment

Scarborough / Ryedale / Whitby / Pocklington Single point of contact 01653 609609

- Available7 days a week, 08:00-20:00. Referral cut off time 18.00.
- Urgent Community response (2-hour timeframe) available for patients with immediate need to prevent hospital admission
- Patients must be registered with a Scarborough and Ryedale / Whitby Coast and Moors PCN or Pocklington GP practice (incl. temporary registration) to access services
- This health or social care need requires urgent treatment or support within 2 hours and can be safely delivered in the home setting
- Referrals to support discharge from hospital should be made via the hospital discharge service for intermediate care.

Inclusion Criteria

- New or acute problem (e.g., infection)
- Exacerbation of chronic condition where it can be safely treated out of hospital, but its functional consequences may mean the individual is at risk of hospital admission.
- Serious illness where treatment at home is in keeping with the persons wishes as part of a pre agreed treatment escalation plan - such as palliative care crisis
- Breakdown of unpaid carer arrangements which causes an immediate health risk to an individual e.g., main carer admitted to hospital or carer stress causing breakdown in ability to provide safe health and care support.
- Local authorities have a responsibility to respond to people experiencing a social care crisis
- Common conditions covered falls, decompensation of frailty, reduced function / deconditioning, EOL crisis support, equipment provision to reduce risk of hospital admission, unpaid carer breakdown which may lead to a health care crisis.

Exclusion Criteria

- Patient under 18 years old
- Patients not registered with a qualifying GP practice
- All presentations requiring a specialist or acute pathway, or not suitable for community care,
- Acutely unwell or injured requiring emergency care /intervention in an acute hospital bed
- Experiencing a mental health crisis and requiring referral / assessment by a specialist mental health team
- Needs acute / complex diagnostics and clinical intervention for patient safety in hospital
- Patients admitted to an acute setting – these referrals come to intermediate care via Hospital discharge service
- Overnight needs (Community nursing scar / ryedale and whitby available)

Referral Process

- Patient must consent and be involved in care planning, or have a Best Interest decision indicating need for urgent community response
- Call to SPOC is initially to non-clinical call handler but passed to a clinician or call back from clinical co Ordinator arranged for handover / clinical triage.
- If referral is from a healthcare professional Provide SBAR handover with relevant observations and findings (NEWS2)
- If referral not agreed, then responsibility remains with referring clinician and alternative care option should be explored.

Appendix E - UCR Patient Information Leaflet

Respect—Our staff will treat you with dignity and respect at all times. We expect polite behaviour towards our staff

No Smoking -To protect the health of our staff we will request that you do not smoke during our visits.

CONTACT US

Single Point of Contact Number:
01653 609609. Email: hnf-tr.csspoc@nhs.net

Please contact your GP, or **111** (which is available 24 hours a day, 7 days a week), if you have an urgent medical problem and you're not sure what to do

Please call 999 in the event of a life threatening emergency

Humber Teaching NHS Foundation Trust Complaints and Feedback team

Humber Teaching NHS Foundation Trust
Trust Headquarters
Willerby Hill
Beverly Road
Willerby
HU10 6ED

01482 303930

HNF-complaints@nhs.net

HumberNHSFT

HumberNHSFT

humber.nhs.uk

NHS
Humber Teaching
NHS Foundation Trust

Urgent Community Response (UCR) Service

Pocklington, Scarborough, Ryedale, and Whitby Community

Patient Information

Publication Date: Feb 2022
Review Date: Feb 2023

Who is this service for?

You or the person you are caring for may be experiencing difficulties or be in crisis. Examples of when you might need this service include:

- During a crisis which may be due to a clinical condition such as a new or acute problem, such as an infection, or a worsening of a chronic condition, such as chronic obstructive pulmonary disease (COPD)
- When you or the person you are caring for has a serious illness where treatment at home is in keeping with your wishes or the wishes of the person you care for as part of a pre-agreed treatment plan, such as a patient receiving palliative care
- When you or the person you are caring for experiences a social crisis such as: breakdown of unpaid carer arrangement, causing immediate health risk

Why you might need this service?

You might need this service if:

- You (or the person you care for) are over the age of 18
- You (or the person you are caring for) Is living in their own home or a residential/care home setting
- You or the person you are caring for is in a crisis (as defined above) and needs care within two hours to stay safely at home to avoid an admission to hospital. This includes people living with dementia

How this service might be able to help you (not an exhaustive list):

- Following a fall
- During a rapid decline linked with frailty
- Reduced function or reduced mobility
- Palliative care/end of life crisis support
- Urgent equipment provision
- When acutely confused or delirious
- For urgent catheter care
- For urgent support for uncontrolled diabetes
- Unpaid carer breakdown which if not resolved will result in a health care crisis for the person being cared for

What does the service do?

As part of our Community Ageing Well Programme, we have a team of Nurses, Physiotherapists, Occupational Therapists and Support Workers, who can provide a two-hour crisis response to help people living with frailty, multiple long term health conditions, and/or complex needs to stay independent, healthy, and at home for as long as possible.

This care is available to people in their home or usual place of residence, which includes care homes, to prevent avoidable hospital admission and treat urgent need.

Equipment Provision

It may be helpful to supply you with equipment to enable you to be at home. Examples include; walking frames, commodes, pressure relieving mattresses. Equipment is supplied through an outside company called Medequip and will be delivered to your home.

Who does this service work with?

GP Practices, Hospital Discharge Teams, NHS 111 and ambulance services, and social care teams, as well as working alongside mental health, housing sector, voluntary sector, and community teams.

When is the service delivered?

The service operates 7 days a week, from 08:00 to 20.00.
Patients who require a two hour response need to be referred by 6pm on referral day
Community Nursing teams can help people at home until 22.00

How long can the team support you?

This depends on your individual assessment and health needs, and will be discussed with you. Initial support may Include up to 48 hours, and then we may discuss referral to other community health and social care or voluntary sector providers, to support your ongoing care.

Which area is covered by this service?

The service is delivered across Whitby, Scarborough, Pocklington and Ryedale Community. There is no charge for this service.

Who do you call if you have any questions?

Please feel welcome to contact the team if you have any queries or concerns, and a Health Care Professional will get back to you.
The telephone number for Single Point of Contact is: 01653 609609

Appendix F - Whitby and Pocklington Model

The UCR service in Whitby and Pocklington localities will be delivered by the existing community nursing and therapy teams over a 7 day periods 8-8.

Patient care and documentation process will follow this SOP. Staff will be designated on a rota to provide cover. It is expected that these staff will prioritise their dairy in line with guidance in Community - Referral and Triage SOP delegating care when appropriate to do so in line with Community - Delegation of Care to Non Registrants SOP.