NHS England

Transforming urgent and emergency care services in England

Guidance for Commissioners regarding Urgent Care Centres, Emergency Centres and Emergency Centres with specialist services

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Transforming urgent and emergency care services in England

Guidance for Commissioners Regarding Urgent and Emergency Care Networks, Urgent Care Centres, Emergency Centres and Emergency Centres with specialist services

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Equality and Health Inequalities

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

Local commissioners are reminded to pay due regard to the two duties above when this guidance is implemented locally.

Information Governance

Safe and efficient patient care requires effective, timely and appropriate transfer of key information that follows the patient through the healthcare system. This is particularly important in the urgent and emergency care system where, by definition, the patient is accessing care from outside of their routine care providers.

The informed consent of patients should normally be sought and obtained before accessing or sharing information about them. This informed consent needs to ensure that the patient understand who will access their data and for what purposes. If they are adults and lack the capacity to make these decisions, those decisions should be made in their best interests in accordance with the Mental Capacity Act 2005 and its Code of Practice.

If they are children aged under 16, those decisions should be made by someone with parental responsibility for them, unless they are Gillick competent and, after applying the Fraser Guidelines, it is best interests to respect their decision. If they are children aged 16 or 17, the principles set out in paragraph 12.13 of the Mental Capacity Act Code of Practice should be followed.

The wishes of children (and those with parental responsibility for them) can/should be overridden in their best interests to save them from significant harm; the wishes of adults with capacity cannot be overridden unless overriding their wishes may prevent serious crime Significant abuse or neglect are/may be crimes.

All of the above is subject to what might happen in an emergency when people cannot make, or cannot properly be expected to make, decisions. When that is so, all decisions to do with their immediate care and welfare should be made in their best interests in accordance with chapter 5 of the Mental Capacity Act Code of Practice.

Contents

Document Summary

Purpose

1. This document is designed to help the NHS deliver co-ordinated urgent and emergency care by describing standards for the different types of acute receiving facilities that function within Urgent and Emergency Care Networks. The document recognises transition will be required in all parts on England, and that this will take time; some variation is inevitable to meet local needs.

Audience

2. The primary audience of this document is commissioners and providers of acute health care services.

3. Because the primary audience of the document is those who plan and deliver care it contains some medical and other complex terms, but wherever possible we have attempted to explain things in plain English.

Structure

4. The document starts by describing why we have moved to a network approach for urgent and emergency care, and the role of facilities providing services within a Network.

5. The document then goes on to recommend a more consistent specification of facilities and their relationships, and how this will vary across England to meet the needs of specific geographies, populations and current service models.

How it will be used

6. This document is intended to provide a national framework on how Urgent and Emergency Care Networks might operate. We envisage that the principles set out in the document will be applied throughout, with a local approach to meet the needs of local communities across England developed accordingly.

7. In all cases the revised guidance ''*Planning, assuring and delivering service change for patients*'[1] should be consulted in respect of any service reconfiguration decision by the body(ies) with statutory responsibility for commissioning the service. The revised guidance also covers the assurance process against the four tests of service change and the roles and responsibilities of NHS England and partners. In particular, the role of clinical senates in undertaking independent review should be noted.

8. Commissioners may also wish to seek additional external independent advice in relation to reconfiguration of UEC systems.

[1] https://www.england.nhs.uk/wp-content/uploads/2015/10/plan-ass-deliv-serv-chge.pdf

Introduction

Purpose

9. The first stage report of Professor Sir Bruce Keogh's review of Urgent and Emergency Care (the "Review") recommended the development of Urgent and Emergency Care Networks, and also the designation of Urgent Care Centres, Emergency Centres and Major Emergency Centres (now referred to as Emergency Centres with specialist services) within those Networks.

10. The long-term vision is to create an urgent and emergency care system that is capable of delivering the right care, first time for the majority of patients through a networked model seven days a week, and which is easy for our patients to navigate and understand.

11. Formalising the clinical interdependences between community services (general practice, NHS111, ambulance services and Urgent Care Centres) and those hospitals within trusts with Emergency Departments/A&E Departments (Emergency Centres) will enable the development of a single system that is greater than the sum of its parts. This will also apply between those Emergency Centres that do, and do not provide certain specialist services.

12. This guidance recognises the division of Urgent and Emergency Care Networks at a strategic level and the operational role of System Resilience Groups for local health economies. This reflects the different challenges faced by our CCGs across the country, and allows local commissioners to develop solutions for their population with local clinicians in order to meet the standards outlined below.

13. Commissioners must have robust plans to ensure that any changes to commissioned services fully realise the available financial savings at the local healthcare economy level and that these savings are realised, where possible, at the same time as any new costs are brought on stream. When evaluating these potential savings commissioners should include all costs and savings across the whole healthcare economy that are borne by CCGs, NHS England, or any other organisation with delegated authority to commission healthcare locally.

14. This document sets out a series of general principles and standards to guide implementation, which will occur progressively. Networks are expected to have designated clinical pathways by December 2016 and to have started implementation of these principles. The timescale for implementation should be agreed locally in line with any necessary service changes; progress is anticipated by autumn 2017 with completion by 2020. A route map for implementing the objectives of the review has been developed; Network plans are being developed in late 2015 / early 2016. Further advice is available from the Review team at NHS England england.urgentcarereview@nhs.net.

15. The guidance document '*Planning, assuring and delivering service change for patients'* must be considered in any planning for reconfiguration. Commissioners may wish to seek additional external independent advice in relation to reconfiguration of UEC systems. (Refer to paragraphs 6-8 above).

Primary and Community Care

16. The effective provision of comprehensive and responsive primary and community care, to ensure a timely same day response to all urgent care needs, is a fundamental principle of the Review. To achieve a comprehensive and enduring shift in urgent care provision from hospitals to the community requires primary care and community facilities to be developed and reconfigured to meet the vast majority of patient needs. The development of Urgent and Emergency Care Networks, and the designation of the facilities within those Networks, will have very limited impact if the provision of primary and community services is not addressed at the same time, through a unified and coordinated approach of general practice, community care, NHS111, ambulance services, community pharmacies, urgent primary care and minor injury and illness services.

Physical and Mental Health

17. All Urgent and Emergency Care Networks, and their components, are intended to apply equally to patients with physical and mental health needs. Commissioners and providers have a responsibility to ensure that mental health is afforded the same priority as physical health throughout the urgent care system, in accordance with the principles of the crisis care concordat so that people of all ages experiencing mental health crisis have timely access to compassionate expert advice and support wherever they present in the urgent and emergency care system. Many people presenting with physical health needs may also have co-morbid mental health needs, so services should be equipped to detect and manage these, for example through models such as liaison mental health which allow access to expert mental health care in traditionally 'physical health' settings

Definitions and Nomenclature

Urgent Care and Emergency Care

18. Consultation with patients and the public, undertaken during the early phases of the Review, indicated that patients do not distinguish between urgent and emergency healthcare needs, and therefore the two terms can be used interchangeably. As an overall guide, urgent and emergency care is the range of responses that health and care services provide to people who require – or who perceive the need for – same day advice, assessment, transport, care or treatment. Same-day responsiveness is an expectation of the modern healthcare system, and an underlying principle of the Review. Note that the judgement of urgent and emergency is made by the patient and not by a clinician retrospectively: this is because the true urgency of a problem cannot be determined until it has been assessed. Clinicians may choose to distinguish between emergency (time-critical) and urgent (not time-critical) care, and the system nomenclature has been adapted accordingly. However patients should not be expected to choose correctly between these two options: **it is the function of the system to guide the patient to the correct level of care and to provide clarity as to which services are provided where, along with the pathways to access these services reliably 24/7.** Wherever a patient enters the system they will have the same level of access to the system and, if necessary should be referred on through the system via direct booking where possible.

Networks

19. Urgent and Emergency Care Networks are described previously[2] and are currently in set-up. Networks are expected to describe how and where patients can access the care they need expeditiously and as conveniently as possible. They will describe the access to definitive care of all categories, severity and complexity of emergency for their defined geography. Networks will oversee the designation of services and will monitor network performance and service access. For more detail please refer to "Role and Establishment of Urgent and Emergency Care Networks".

20. The granular design, designation and delivery of local bespoke services will be through the System Resilience Groups that bring together communities of clinicians who work together, to achieve the best outcomes for their patients. There may be several System Resilience Groups within each Network.

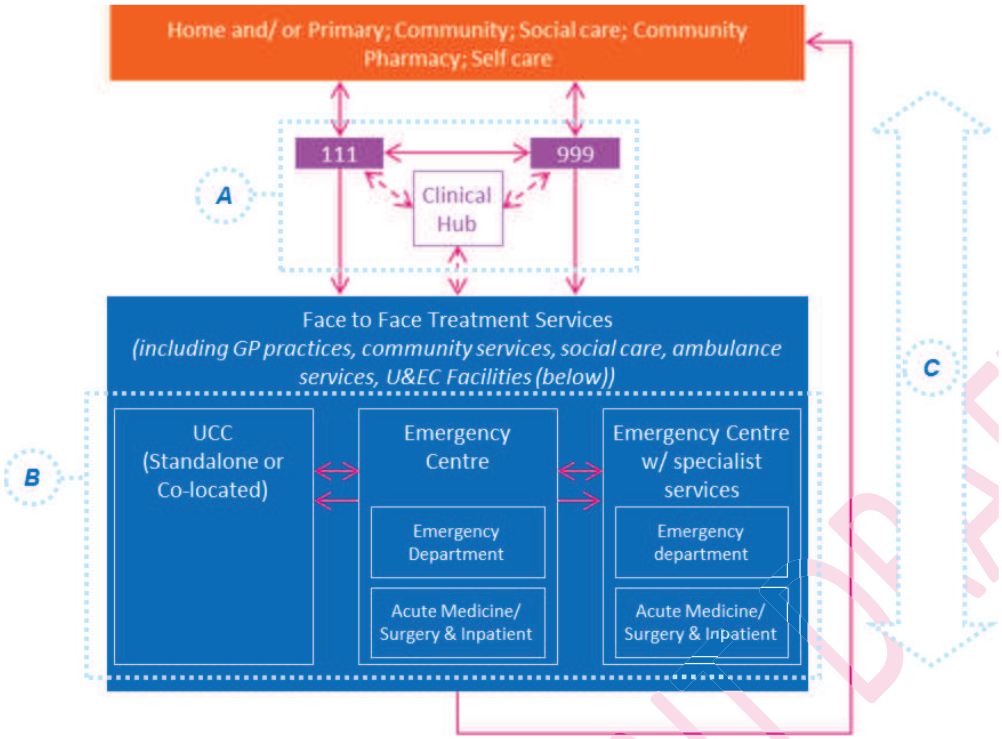
Urgent Care Centres

21. Consultation with patients and the public has indicated considerable confusion regarding the naming of various facilities, and an inconsistent service offer (p16 of the Review[3]). We recommend that all urgent primary and community care facilities are named "Urgent Care Centres", and that these facilities are developed to provide a broad response to all urgent care needs 24/7.

22. This new offer of fully functionally integrated 24/7 urgent care service with 111 as the 'front door' of the UEC system providing access to the right advice in the right place, first time at any hour of the day and any day of the week is illustrated in Figure 1. Also refer to *Commissioning Standards for Integrated Urgent Care*[4].

[2] http://www.nhs.uk/NHSEngland/keogh-review/Documents/Role-Networks-advice-RDs%201.1FV.pdf
[3] http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf
[4] https://www.england.nhs.uk/wp-content/uploads/2015/10/integrtd-urgnt-care-comms-standrds-oct15.pdf

Figure 1



A: Commissioning Standards for Integrated Urgent Care
B: UEC facilities specifications
C: UEC system specification

Emergency Centres

23. Certain hospitals within Trusts which are able to receive, assess, treat and refer all patients (both adults and children) with urgent and emergency care needs would be designated as Emergency Centres. Designation is by hospital, not by Acute Trust, so a Trust comprising multiple hospital sites may have different designations at different sites. Emergency Centres will usually undertake elective work alongside their emergency caseload. Where applicable, separate paediatric emergency departments (A&E) and adult emergency departments (A&E) would also be recognised within network arrangements. Because the successful functioning of an Emergency Centre relies on a range of integrated services it should be noted that the entire hospital is designated as an Emergency Centre, including the Emergency Department (also known as an Accident and Emergency Department) that is located within it. Following initial stabilisation some patients who require specialist care will be transferred to a different Emergency Centre with specialist services; this transfer capability is integral to the functioning of an Emergency Centre and the network in which it operates.

Emergency Centres with specialist services

24. Certain hospitals within Trusts which are able to receive, assess, treat and refer all patients (both adults and children) with urgent and emergency care needs, and which also receive those ambulances that have bypassed an Emergency Centre and patients transferred from Emergency Centres, would be designated as Emergency Centres with specialist services. Designation is by hospital, not by

Acute Trust, so a Trust comprising multiple hospital sites may have different designations at different sites.

25. Because the successful functioning of an Emergency Centre with specialist services relies on a range of integrated services it should be noted that the entire hospital is designated as an Emergency Centre with specialist services, including the Emergency Department (A&E) that is located within it. **From a patient's perspective no distinction is made between Emergency Centres and Emergency Centres with specialist services:** all carry red Emergency signage, and represent access points to an Urgent and Emergency Care Network that will guide or convey patients to the service best suited to their needs.

Emergency Departments/Accident and Emergency (A&E)

26. The hospital departments within Emergency Centres and Emergency Centres with specialist services that receive unselected patients (both adults and children with physical and mental health needs) and are specifically configured for the reception, resuscitation, diagnosis and onward referral of patients with urgent and emergency care needs, are called Emergency Departments (also known as Accident and Emergency Departments, or A&E). These Departments are always open, are under the continuous supervision of a team of consultants in Emergency Medicine, and receive patients from the ambulance service and other sources (specific information within Emergency Centres, para 32).

27. Some patients who have been seen and assessed elsewhere (e.g. in general practice or an Urgent Care Centre) may bypass the Emergency Department in order to directly access the facilities within that Emergency Centre or Emergency Centre with specialist services hospital: this is appropriate when there is no added value to the patient from being seen in an Emergency Department. Emergency Departments receive support from the centre in which they are based, and from the Urgent and Emergency Care Network of which they are an integral component.

28. It is envisaged that the vast majority of units currently designated as "Type 3 A&E Departments" will be developed into Urgent Care Centres, which will improve clarity and consistency across the Urgent and Emergency Care System.

29. Current "Type 2 A&E Departments" that provide services to women and children only will be incorporated into Strategic Urgent and Emergency Care Networks as Emergency Departments integral to either Emergency Centres or Emergency Centre with specialist services, and will conform to the requirements of these centres.

30. "Type 2 A&E Departments" that currently provide highly specialist care (e.g. those associated with dental and eye hospitals) will continue to do so under the designation "Specialist Receiving Facility", and will not be considered as Emergency Departments, but as a component of the "Specialist Hospital" in which they are based. Similarly, specialist facilities based within a hospital that does not include an Emergency Department will not be considered as Emergency Centres, but be designated as a "Specialist Receiving Facility".

Urgent Care Centres

Principles

31. Urgent Care Centres are community and primary care facilities providing access to urgent care for a local population. They encompass Walk-in Centres, Minor Injuries Units, GP-led Health Centres and all other similar facilities, including the majority of those currently designated as “Type 3 A&E Departments”. A consistent nomenclature should be accompanied by a consistent service, so that patients are clear about what they can expect from all Urgent Care Centres, anywhere in England. To achieve this two important principles underpin the development of Urgent Care Centres:

    - Urgent Care Centres offer access to a full range of urgent care services

    - Urgent Care Centres provide 24/7 access to the Urgent and Emergency Care Network

A Full Range of Urgent Care Services

32. Urgent and Emergency Care Networks should work to develop all Urgent Care Centres so that they are able to provide access to a broad range of physical and mental illness and injury care, in both adults and children. This will be achieved by a team of on-site healthcare professionals, integrated diagnostic facilities and agreed pathways into other community-based and primary care services. It is the responsibility of the Network to ensure these services are provided consistently; it is not acceptable to simply default to a higher level of care. Ambulance services may convey patients to Urgent Care Centres within agreed pathways where the patient’s condition is suitable for primary care management. Where patients with more serious illness or injury walk into an Urgent Care Centre, clear protocols, agreed with the ambulance service, will facilitate rapid transfer to an Emergency Centre or Emergency Centre with specialist services.

24/7 Access to Urgent Care

33. All Urgent Care Centres must act as a consistent access point to the Urgent and Emergency Care Network 24/7. This does not mean that an Urgent Care Centre must be open and staffed 24/7, but it is recommended that all Urgent Care Centres are open and staffed consistently for at least 16 hours (e.g. 8am to midnight) on every day of the year. (Except in those exceptional situations where it would not be affordable to do so and the locality would be able to demonstrate this to the urgent and Urgent and Emergency Care Networks). Where local activity does not justify staff presence overnight arrangements should be in place to ensure immediate access to assessment, and where necessary treatment, within the network for patients who arrive at or contact the Urgent Care Centre overnight; it is not acceptable to simply default to a higher level of care. Such access could be provided through the integrated urgent care clinical hub offering patients who require it access to a wide range of clinicians, both experienced generalists and specialists. It will also offer advice to health professionals in the

community, such as paramedics and emergency technicians, so that no decision needs to be taken in isolation.

NB. It is acknowledged that currently there may be alternative routes of telephone access to the integrated urgent care system to reflect current local arrangements, such as Out of Hours and provision of extended access primary care services. In this instance it must be ensured that the appropriate access number/route is provided at the first point of contact.

Co-location with Emergency Departments (A&E)

34. For a proportion of Urgent Care Centres, co-location with an Emergency Department (A&E) will address many of the requirements relating to range of services and 24/7 access described above, and it is strongly recommended that Urgent Care Centres are co-located with Emergency Departments. Such co-location allows efficient patient streaming and the development of a service likely to meet the needs of the vast majority of patients in a single location, ensuring enhanced convenience and efficiency, particularly where general practitioners are present 24/7.

35. For non-co-located Urgent Care Centres in rural areas it may be necessary to develop and enhance services, including where appropriate use of telemedicine, so that more care can be delivered locally and therefore less patients will need to be transferred to Emergency Centres and Emergency Centre with specialist services. For non-co-located Urgent Care Centres in urban areas consideration should be given to the role and purpose of the Urgent Care Centre within the wider Network, to ensure a consistent and efficient service, and avoid unnecessary duplication.

Standards for Urgent Care Centres

36. All Urgent Care Centres must conform to the following minimum standards. Local Urgent and Emergency Care Networks may also choose to build upon or add to these, according to their requirements.

    (1) All Urgent Care Centres must be part of an identified Urgent and Emergency Care Network, with integrated governance structures.

    (2) Every Urgent Care Centre should have a formal written policy for providing urgent care, and clear pathways of care for all common conditions (refer to appendix 1). This policy is to be reviewed and ratified by the Urgent and Emergency Care Network annually.

    (3) All Urgent Care Centres should have an identified clinical lead, and participate in clinical and non-clinical audit, demonstrating effective engagement in a programme of continuous quality improvement.

    (4) During the hours that they are open (at least 16 hours a day, every day of the year) all Urgent Care Centres should be staffed by multidisciplinary teams, including at least one registered healthcare practitioner and a least one other person excepting those exceptional cases described in point 32 above.

(5) During the hours that they are not open, all Urgent Care Centres should continue to provide immediate access to the Urgent and Emergency Care Network for persons contacting the Urgent Care Centre by phone or arriving in person (e.g. through Integrated Urgent Care, the ambulance service or similar arrangements).

(6) All Urgent Care Centres will receive patient referrals from ambulance and other urgent and emergency services within agreed protocols and pathways of care.

(7) An escalation protocol is to be in place to ensure that seriously ill/high risk patients presenting to an Urgent Care Centre are seen immediately by a registered healthcare practitioner, and where treatment in an Emergency Centre or Emergency Centre with specialist services is required this is facilitated by attendance from the ambulance service within agreed timescales.

(8) All registered healthcare practitioners working in an Urgent Care Centre must have a minimum level of competence in caring for adults, and children and young people, including:

a. Basic life support, including automatic external defibrillator (AED) training
b. Recognition of serious illness and injury
c. Pain assessment
d. Identification of vulnerable patients

(9) At any time the service is open at least one registered healthcare practitioner is to be trained and competent in advanced life support and paediatric advanced life support.

(10) The following equipment to be immediately available at all Urgent Care Centres: a full resuscitation trolley; a defibrillator (this may be an automated external defibrillator); oxygen; suction; emergency drugs.

(11) Urgent Care Centres should normally have on-site plain film x-ray and blood testing, reporting and analysis. Where this is not currently available, local protocols should specify alternate routes of access and reporting standards. Access to this testing should be available throughout the Centre's hours of operation.

(12) Urgent Care Centres should normally have a medical or non-medical prescriber present throughout their hours of operation. Patient Group Directions (PGDs) to support the treatment of common injuries and illnesses may be used until sufficient staff are qualified as prescribers.

(13) All Urgent Care Centres should have arrangements in place for staff to access an up-to-date electronic patient care record. This access will be based on prior patient consent, confirmed where possible at the time of access, or in the patient's best interests in an emergency situation where the patient lacks

capacity to consent. Urgent Care Centres should also have access to real-time support and advice from experienced doctors in primary and secondary care without necessarily requiring patients to be transferred to another service.

(14) All Urgent Care Centres should collect and return anonymised data relating to patients attending the service, in accordance with nationally specified standards.

(15) All registered healthcare practitioners working in an Urgent Care Centre should be able to refer patients directly to other services throughout the Urgent and Emergency Care Network (including primary care, mental health, and secondary care and specialist services). See 'Improving pathways between Urgent and Emergency Services in England' for more information.

(16) All Urgent Care Centres should provide guidance and support on how to register with a GP.

(17) All patients attending an Urgent Care Centre should, with their consent, have an episode of care summary communicated to the patient's GP practice by 08.00 on the next working day, accompanied by a real-time update of the electronic patient care record. For children the episode of care should also be communicated to their health visitor or school nurse, where known, within 2 working days.

(18) Patient experience data should be captured, anonymised, recorded and routinely analysed and acted on by all Urgent Care Centres, within the wider Urgent and Emergency Care Network.

(19) All patient safety incidents should be reported to the National Reporting and Learning System and reviewed locally to identify and implement learning. Similarly all National Patient Safety Alerts should be implemented in full and in the spirit they are intended.

(20) Where appropriate, patients attending an Urgent Care Centre should be provided with health and wellbeing advice and sign-posting to local community and social care services where they can self-refer (for example, smoking cessation services and sexual health, alcohol and drug services).

(21) All Urgent Care Centres should provide appropriate supervision for training purposes including both educational and clinical supervision.

(22) All healthcare practitioners working in Urgent Care Centres should receive training in the principles of safeguarding children, vulnerable and older adults and identification and management of child protection issues.

Emergency Centres

Principles

37. Emergency care is about the whole hospital not just the Emergency Department (A&E). Hospitals within trusts which are able to receive, assess, treat and refer all patients (both adults and children) with urgent and emergency care needs are designated as Emergency Centres. Emergency Centres include an Emergency Department, which is always open and under the continuous supervision of a team of consultants in Emergency Medicine, who are not necessarily continuously present, but are available to attend within 30 minutes at all times, and who have clinical accountability for the care delivered in that Emergency Department.

38. Emergency Centres will contain some facilities and beds to admit and investigate patients' illnesses and injuries as well as having a range of outpatient and supporting services (see below). In rural areas Emergency Centres will be the initial receiving destination for almost all emergency and ambulance patients. These patients will undergo initial treatment and stabilisation prior to admission to that centre, or onward transfer, under agreed protocols and through a designated transfer and retrieval service, to more specialist care at Emergency Centre with specialist services. In more urban environments when the patient has an identified specialist need and the increase in journey time is clinically justified, ambulance staff may bypass an Emergency Centres in favour of an Emergency Centre with specialist services.

Standards for Emergency Centres

39. All Emergency Centres must conform to the following minimum standards. Local Urgent and Emergency Care Networks may also choose to build upon or add to these, according to their requirements.

    (1) All Emergency Centres must be part of an identified Urgent and Emergency Care Network, with integrated governance structures.

    (2) Every Emergency Centre should have a formal written policy for providing emergency care, and clear pathways of care, including acceptance and referral criteria, for all common emergency conditions within the over-arching Network (refer to appendix 1). This policy should include both physical and mental health, and will be reviewed and ratified by the Urgent and Emergency Care Network annually.

    (3) Emergency Centres must contain an Emergency Department (A&E) that operates structurally and functionally within a supporting hospital. The Emergency Department must include a resuscitation area with appropriate equipment to provide advanced paediatric, adult and trauma life support prior to transfer to definitive care.

    (4) All Emergency Centres must have 24/7 dedicated nursing staff with a dedicated Nurse Manager or equivalent.

(5) All Emergency Centres must have rostered medical staff present 24 hours a day, seven days a week, with continuous support from consultant medical staff who are able to attend within 30 minutes at all times. They should provide a consistent standard of senior-led care at all times.

(6) Junior medical staff (including Foundation grade doctors and ST1, ST2 and ST3 grades and equivalent staff) should not work in the Emergency Department (A&E) of an Emergency Centre without direct (physically present) supervision from more senior medical staff (ST4 or above, or equivalent).

(7) All Emergency Centres must have 24/7 access to blood products.

(8) All Emergency Centres must have 24/7 access to pathology and radiology services, with plain X-ray facilities, CT scanning (including reporting within one hour) and laboratory or point of care testing immediately available on site at all times.

(9) All Emergency Centres must have 24/7 access to care or advice from all specialties, including mental health, directly or through the Network (in some cases this may be provided remotely, for example using telemedicine).

(10) All Emergency Centres must include facilities for ambulatory care, admission avoidance, early supported discharge and a frailty pathway.

(11) All Emergency Centres must have clear exit pathways and repatriation protocols, supported by an escalation plan and a full capacity protocol to deal with overcrowding , that is enacted through the Network.

(12) All Emergency Centres must have 24/7 access to specifically commissioned transfer and retrieval services, underpinned by agreed protocols and standards.

(13) All Emergency Centres should comply with nationally and contractually agreed acute care clinical standards for 7 day services.

(14) All Emergency Centres should collect and return anonymised data relating to patients attending the service, in accordance with nationally specified standards.

Emergency Centre with specialist services

Principles

40. An Emergency Centre with specialist services has all the features of an Emergency Centre, but also includes 24/7 access to some specialist facilities that receive patients from Emergency Centres, or directly from an ambulance which has bypassed an Emergency Centre. Such facilities should include a grouping of identifiable specialist services that support a network, current examples include:

(a) major trauma management including neurosciences, plastic surgery, burns

(b) primary percutaneous angiography for ST-segment elevation myocardial infarction

(c) stroke thrombolysis

(d) emergency vascular surgery

(e) Specialist paediatric services

all supported on-site by level three critical care and interventional radiology.

41. Emergency Centres with specialist services have a concentration of specialist expertise, and services that may fall within the remit of specialist commissioning. They provide support and coordination to the whole Network for patients with specialist emergency care needs, and work in partnership with the other system components to ensure that patients are able to access specialist care in a timely way, including the implementation of agreed transfer, retrieval and repatriation protocols.

42. Emergency Departments that are integral to Emergency Centres with specialist services will provide consultant presence over extended hours, immediate access to enhanced diagnostics, such as CT and MRI scanning and interventional radiology, and a wider range of facilities, as a result of the increased capabilities of the hospital in which they are located. However it should be noted that senior staff working in Emergency Centres will need to have a wide range of highly developed emergency care skills to provide initial care to seriously ill and injured patients with less support from the hospital in which they are located, particularly in rural areas, and therefore strong investment in this aspect of the Urgent and Emergency Care Network, combined with a commissioned service to achieve timely retrieval and repatriation, is essential to the delivery of an effective and equitable service.

Remote and Rural Settings

43. Innovative models of care will be required to implement these principles in remote and rural settings. The up-skilling of a range of staff from multiple healthcare professions and disciplines, with good on-site diagnostics and consistent off-site support through 24/7 access to network expertise, will be essential. Remote and rural Urgent Care Centres and Emergency Centres will need defined mechanisms to ensure the safe transfer of patients to specialist services, following initial resuscitation, diagnosis and stabilisation; for example a dedicated pre-hospital critical care transport and retrieval service. Innovative models of supervision and access may be justified in exceptionally remote and rural areas, in consultation with commissioners, area teams and the relevant Medical Royal Colleges. System performance and patient outcomes should be closely monitored and supported through the network.

Conclusions

44. The key component of an Urgent and Emergency Care Network is the Network itself, not the buildings in which healthcare has been traditionally delivered. This Network will include a population of at least one million people, have strategic and operational components, and should deliver reliable access to a consistent and high quality service for both physical and mental health all day and every day.

45. Success in shifting the focus of Urgent and Emergency Care from hospital to community based settings will require the development and coordination of existing services, particularly in primary and community care, to provide a clear and constant offer underpinned by established service specifications for each component, and agreed pathways of care that support effective patient flow.

46. Although we have set out a range of principles and standards, these will need to be developed and applied according to local circumstances and requirements, and informed by reliable data with progressive evolution over time. Patient safety, clinical outcomes and consistency and equity of access should be the driving principles.

47. We anticipate that the establishment of effective Urgent and Emergency Care Networks and the designation of services will inevitably lead to difficult commissioning decisions. However clinical senates are a resource that is available to support this decision making, and the final result will be more consistent access to a better standard of urgent care, in a coordinated and sustainable system.

Appendix 1

Urgent and Emergency Care Networks: Common Condition Pathways

An early action for urgent care networks and their constituent SRGs, providers and commissioners is to develop consistent pathways of care for common urgent care conditions.

A suggested initial list of conditions is shown below; this should be expanded and developed over time according to local need. It should be noted that many of these are symptom presentations rather than diagnoses, since the final diagnosis may not be apparent when the patient first presents to urgent and emergency care services.

Children	
Accidental injury	Major trauma
Acute abdominal pain	Mental health complications of physical health conditions e.g. diabetes
Acute psychosis	Mental health crisis
Alcohol intoxication	Minor head injury
Allergic reaction	Non accidental injury
Asthma	Psychosis relapse
Burns and scalds	Rash
Delirium	Respiratory tract infection
Depression	Seizures
Drug intoxication	Self-harm
Earache	Suicidal thoughts
Eating disorders	Traumatic injury with fracture
Feverish illness	Traumatic injury without fracture
Lower respiratory tract infection	Upper respiratory tract infection
Major illness (e.g. meningitis)	Vomiting and/or diarrhoea
Adults	
Accidental injury	Mental health crisis
Acute abdominal pain	Minor head injury
Acute psychosis	Neck sprain
Alcohol intoxication	non accidental injury
Allergic reaction	Non-traumatic back pain
Burns and scalds	Non-traumatic chest pain
Delirium (acute confusion)	Nosebleed
Dementia	Pain and/or bleeding in early pregnancy
Depression	Psychosis relapse
Drug intoxication	Seizures
Eating disorders	Self harm
Exacerbation of asthma	Severe sepsis
Exacerbation of COPD	Sexually transmitted infection
Fall in older adult with fracture	Stoke/transient ischaemic attack
Fall in older adult without fracture	Suicidal thoughts
Foreign body in throat	Testicular pain

Gastrointestinal bleeding	Traumatic injury with fracture
Headache	Traumatic injury without fracture
Labour/imminent delivery	Upper respiratory tract infection
Lower respiratory tract infection	Urinary tract infection
Major trauma	Vomiting and/or diarrhoea
Mental health complications of physical health conditions e.g. diabetes	