



Community health services two-hour crisis response standard guidance

Guidance for providers of care, integrated care systems
and clinical commissioning groups

July 2021

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Introduction

The [NHS Operational Planning and Contracting Guidance 2021/22](#) set out the first stage for implementing the community two-hour crisis response standard (the standard) in England by March 2022. All integrated care systems (ICSs) in England must, in this year, ensure crisis response care is available to all people within their homes or usual place of residence, including care homes, within two hours. The approach was introduced in the [NHS Long Term Plan](#) and builds on National Institute of Health and Care Excellence (NICE) [guidelines](#).

The standard should improve patient outcomes by meeting their urgent care needs at home or usual place of residence in a timely way. The ambition is to provide crisis care within the community to prevent avoidable hospital admissions and accelerate the treatment of people's urgent care needs.

Successful delivery of crisis response care within two hours requires close partnership working between a variety of health and social care partners/teams.

This guidance sets out essential operational and clinical requirements for NHS-funded crisis response services that ICSs, providers and commissioners must achieve to meet the new national standard. ICSs have received additional funds to support this work.

The guidance builds on existing good practice and sets out the minimum expectations in terms of increasing capacity and hours of operation for all systems in England in 2021/22.

Some areas are already meeting these expectations and we encourage them to go further. From April 2022 there will be further expectations, including monitoring of achievement against the standard and of the effectiveness and quality of delivery across the country, linked to other urgent care services in each system.

The guidance is a **working document** which was co-developed with clinicians and professionals and will be updated with more evidence, feedback and learning as ICSs implement the standard at scale. Please share feedback on the guidance with us by emailing: england.ageingwell@nhs.net

To learn more about the standard and access further tools and support visit [the Urgent Community Response Future NHS page](#).

We would like to thank and acknowledge the support of the following in developing this guidance. British Geriatrics Society, Age UK, NHS Providers, Association of Directors of Adult Social Services, Local Government Association, Royal College of Nursing, Royal College of Occupational Therapists, The Chartered Society of Physiotherapy, Queen's Nursing Institute, Care Quality Commission, National Institute for Health and Care Excellence and clinicians from across England.

Operational requirements

1. Overview

- 1.1. By 31 March 2022 all ICSs in England must ensure delivery of the national community two-hour crisis response standard (the standard).¹ Community health services' crisis capacity should be enhanced and strengthened so that people receive appropriate and timely care in their home/usual place of residence within two hours when they are in a crisis. This change will require a shift in resources to home and community-based resources and should align with and complement adult social care crisis services locally.
- 1.2. All ICS planners, commissioners and providers must meet the following four minimum requirements in 2021/22.

Requirements	Ambition	Actions for ICS planning leads, commissioners and providers
1. Provide services <u>at scale</u>: ensuring full geographical coverage of two-hour crisis response care across every ICS	Ensuring that anyone who requires a two-hour response receives one, regardless of where they live	<ul style="list-style-type: none"> a) Map the current geographical coverage of crisis response care services (including adult social care crisis teams to avoid a risk of duplication) and expanding provision (where necessary) to ensure full geographical coverage across an ICS. b) Align the delivery models used by different crisis response services across the ICS to provide a consistent model for the population of each ICS. c) Use demand and capacity modelling to predict, plan and implement future workforce requirements and workforce development needed to achieve a two-hour response.²
2. Provide services from 8am to 8pm, seven days a week, <u>at a minimum</u>	Ensuring that people have access to the same high-quality home-based care at weekends and in the evenings as they do on a weekday	<ul style="list-style-type: none"> a) Map current operating hours of crisis response teams in ICSs and expand working hours to provide care from 8am to 8pm if not already consistently in place. b) Expand services beyond 8am to 8pm, seven days a week, in areas that are already

¹ NHS England and NHS Improvement (2021) [NHS Operational Planning and Contracting Guidance 2021/22](#)

² NHS England and NHS Improvement (2021) [Demand and capacity training and guidance](#)

		<p>meeting this requirement, through consultation with local urgent care networks and based on the needs of the local population.</p> <p>c) Consult with staff and unions regarding changes to working patterns.</p> <p>d) Map demand to understand the variation in need for a two-hour response at different times of the day, night or week and organise workforce according to need.</p> <p>e) Use capacity and demand modelling to prepare for expanded hours of provision beyond March 2022.</p> <p>f) Use existing reablement services and support alongside other social care emergency or duty arrangements, eg crisis support for unpaid/family carers.</p>
<p>3. Accept referrals into crisis response services from all appropriate sources</p>	<p>Providing a seamless integrated experience for each person and enabling professionals to easily access the service</p>	<p>a) Ensure referrals can be received from all local health and care partners including:</p> <ul style="list-style-type: none"> • NHS111 • 999 • general practice • social care providers (such as care homes) including personal assistants • clinical hubs in ambulance control rooms and patient-facing ambulance clinicians • specialist services • care workers • local authorities. <p>Please note this list is not exhaustive.</p> <p>b) Accept self-referrals from individuals and carers (which may be directly to the service or via NHS111).</p> <p>c) Make crisis response services accessible via NHS111 by profiling and adding two-hour crisis response services to the local Directory of Services (DoS), to ensure that they are visible to and able to accept transfers of care from clinicians within NHS111/integrated urgent care and other users of the DoS.</p> <p>d) Where technically possible services should be able to send a referral to crisis response services electronically.</p>

<p>4. Submit complete data returns to the Community Services Data Set (CSDS) to demonstrate the achievement of the two-hour standard</p>	<p>Demonstrating impact by collecting data that will support counting of the national standard; quality improvement and improved patient outcomes and experience</p>	<p>a) Ensure clinical activity is recorded in line with CSDS technical guidance including clock starts and clock stops.</p> <p>b) Put processes in place to extract clinical activity from the clinical systems to CSDS.</p> <p>c) Submit data for crisis response activities, including those that can be delivered in more than two hours.</p> <p>d) Use CSDS data for benchmarking and learning locally.</p>
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1.3. ICS planners and commissioners must ensure full alignment between crisis response provision and other urgent care services:

- **Unplanned care programmes** such as NHS111, urgent treatment centres, same day emergency care and 999. Crisis response care has a crucial role in supporting increased rates of ambulance non-conveyance and ensuring a greater number of people who receive same day emergency care can return home without being admitted.
- **Primary care** such as GP out-of-hours, general practice and primary care network teams.
- **Hospital discharge teams and transfer of care hubs:** these may be integrated with crisis response services.

1.4. Crisis response services will rely on other planned care teams to provide ongoing support. These include:

- **Adult and older adult mental health services:** as part of the NHS Long Term Plan, a significant expansion in new integrated models of community mental health services is underway, as well as of urgent mental health crisis services. Alignment and close working is expected to be needed for older adults who are more likely to have multiple co-occurring mental and physical conditions.
- **Proactive care services** such as multidisciplinary rehabilitation teams, anticipatory care and enhanced health in care homes, which provide proactive health management support to help people live well for longer.
- **Community and district nursing services** may well provide the core service model for crisis response services. These services could be enhanced to

respond to all two-hour community crises with a full multidisciplinary approach. However, organised locally, district nursing teams will be an important service to provide ongoing planned care after the crisis has been attended to.

- **Planned care (with set caseloads)** such as hospice at-home services, rehabilitation teams and long-term support provided to people in their homes. This would also include hospital at home or virtual ward models of care supporting admission avoidance and transfers of care into community settings.
- **Social care:** urgent social care interventions and social care are integral to supporting people to stay at home or in their usual place of residence and prevent hospital admission.
- **Reablement services:** crisis response services should work closely with reablement services and support such as social care emergency crisis support for unpaid/family carers.

2. Design and delivery principles in developing the service model

- 2.1. The service should be commissioned to provide a crisis response and co-ordinated through a local single point of access, ensuring a 'no wrong door ethos is applied'. The single point of access should ensure access to multidisciplinary clinical and non-clinical input as required. Where an individual has been triaged by another service such as 999 or NHS111, there should be no need for further triage.
- 2.2. The professional who is deployed to a person in crisis should be matched to their needs to avoid the need for further or repeated assessment. This deployment, while centrally co-ordinated, can involve professionals across a range of teams and organisations depending on how services are configured.
- 2.3. In line with national MDT development guidance,³ crisis response team members should work in an interdisciplinary way. This involves staff members from different disciplines taking on each other's traditional role by agreement to make optimum use of team skills and knowledge. As part of this way of working assessments may

³ NHS England (2015) [MDT development – working toward an effective multi-disciplinary/multi-agency team](#)

be carried out by different disciplines working together, with insights from one discipline informing the assessments of another.⁴

- 2.4. The crisis response service should be designed with a focus on reducing the health inequalities in the local population. This can be achieved through increasing access to care in a crisis at home for those who regularly default to using emergency departments services or 999 services. Services should accept referrals for people both known and new to their services. They should review population, service data and patient feedback, and then act on this insight with referrers, to ensure all local communities use and benefit from this service when needed.
- 2.5. Crisis response services should establish shared care approaches with same day emergency care teams and support rapid access to same day diagnostics in acute units and, where appropriate, community diagnostic hubs.
- 2.6. Crisis assessment and care should be holistic and personalised to avoid layering services and duplication of assessments and visits.
- 2.7. To meet the national standard of responding within two hours, clock starts and stops need to be consistently recorded and submitted to the CSDS. This requires all services and organisations delivering the response to comply with the [CSDS technical guidance](#), noting this is a legal requirement under the NHS Standard Contract.
- 2.8. To meet the national standard, the assessment and care should start in under two hours (clock stop), with these short-term interventions typically lasting under 48 hours to ensure the team can continue to respond to new demand.
- 2.9. Planned or non-crisis care delivered within two hours does not count for this standard but should be recorded as usual in the relevant patient record system.
- 2.10. Due to its nature, the vast majority of two-hour crisis response care should be delivered in person. There may be instances where a two-hour crisis response service 'responds' to a patient remotely, using telemedicine or video consultation, such as where their place of residence is a care home. Where this occurs, it should be:
 - a comprehensive assessment, not a prioritising and scheduling process

⁴ Ibid.

- based on sound clinical judgement
- only when the person is capable of receiving and participating in an assessment done in this way
- following an appropriate risk assessment to ensure patient safety.

Demand and capacity

2.11. Demand and capacity modelling is a crucial tool for supporting providers and systems to understand the demand and plan sufficient capacity, so that patients do not wait unnecessarily for treatment and receive a safe, high quality service.⁵

2.12. To support demand and capacity modelling for two-hour crisis response services, the following tools could be used:

- [NHS England and NHS Improvement demand and capacity models, training and guidance](#)
- The NHS Elect Same Day Emergency Care '[opportunity Identifier tool](#)'. This tool has been developed to help provide an insight into the opportunity available within hospital sites for same day emergency care services and acute frailty services. It identifies specific conditions, numbers of patients and length of stay and may help to provide insights into where crisis response services could have an impact and support demand modelling.

2.13. When modelling capacity and demand, crisis response services should consider the cost of their services and the optimum operating model. ICSs, commissioners and providers should have an understanding of the cost of their service and seek to provide a cost-effective service. More details on cost will be included when we update this guidance.

2.14. Demand and capacity modelling needs to be regularly reviewed alongside percentage achievement of two-hour crisis response and plans put in place to meet demand.

⁵ NHS England and NHS Improvement (2021) [Demand and capacity – an overview](#)

Case study: Sharing data to support commissioning and capacity management

Overview: The North West London (NWL) system includes five community providers and eight CCGs that have worked together over the past year to develop consistent data reporting that is designed to effectively capture daily demand, capacity and performance levels for rapid response, community nursing and community beds across the eight boroughs.

Establishing a process to share data with commissioners:

- **Establish local data reports:** In NWL, members of the ICS community team have worked closely with operational leads from each provider over the past year to agree measures that rate the demand and capacity levels in rapid response teams, community nursing teams and community beds.
- **Extracting key data:** Providers complete reporting with a 48-hour lag time. This enables retrospective, actual data to be pulled automatically from SystemOne or Emis, reducing the burden on provider teams. This data is submitted directly into the Performance/BI team who can upload it and produce trend reports. For example, rapid response data includes the number of referrals accepted, visits completed (in hours), staffing (in hours), percentage of patients triaged and seen within two hours, and the source of referral.
- **Using data to support commissioning:** The trend reports are provided back to the community providers on a daily basis. As the reports provide an up-to-date picture of activity, providers can use the information to make live changes to service lines. Any anomalies and system issues noted are raised weekly with community provider chief operating officers. The data is also shared across the system to give partners confidence that there is capacity in the community and, conversely, to flag when capacity is tight. The data enabled surge triggers to be applied as part of a planned response to wave two of COVID-19.

Next steps: The NWL system plans to embed the reporting processes and refine the trend mapping and analysis. It hopes to use the data to support any increased investment in community services.

3. Monitoring and benchmarking

- 3.1. All providers of NHS-funded crisis response services are legally required to submit data to CSDS under section 250 of [the Health and Social Care Act 2012](#).
- 3.2. All providers of community health services that deliver a two-hour crisis response are required to make this data return monthly into CSDS and this must be concluded by **30 September 2021**.
- 3.3. From October 2021 to March 2022, we will work with providers to improve the quality of the data submitted. This will ensure that from April 2022 two-hour crisis response data will be published for every provider and ICS as an official statistic in line with other key NHS performance statistics.
- 3.4. Monitoring of trajectories provided as part of the 2021/22 planning and contracting round will occur each quarter alongside the legally mandated data submissions to CSDS. NHS England and NHS Improvement regional teams will monitor the performance of their area and will support systems in overcoming data collection and reporting issues. Regional teams will support ICSs in implementing the two-hour crisis response standard.
- 3.5. From April 2022, CSDS data for two-hour crisis response will be published for every provider and ICS as an official statistic in line with other key NHS performance statistics.

Performance framework for the two-hour guidance: how will we know we are succeeding?

System performance will be measured based on:

- submission of data to CSDS
- delivery of services from 8am to 8pm, seven days a week
- delivery of services at scale ensuring full coverage across the ICS footprint
- acceptance of referrals from all appropriate sources
- % achievement of the delivery of crisis response care within two hours.

Future ways of understanding the effectiveness of system performance may include the relationship of crisis response services and data on:

- hospital admissions
- emergency department attendance
- same day emergency care attendance
- ambulance conveyance rates
- NHS111 referrals
- self-referrals
- onward referrals from the crisis response team.

NHS England and NHS Improvement will set national targets for the delivery of crisis response care within two-hours using CSDS.

3.6. ICSs must:

3.6.1 Implement reporting processes that align to the frequency and detail that is required for reporting of both local and national key metrics.

3.6.2 Establish their own monitoring and evaluation plans to maximise the impact of the standard and monitor use of the service to identify potential cohorts who are not benefiting from it. This should include checking geographical coverage, analysing ethnicity data and monitoring patient conditions to identify disparities in access.

3.6.3 Monitor call waiting times and the time lapsed from identifying need to receipt of care.

3.6.4 Understand wider system impact by working with local hospitals to review records of hospital attendances and admissions to identify patients who could have benefited from a crisis response but did not do so, and then identify the lessons that can be learned from this and potential solutions.

Benchmarking

3.7. For 2022/23, NHS England and NHS Improvement will develop how data can be made available in a more timely way. This will support quality improvement and

benchmarking of two-hour crisis response services locally, regionally and nationally. This is important as benchmarking and quality improvement are crucial in delivering improvements in patient care, identifying unwarranted variation and demonstrating the impact of community services on managing patient demand. Further information on this topic and next steps will be included in future versions of this guidance.

Challenges and considerations

- 3.8. Through working with NHS accelerator sites some practical challenges with implementing the standard have been addressed. We will continue to gather tools, solutions and case studies that can help with implementation. These will be shared in webinars and learning events throughout 2021 and on the Urgent Community Response Futures Platform.

Clinical requirements

4. What are the criteria for NHS-funded community crisis response services?

4.1. Community crisis response services are for adults (over the age of 18) and a person should receive a community NHS two-hour response if the following characteristics are present:

- The person is experiencing a crisis which can be defined as a sudden deterioration in their health and wellbeing.
- The crisis may have been caused by a stressor event which has led to an exacerbation of an existing condition or the onset of a new condition or significant deterioration in clinical state or baseline functioning.
- This health or social care need requires urgent treatment or support within two hours and can be safely delivered in the home setting.

4.2. The crisis may be due to:

4.2.1. **A clinical condition such as:**

- a new or acute problem (such as an infection)
- an exacerbation of a chronic condition, where the condition can be safely treated out of hospital, but its functional consequences may mean that the individual is at risk of hospital admission.

4.2.2. **Serious illness where treatment at home is in keeping with the person's wishes as part of a pre-agreed treatment escalation plan, such as:**

- A patient in receipt of palliative care who may in a crisis wish to be treated at home or usual place of residence as part of a pre-agreed treatment escalation plan rather than be admitted to hospital. This will be with the full understanding that the same level of diagnostics and support may not be provided in the community.

4.2.3. A social crisis such as:

- A breakdown of unpaid carer arrangements which causes an immediate health risk to an individual, eg if their main carer is admitted to hospital or if carer stress is causing a breakdown in ability to provide safe health and care support.
- Local authorities have a responsibility to respond to people experiencing a social care crisis.⁶

5. What differentiates a two-hour response from other types of responses?

- 5.1. A two-hour response is typically required when a person is at risk of admission (or re-admission) to hospital due to a 'crisis' and they are likely to attend hospital within the next 2 to 24 hour, without intervention to prevent further deterioration and to keep them safe at home.
- 5.2. Where a person does not require a response within two hours, they should receive care within the timescales they require and be supported to remain safely at home with appropriate services. The associated data should be collected as described in the [CSDS technical guidance](#), but these responses are not counted as part of the national standard. Full submission of data to CSDS will give an understanding of the volume of this activity.

⁶ The Care Act 2014 specifies that local authorities must provide or arrange services that help prevent people developing needs for care and support or delay people deteriorating such that they would need ongoing care and support. [Department of Health and Social Care \(2016\) Care Act Factsheet 1: General responsibilities of local authorities: prevention, information and advice, and shaping the market of care and support services](#)

6. Typical inclusion and exclusion criteria

6.1. The person:

Inclusion	Exclusion
<ul style="list-style-type: none"> • Over 18 years. • Is living in their own home or a residential/care home setting. • Is in a crisis (as defined above) and needs intervention within two hours to stay safely at home/usual place of residence and avoid admission to hospital. • Is living with dementia – best practice is to share responsibility for care with older people’s mental health teams. 	<ul style="list-style-type: none"> • Is acutely unwell or injured, requiring emergency care intervention and an admission into an acute hospital bed. • Is experiencing a mental health crisis and requires referral/assessment by a specialist mental health team.* • Needs acute/complex diagnostics and clinical intervention for patient safety in hospital.

* Exclusion applies to people with functional mental health crises and no co-occurring urgent physical needs. In these instances, specialist NHS and adult social care mental health crisis services should respond (NHS England and NHS Improvement are expected to set out separate waiting time expectations for urgent mental health crisis response).

6.2. The exclusion criteria above should be applied unless a treatment escalation plan, advance care plan⁷ or advance decision to refuse treatment⁸ is in place which states the person wishes for treatment to be delivered in their usual place of residence; or where the family have a lasting power of attorney for health and welfare,⁹ the patient no longer has capacity to make decisions and the family wish for treatment at home.

Professional judgement should always be used to decide if a person needs a two-hour NHS crisis response, or more than two hours, and should take into consideration co-morbidities and the complexity of a person’s needs. Where a multidisciplinary response is required, partners in the service should agree that the response is the most appropriate. A two-hour crisis response will not always be appropriate and entry into a service should be determined on a case-by-case basis. Where an exclusion criterion is used, the crisis response team should work to find alternative NHS support for the person being referred, rather than simply rejecting a referral.

⁷ [Gold Standards Framework \(2018\) Advance care Planning.](#)

⁸ NHS (2020) [Advance decision \(living will\).](#)

⁹ [Lasting power of attorney: acting as an attorney: Health and welfare attorneys](#)

7. Common clinical conditions or needs

7.1. The following list is **not** meant to be exhaustive or used to exclude patients. These are common clinical conditions or needs that may lead to a patient requiring a two-hour response in a **crisis**.

Condition/need	Supportive definition
Fall	With no apparent serious injury, including to the head, back, hip, or where able to rule out a fracture, and where there has been no loss of consciousness. ¹⁰
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. ¹¹ Decompensation caused by a minor stressor event, such as a urinary tract infection (UTI), that can cause a sudden or disproportionate decline in function. ¹²
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. ¹³ 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 crisis response 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. ¹⁴
Urgent equipment provision	Alongside an assessment, makes 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 ^{15,16}). The patient should be assessed and physical health needs managed to establish the cause (eg UTI, cellulitis, pneumonia) so that their needs are managed safely at home. ¹³
Urgent catheter care	Where a person has a blocked catheter and/or pain from a catheter-related issue and is at risk of harm and has a very high

¹⁰ NICE (2017) [Falls in older people. Quality Standard 86 \[QS86\]](#).

¹¹ Frailty Prevention (2015) [What is frailty?](#). (accessed 30 March 2021)

¹² Clegg A, Young J (2011) [The frailty syndrome](#). *Clin Med J* 11(1): 72.

¹³ British Geriatric Society (2021) [Silver Book II: Geriatric syndromes](#).

¹⁴ NICE (2017) [End of life care for adults](#).

¹⁵ Sepsis Trust (2020) [Sepsis Screening Tool Community Nursing](#).

¹⁶ NICE (2017) [Sepsis: recognition, diagnosis and early management. NG51](#).

Condition/need	Supportive definition
	risk of admission to hospital. ¹⁷ Where a district nurse service hasn't the capacity to respond or is part of the explicit function of the crisis response team
Urgent support for diabetes	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 ^{15,15} , hyperglycaemia/ketoacidosis).
Unpaid carer breakdown which if not resolved will result in a health care crisis for the person they care for	<p>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 crisis response.</p> <p>Where crisis response 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:</p> <ul style="list-style-type: none"> • make an urgent referral to the relevant service where the crisis response team does not have Care Act 2014 responsibilities • provide care in line with the Care Act 2014 where the crisis response team does have Care Act responsibilities • work jointly with local authorities or care providers.

7.2. Where a response is not needed within two hours, the individual should receive an appropriate and timely response in line with a 'no wrong door' approach with the aim of meeting a person's need. This will require close partnership working with health and social care services, as well as voluntary and community sector support.

8. Referral and assessment processes

8.1. Referrals to two-hour crisis response services will come from a variety of sources. Figure 1 below shows the current referral routes and volumes for accelerator sites.

8.2. We anticipate over time as pathways become more established that an increasing number of referrals will come from NHS111, same day emergency care, ambulance and self-referrals (Figure 2).

¹⁷ NICE (2017) [Healthcare-associated infections: prevention and control in primary and community care.](#)

Figure 1: Estimates of referral routes into accelerator site two-hour crisis response services (June 2021)

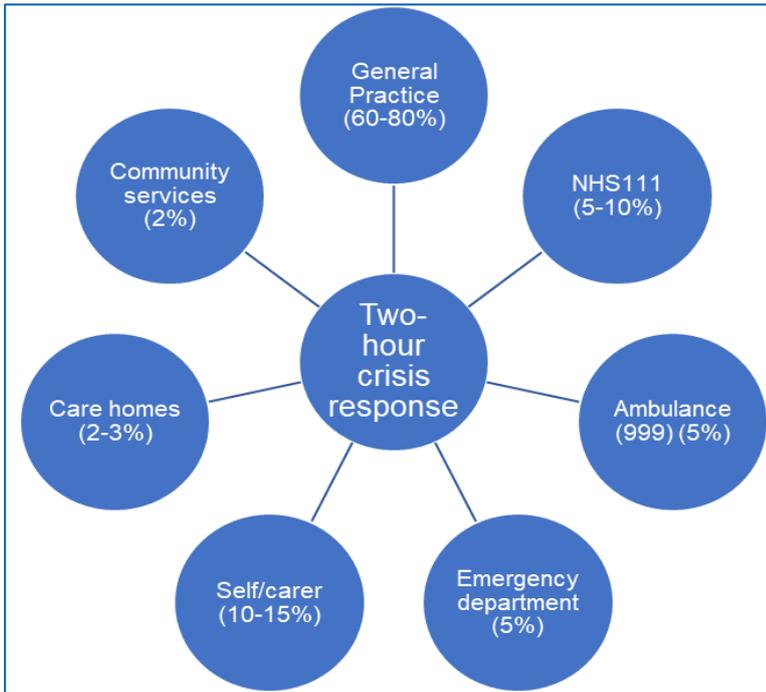
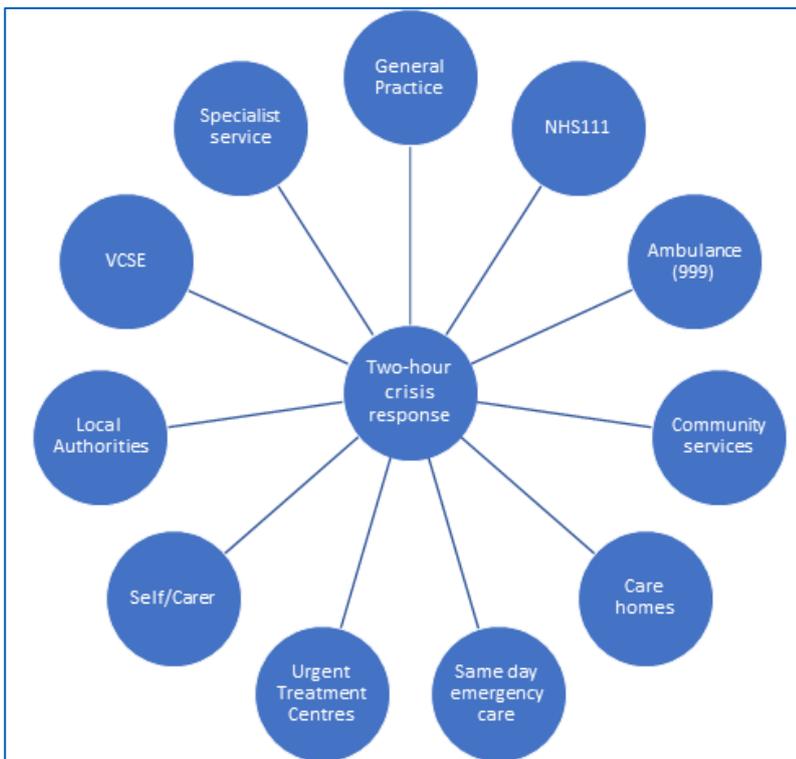


Figure 2: Anticipated referral routes into two-hour crisis response services



- 8.3. While it is anticipated that referral numbers from general practice may stay the same, the proportion of referrals is expected to increase from other sources, such as NHS111.
- 8.4. The following actions will support providers increasing referrals from the key sources outlined above. Further steps will likely be needed to ensure a streamlined referral process is developed.
- Collaborative working with other providers, ICS leads, Directory of Services (DoS) leads and commissioners. This will also include care home leads, NHS England and NHS Improvement regional ageing well leads, NHS111 providers and local 999 ambulance trusts.
 - Adding (profiling) the two-hour crisis response service to the DoS. This is supported by commissioners.
 - Exploring digital solutions to enable the seamless transfer of information between services and organisations. Secure email may initially be used until interoperability between systems develops.
 - The sharing of service information, including case studies, to help referring clinicians understand two-hour crisis response service capability and with the referral of appropriate patients.
- 8.5. All crisis response services should have established processes to correctly prioritise and schedule a person into the right care. There should be appropriate systems and processes in place to:
- ensure appropriate skills and expertise of the assessment team
 - escalate cases where needed
 - monitor call waiting and initial assessment times
 - ensure patients receive timely and appropriate care.
- 8.6. In line with best practice, some services find it beneficial to use trusted assessor principles¹⁸ both within and across teams and organisations. These enable another professional's judgement to determine that a two-hour response is necessary and for the crisis response service to respond. This requires a common understanding

¹⁸ NHS Improvement (2017) [Developing trusted assessment schemes: Essential elements](#).

of two-hour crisis response service capability across places and ICSs and can help reduce the need for multiple assessment activity and provide a seamless service.

9. Crisis assessment and intervention

9.1. The following is a non-exhaustive list of the common assessments, screening tools and interventions typically undertaken/used by two-hour crisis response teams to a person in their home or usual place of residence.

Activities and tools to support assessment and diagnosis:

- make the person/situation safe, provide reassurance and consider any capacity, consent or safeguarding concerns, escalating to appropriate services as required
- holistic history including review of clinical records to understand medical history and presenting issue
- clinical observations, including blood pressure and oxygen saturations
- calculation of [NEWS2](#) (national early warning score) as part of the wider assessment to quickly identify deterioration and to support care decisions or escalation
- blood, urine and other diagnostics
- assessment and provision of equipment to make a person safe at home and support/maintain independence
- medicines optimisation assessment¹⁹
- symptom assessment
- administration of medication, to resolve immediate crisis, including nebuliser therapy for chronic obstructive pulmonary disease/asthma exacerbation.

Screening tools:

- nutrition assessment, eg [Malnutrition Universal Screening Tool \(MUST\)](#)
- risk of developing pressure sores, eg [Waterlow](#) or [Braden](#) score
- frailty, eg [Rockwood clinical frailty score](#)
- delirium, eg [4AT \(Rapid test for delirium\)](#).

Interventions that may be required in the first 48 hours:

¹⁹ NICE (2015) [Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes](#).

- prescription and delivery of appropriate care interventions to support nutrition, personal hygiene, continence, wound care, mobility and rehabilitation to regain or optimise functioning, etc.
- prescription and/or administration of medication for pain or symptom relief
- catheter care to relieve immediate discomfort
- antibiotic prescribing, including intravenous antibiotics as skills allow

9.2. All services delivering two-hour crisis care should aspire to undertake point of care (POC) testing at a patient's side Where POC testing is not yet readily available, teams should ensure they are able to access advanced diagnostics, to support clinical decision-making, risk management and ongoing care planning.

10. Workforce and workforce development

10.1. Different models are used to deliver crisis response care. Typically, provision includes the use of a flexible workforce who are deployed according to each person's needs. Crisis response teams commonly include:

- registered nurses (including district nurses)
- advanced clinical practitioners (from a range of professional backgrounds including allied health professionals and nurses)
- physiotherapists
- occupational therapists
- health and care support staff
- social workers
- paramedics.

10.2. Teams should be supported by other relevant professionals including GPs, geriatricians, social care teams, mental health, learning disability and autism workers, paramedics and voluntary sector organisations.

10.3. A system-wide approach should ensure collaboration to share workforce skills and expertise in the best interests of system-wide change, eg by making senior frailty and learning disability experts available to provide expert resource to crisis response teams.

10.4. Commissioners and providers should ensure that they have the appropriate workforce and skill mix in place to deliver crisis response care and meet local

population needs and that teams have access to the following skills, training, tools and support. They should also support newly qualified professionals, students and higher education institutions to develop the necessary skills needed for a career in community crisis response services.

<p>Advanced clinical practice</p>	<p>Teams should be supported to develop and implement advanced clinical practice skills, in line with HEE guidance,²⁰ and have access to:</p> <ul style="list-style-type: none"> • advanced clinicians who have the skills, knowledge and experience to make complex clinical decisions, sometimes in the face of uncertainty and varying levels of risk, and have a high degree of autonomy and accountability (eg a community geriatrician, district nurse, or GP with a special interest). This will include the ability to make a working diagnosis of the underlying cause of the crisis • other specialties, such as hospital-based diagnostics or community diagnostic hubs, phlebotomy, prescribers and 'hot clinics', so that people can be diagnosed quickly if needed.
<p>Training and education</p>	<p>Teams should receive appropriate training so that they can understand and support the diverse needs of their local populations. This includes:</p> <ul style="list-style-type: none"> • comprehensive frailty training and use of the Frailty Core Capabilities Framework²¹ • training on symptom assessment • training on dementia, mental health and mental health first aid • education around the needs of, and reasonable adjustments for people with a learning disability and/or who is autistic.
<p>Diagnostic tools</p>	<p>Work should be undertaken to enable POC testing to help clinicians make a working diagnosis and support risk management and ongoing care planning for the person.</p>
<p>Current and future workforce development</p>	<p>The capacity and capability of crisis response teams should be enhanced in anticipation of a further expansion of crisis response services to meet the population health needs in the period up to 2024.²²</p> <p>The workforce and capacity of rehabilitation services and other pathways that crisis response services commonly refer patients onto should also be enhanced and strengthened in anticipation of an increased number of referrals as part of the expansion of two-hour crisis response care.</p>
<p>Digital and shared health and care records</p>	<p>Being able to view and record patient information in shared care records will support the delivery of care at home.</p>

²⁰ [Health Education England \(HEE\) Multi-professional framework for advanced clinical practice in England](#)

²¹ Health Education England, NHS England and Skills for Health (2018) [Frailty: A framework of core capabilities](#).

²² NHS England (2020) [We are the NHS: People Plan for 2020/21 – action for us all](#).

Skill mix

10.5. The skill mix of the two-hour crisis response workforce should reflect patient care needs and local requirements, considering the experience and capabilities of the workforce employed. We are keen to work with local providers to establish what the optimal blend of skill mix and ratio is and will include further information in future versions of this guidance.

Caseload management

10.6. Caseload management is important in improving care outcomes for patients and enhancing patient experience. We plan to work with local providers to understand from best practice what the optimum caseload size of a two-hour crisis response team is and will include this information in future versions of this guidance.

Case study: Using digital tools to enhance performance and understand demand

Overview: In 2018, Leicester Partnership Trust (part of the Leicester, Leicestershire and Rutland (LLR) accelerator site), identified a need to improve its understanding of demand in the community and the capacity within its teams. The solution was using Autoplanner, a software built into the Electronic Patient Record system.

Using automatic workforce software:

- Autoplanner allows the trust to look at all open referrals and care plans linked to a team's caseload, giving information on the needs of patients, geographical spread and staffing information. The software also prioritises those in most urgent need, meaning easier identification of those referrals into the urgent community response teams who require a two-hour crisis or two-day reablement response.
- The software also provides workforce information, such as the number of staff working, their available hours and the team's skill mixes to help match clinician skill sets to the care plans and therefore best use team time.
- The software matches open referrals to the right professional (e.g. community nurses or healthcare assistants) and brings significant efficiency to the team. In

2019, savings of 12 hours/day of clinical staff time and 2.5 hour/day of planning time was saved for each of the 30 teams.

- More broadly, the software has influenced the health and wellbeing of staff. It plots the most efficient route to a patient's home, saving travelling time and leaving adequate time to schedule breaks/other commitments into each shift. It also supports organisational development as it can help identify training needs against referral priorities.

The Autoplanner functionality as part of SystemOne modules were made available in August 2018 and can be used by other relevant providers.

Further support

For information and general queries regarding the two-hour crisis response standard and related guidance, please email england.ageingwell@nhs.net.

To access digital tools, resources and ongoing updates regarding the standard, please visit the Community Services and Ageing Well Future NHS platform:

<https://future.nhs.uk/Ageing/grouphome>.

Resources

- Technical information for implementing the two-hour crisis standard (including clock starts and stops): [Urgent community response – two-hour and two-day response standards 2020/21 Technical data guidance](#).
- Planning guidance and finances regarding implementation of the two-hour crisis response standard: [NHS Operational Planning and Contracting Guidance 2021/22](#).
- Referral, assessment and delivery of home-based services to reduce the need for a hospital admission: [NICE guideline NG74](#).
- [NHS England and NHS Improvement demand and capacity models, training and guidance](#).

Contact us:
england.ageingwell@nhs.net

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

This publication can be made available in a number of other formats on request.

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