

Urgent community care: clinical decision-making framework



Who should use the framework

The framework should be used by systems working with:

- local ambulance teams
- community, primary care and acute providers
- [Single Point of Access](#) (SPOA) also known as Unscheduled Care Co-ordination Hubs (UCCH)

Integrated system working will help teams manage urgent care needs in the community when this is the best option for people.

Please note that this framework is not clinical policy, it provides support for clinical decision-making. Further work is in progress to support implementation.

Introduction

Around 1 in 5 people who attend the emergency department (ED) do not require urgent or emergency care. Many people, particularly those living with frailty, can be treated safely and effectively in the community. When this happens, often outcomes and experiences improve.

From hospital to community care

Returning to constitutional standards and delivering the ambitions of the 10 Year Health Plan requires more care to be delivered closer to home. This depends on:

- effective governance
- appropriate clinical decision-making

What this framework covers

This framework supports teams to **balance patient, clinical and system risk**, so more people can benefit from safe care out of hospital.

It lists **8 key actions** for managing patients in the community. It also identifies which patient cohorts and presentations should be considered for community-based care.



"As everyone reading this knows, sometimes, but not always, coming into hospital is absolutely the right course of action for an older person. With the right clinical expertise and by working with and listening to patients (and where relevant their families and carers), safely caring for them at home can be the better alternative. This guidance can **help teams to support safe and effective care at home**, not as a means to simply divert people from hospital but to deliver better outcomes, guided by patients' wishes and preferences and the best clinical advice."

Caroline Abrahams, Charity Director, Age UK

The Association of Ambulance Chief Executives (AACE), the British Geriatrics Society (BGS), the UK Hospital at Home Society and the Society for Acute Medicine (SAM) welcome the publication of this framework and the ambition to increase the availability of safe, effective urgent care provision in the community for people who could benefit.

By providing structured clinical guidance, it will support professionals to work together collaboratively to deliver better outcomes.

Key actions for managing patients in the community

1. Start with patient choice and shared decision-making

Patients should be offered the option to be treated and managed in their homes or usual place of residence, wherever possible. Discuss:

- risks and benefits of hospital care versus management in the community
- escalation triggers (including safety netting), processes and points of contact

The [Royal College of Physicians' guide to communication about uncertain recovery](#) can help guide these discussions.

Based on these conversations, clearly [document and share advance care planning](#) (ACP) and treatment escalation preferences (TEP).

Community care should be considered for people with moderate frailty – Clinical Frailty Score (CFS) of 5 to 6 – and is usually appropriate for people with severe frailty, CFS of 7 to 9.

2. Consider home factors and the support available

When deciding between home care and ED conveyance, consider:

- informal or formal support from carers (carers should also be part of shared decision-making); an assessment is needed to consider whether this is sufficient to meet the patient's needs, and if not, whether the care package can be increased on a short-term basis to address the gap
- the needs of unpaid carers; check if a carer's assessment is appropriate and ensure carers have the information they need and know how to access further advice and support, including local voluntary, community and social enterprise (VCSE) services, such as:
 - the [Age UK](#) helpline (8am – 7pm helpline, 0800 678 1602, 365 days a year)
 - [virtual wards information and checklist](#) from Carers UK
- whether a residential or nursing home can meet the patient's needs; residential homes provide 24/7 care, and nursing homes will have 24/7 onsite clinical cover

3. Use integrated community services to treat urgent care needs at home

With services such as Hospital at Home (otherwise known as virtual wards), many acutely unwell patients can be safely treated and managed at home, including those living in care or nursing homes. Ensure:

- community teams can access the appropriate interventions, diagnostics and monitoring to support that choice, with appropriate oversight and clear escalation protocols (especially out of hours)
- a Comprehensive Geriatric Assessment, including medication review, is completed or updated for those living with frailty
- high-quality end of life care is available where appropriate

Note: Research and resources on Hospital at Home services are available from the [Hospital at Home Society](#).

4. Be clear who is clinically responsible

There must be clarity on where clinical responsibility for the patient lies at all times, including:

- after the assessment phase

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- when clinical handover occurs
 - during the treatment and management phase, including the ability to delegate levels of risk where appropriate

5. Use senior clinical decision-making

Senior clinicians should support care co-ordination and care delivery teams at key decision points, helping them:

- assess risk
- avoid unnecessary admission
- make shared decisions with patients and carers using trusted assessments (as detailed by the [Local Government Association](#))

6. Work as one integrated community team

Management in the community may require:

- advanced practice level skills
- consultant level support from relevant specialist areas
- capacity for physical visits when required
- remote monitoring

This approach will require integrated working across urgent community response (UCR) and Hospital at Home teams, in collaboration with primary care.

7. Ensure rapid access to diagnostics and treatment

There should be appropriate and timely access to:

- [diagnostic interventions](#), including:
 - [point of care testing](#) (POCT)
 - ultrasound and bladder scanning
 - electrocardiogram (ECG)
 - urgent outpatient radiology
- hospital level interventions, including:
 - oxygen
 - intravenous (IV) fluids
 - oral and IV antibiotics
 - oral and IV diuretics
 - catheterisation

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- medications, such as grab-bag or electronic prescribing, including ‘just in case’ medications; also see National Institute for Health and Care Excellence (NICE) [guidance on pharmacological interventions in the care of dying adults in the last days of life](#)
 - multidisciplinary teams and senior clinical decision-makers with responsibility for ongoing care to ensure a holistic assessment and treatment plan can be put in place, including:
 - access to adaptive equipment if required
 - short-term increases in personal care provision when required

8. Maintain strong governance

Processes and protocols should be in place prevent safety issues or risks at the interface between organisations, with clear lines of governance and clinical responsibility.

Clinical presentations with the potential to be managed in the community

1. Long lie patients (especially living with frailty)

Key links:

- [Falls: assessment and prevention in older people and in people over 50 at higher risk](#)

Considerations

- should normally be managed in the community
- falls trained community first responders can offer early support where appropriate
- full clinical assessment will be required, including comprehensive falls assessment and medication review
- if the patient is clinically well, once off the floor, bloods can be done by the UCR team at home and patient kept on a virtual ward with Hospital at Home support if necessary

Key enablers and diagnostics

- diagnostics required may include:
 - blood tests looking for causes of fall
 - renal function testing
 - imaging, for example x-ray and magnetic resonance imaging (MRI)
- IV fluids should be available if required
- serum creatine kinase (CK) is not always required, and when needed, it is not a time-critical test and can be done in hospital laboratory

May require senior advice, acute assessment or both

- significant change in mobility with suspected fracture, for example, no longer able to walk or requiring radiology investigation
- significant trauma or injury
- grossly abnormal renal profile
- clear loss of consciousness without recovery while being assessed

2. Acute respiratory illness, including viral and bacterial pneumonia and exacerbations of chronic obstructive pulmonary disease (COPD)

Key links:

- [guidance note: virtual ward care for people with acute respiratory infection including chronic obstructive pulmonary disease](#)

Considerations

- many patients conveyed to hospital do not have an oxygen requirement and potentially could be managed at home
- the use of [CRB 65/CURB 65](#) results in higher numbers of older patients being identified as in need of hospital level care; this care can be provided in the home where appropriate instead of in hospital
- consider putting in place urgent short-term oxygen, if required, after clinical assessments
- consider aspiration risk and need for swallow assessments
- consider use of self-monitoring and remote monitoring for signs of deterioration

Key enablers and diagnostics

- ability to provide home oxygen
- remote monitoring options
- acute nebulisers to support treatment at home
- diagnostics required may include:
 - blood gas analysis in suspected type 2 respiratory failure, but less likely in primary respiratory infection
 - remote monitoring of O₂ levels, which can be helpful to monitor need and titration of oxygen
 - POCT C-reactive protein (CRP) pathways to support decisions on need for antibiotics and reduce the risk of antimicrobial resistance
 - point of care ultrasound to manage patients with a new oxygen requirement if there is no access to other imaging
 - access to urgent radiology, including X-ray and computed tomography (CT) if not improving

May require senior advice, acute assessment or both

- if higher levels of oxygen are required, may need acute admission
- CRB 65/CURB 65 score in those with COPD could be used to identify high risk patients who are likely to need to be managed in hospital

3. Falls due to transient loss of consciousness or blackout

Considerations	Key enablers and diagnostics	May require senior advice, acute assessment or both
<ul style="list-style-type: none">• can be managed by a Hospital at Home team with:<ul style="list-style-type: none">○ remote monitoring○ access to cardiology, neurology, and geriatrician expertise○ referral to falls clinics where required• link to day case urgent syncope investigation if available• might need specialist cardiac and neurological advice depending on presentation	<ul style="list-style-type: none">• diagnostics required may include:<ul style="list-style-type: none">○ assessment on a case-by-case basis to see if imaging would be helpful or wanted○ 12-lead ECG○ further cardiac monitoring, for example, 24-hour ECG and lying and standing blood pressure (BP) or 24-hour BP	<ul style="list-style-type: none">• bradycardia or tachycardia post fall• suspicion of an acute cardiac event in progress• possible new diagnosis of epilepsy in very frail patients could be managed by a trial of anti-epilepsy medication

4. Head injury with anticoagulants or antiplatelet treatment in the context of frailty, especially cognitive impairment

Key links:

- [position statement on the 2023 NICE head injury guidelines](#) for further guidance on making safe and appropriate decisions

Considerations	Key enablers and diagnostics	May require senior advice, acute assessment or both
<ul style="list-style-type: none">• many patients should be able to be managed in the community with access to urgent radiology, including a CT head if required• may need different approach for non-frail groups or those associated with alcohol or drug use• in certain cases, a scan may not be required for the ongoing management of the patient, in line with senior clinical decision-making via the SPOA, patient choice and a conversation with family and carers• assess the risk versus the benefit of staying on anticoagulant or antiplatelet treatment and consider stopping for a short period, depending on need• consider case holding overnight if clinically well and have the CT the following day via same day emergency care (SDEC) rather than ED• note that patients with advanced frailty and terminal disease may not benefit from admission, and good palliative care at home might be preferred	<ul style="list-style-type: none">• access to urgent radiology, including CT head• effective monitoring for changes in consciousness or significant changes in cognitive ability; these should trigger escalation	<ul style="list-style-type: none">• major severe head injury on examination• reduction in consciousness, that is, deteriorating Glasgow coma scale (GCS) or neurological changes

5. Infections in the context of frailty requiring short-term IV antibiotics

Considerations	Key enablers and diagnostics	May require senior advice, acute assessment or both
<ul style="list-style-type: none">• many patients could be managed in the community with treatment of acute infection• balancing risk should include considering the potential risks of hospital admission, for example, hospital acquired-infection and deconditioning, including due to longer-term IV use and associated reduced mobility• it is possible to deliver short-term IV normally up to 72 hours and thereafter switch to oral antibiotics• elastomeric pump may be a suitable alternative	<ul style="list-style-type: none">• able to provide short-term IV antibiotics• elastomeric pump• diagnostics required may include:<ul style="list-style-type: none">○ microbiology cultures○ CRP and renal testing○ radiology, if required○ testing white cell count	<ul style="list-style-type: none">• treatment resistance to common antibiotics, although good access to imaging and innovative microbiology advice can help keep patients at home• infection requiring comprehensive investigation, for example, endocarditis

6. Dementia with delirium crisis management

Considerations	Key enablers and diagnostics	May require senior advice, acute assessment or both
<ul style="list-style-type: none">• patients with dementia and delirium may significantly deteriorate if removed from their home environment and should be managed there if it is safe to do so• hypoactive delirium is much more common than hyperactive delirium and needs to be adequately assessed as it is more likely to be missed• access to care is essential to avoid admission, particularly the ability to keep safe overnight• teams should expect that improvement is possible and have an escalation plan (for example, admission to a community bed), including reassessment if that doesn't happen• teams should plan for pragmatic support for patients with dementia and delirium who are coming towards the end of their life linked to good palliative care	<ul style="list-style-type: none">• diagnostics may include testing to exclude potential triggers, such as acute infection and dehydration• access to interventions to support hydration in hypoactive delirium, for example, IV fluid given over 1 hour	<ul style="list-style-type: none">• if a safety risk associated with staying in normal place of residence is identified and cannot be mitigated• carer breakdown

7. Chest pain for severely frail patients

Considerations	Key enablers and diagnostics	May require senior advice, acute assessment or both
<ul style="list-style-type: none">• clinically feasible to be managed in the community• potential cardiac causes would require risk assessment, including discussion with the patient and family and carers if appropriate• low- and intermediate-risk pulmonary embolism (PE) can be safely managed in the community with anticoagulant therapy; if wanted and required outpatient Computed Tomography Pulmonary Angiography (CTPA) is appropriate	<ul style="list-style-type: none">• diagnostics required may include:<ul style="list-style-type: none">○ 12-lead ECG○ Troponin testing○ D-Dimer	<ul style="list-style-type: none">• likely current cardiac event or severe PE might require admission• severe chest pain may require too many resources to be managed in the community

8. Headaches

Key links:

- [NICE guidance](#) on how to assess whether a headache can be managed in the community

Considerations

- likely that long term headaches could be managed in the community with assessment at home to determine which cases need acute assessment or hospital admission

Key enablers and diagnostics

- diagnostics required may include:
 - blood pressure, pulse
 - respiration rate
 - temperature
 - oxygen saturation

May require senior advice, acute assessment or both

- visual disturbance
- dizziness or vomiting
- changes to GCS
- pain preventing sleep
- requirement for scan or lumbar puncture
- younger presentation with acute headache

9. Hypertension

Key links:

- [NICE guidance](#)

Considerations

- would normally expect to manage in the community in line with NICE guidance

Key enablers and diagnostics

- diagnostics required may include:
 - blood pressure
 - urinalysis
 - ECG
- option to offer home blood pressure monitoring

May require senior advice, acute assessment or both

- treatment resistant hypertension may need admission
- cardiac red flags alongside presentation
- poorly controlled with previous cardiology involvement

10. Heart failure, decompensations, fluid overload

Key links:

- NHS England's [guidance note: virtual ward care for people with heart failure](#)
- ESC Heart Failure [Telehealth-aided outpatient management of acute heart failure in a specialist virtual ward compared with standard care](#)

Considerations	Key enablers and diagnostics	May require senior advice, acute assessment or both
<ul style="list-style-type: none">• many people can be managed in the community using telehealth remote monitoring technology to enable heart failure specialist teams to support with treatment decisions	<ul style="list-style-type: none">• daily monitoring (weight, blood pressure, oxygen saturation and electrolytes)• ambulatory and home intravenous diuretics should be available if required• point of care blood testing for renal function• point of care echocardiography supported by AI interpretation and access to specialist advice	<ul style="list-style-type: none">• treatment resistance might indicate cardiology assessment required• acute coronary syndrome• pulmonary oedema• arrhythmia with haemodynamic instability• hypoxia with new oxygen requirement• hypotension (systolic blood pressure <90mmHg)

11. Wheezing children

Considerations	Key enablers and diagnostics	May require senior advice, acute assessment or both
<ul style="list-style-type: none">• link with 48 hour open door policy for parents to return directly to paediatric unit for child's re-assessment• clear clinical guidelines already exist• generalist competencies required for assessment• leadership and support from paediatrics-trained staff	<ul style="list-style-type: none">• with appropriate management, and staff who have the confidence and equipment to complete a full assessment, many children and young people could be managed in the community• team able to manage psycho-social issues, consider safeguarding and parenting issues alongside clinical presentation	<ul style="list-style-type: none">• confirmed diagnosis of asthma due to risk of rapid deterioration and death – skilled assessment required to identify those who need hospital assessment or admission

12. End of life

Considerations	Key enablers and diagnostics	May require senior advice, acute assessment or both
<ul style="list-style-type: none">• should usually be managed without admission to hospital, with the right assessment and support in line with the patient's wishes• currently not well defined or always identified• patient often has an acute presentation, for example, infection• patient choice (including advance care plans if in place) is critical to any decision to convey to hospital• advance directives should be checked for• availability of hospice support	diagnostics required may include: <ul style="list-style-type: none">• POCT to identify or exclude infection	<ul style="list-style-type: none">• patient not able to be safely cared for at home with informal or formal support• level of confusion critical concern

13. Query DVT

Considerations	Key enablers and diagnostics	May require senior advice, acute assessment or both
<ul style="list-style-type: none">• potential to assess at home	<ul style="list-style-type: none">• diagnostics required may include:<ul style="list-style-type: none">○ point of care ultrasound○ D-dimer testing	<ul style="list-style-type: none">• evidence of trauma or possible fracture

14. Hyperemesis

Key links:

- [Society of Obstetric Medicine of Australia and New Zealand's guidance](#)

Note: international examples of this approach demonstrate opportunities to improve service delivery and patient experience for appropriate women. We are seeking examples of good practice from the UK.

Considerations	Key enablers and diagnostics	May require senior advice, acute assessment or both
<ul style="list-style-type: none">• many women are currently managed via gynaecology SDEC on inpatient wards, although most attend as day patients to obtain IV fluids and anti-emetics to manage their symptoms until they resolve• some women attend the hospital late in the evening as they have to work around childcare responsibilities; this can mean that they are admitted overnight• there is an opportunity to provide this treatment at home with oversight from the specialist gynaecology and obstetric teams• an alternative option would be to provide the initial assessment via gynaecology SDEC and to transfer to the Hospital at Home team for ongoing management• if limited resources are available, people living with frailty might benefit more from the capacity in the community, as this cohort is generally in a position to attend hospital if required	<ul style="list-style-type: none">• ability to provide IV fluids• availability of anti-emetics via intramuscular or per-rectum delivery rather than oral (oral treatment is not suitable due to the symptom presentation with sickness)• diagnostics including:<ul style="list-style-type: none">○ thyroid function testing○ urinalysis	<ul style="list-style-type: none">• would expect community team to do urinalysis and bloods and seek advice if ketones don't improve• if the symptoms don't improve then further advice should be sought from the specialist team

15. Catheters

Key links:

- [Getting It Right The First Time \(GIRFT\) urology guide to Urgent and Emergency Care and Same Day Emergency Care](#)

NHS England's guidance on [Urinary catheter tools](#)

Considerations	Key enablers and diagnostics	May require senior advice, acute assessment or both
<ul style="list-style-type: none">• people living with moderate to severe frailty (CFS 6 to 9) requiring catheterisation or re-catheterisation should usually be treated at home, particularly if they are at risk of incontinence• this is a core clinical condition for UCR teams who should have consistent access to staff with the relevant clinical skills• for complex patients the SPOA or UCCH should be contacted to discuss options, including any further investigations that may be required• where people are in retention and acutely unwell, the case should be discussed with the SPOA or UCCH for potential referral to the Hospital at Home team• teams should review standard operating procedures and exclusion criteria, as blanket exclusions should be avoided and should not override advance care planning decisions	<ul style="list-style-type: none">• diagnostics required may include:<ul style="list-style-type: none">○ Bladder scanners• shared decision-making using SPOA or UCCH teams and specialist input as required• acuity assessment• documentation of insertion of catheter needs to be comprehensive, ensuring that records are accessible as part of a shared care record• where this is a new catheter, ensure that the patient, family and carers are given a catheter passport and that education is provided at the time of insertion with follow up and the appropriate referral(s) to support ongoing care	<ul style="list-style-type: none">• urology services and primary care in complex cases for support and follow up