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Right care, right place, first time

## Six Goals for Urgent and Emergency Care

National Single Point of Access (SPoA)  
Framework for Wales



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## 1. Executive summary

The Single Point of Access (SPoA) Framework has been developed to enable delivery of the ministerial priority for urgent and emergency care key enabling action as set out in the NHS Wales planning guidance 2025/26.

The **purpose** of the Framework is to enable health boards to develop a Single Point of Access, developed to clear national standards to reduce variation and provide consistent access to services and clinical pathways seven days a week.

The Framework **aims** to simplify access for Health and Social Care Professionals to remote assessment, advice and treatment for patients under their care (the SPoA is for Health and Social Care professionals only and does not provide direct access for patients and public).

Evidence suggests that implementation of a consistent SPoA can ensure a patient receives the correct and proportionate response once their needs have been assessed, providing timely care closer to home. If consistent implementation of SPoA is achieved, the impact on the wider system is as follows:

- **Appropriate ambulance dispatch:** increase in the number of appropriate or 'approved' dispatches for target patient cohorts and minimalise patients passed to the ambulance service. *(Note: target patient cohorts will be locally agreed but may include people who live in care homes, who are end of life, or who have complex frailty)*
- **Reduced ambulance conveyance:** reduction in the number of inappropriate conveyances to emergency departments (EDs) for target patient cohorts.
- **Urgent community response:** increase access to a two-hour holistic and personalised urgent care response, taking a shared approach across services.
- **Increase in the number of appropriate referrals** and in acceptance rates to wider community, Enhanced Community Care (ECC) services, mental health (including 111 Press 2) and/or social care services. This would also include those people who could continue to be maintained within these services as opposed to being admitted to hospital (case holding).
- **Increase in the number of referrals/acceptance rates** for alternative acute services, for example, Same Day Emergency Care (SDEC).

- **Reduction in the number of ED attendances** for target patient cohorts.

**For our population this will mean:**

- Improved experience and satisfaction
- Increased access to same day urgent assessments where appropriate
- Faster access to the right care, resulting in improved patient outcomes
- Optimised care at home, or in their normal place of residence.

**For the wider system this will mean:**

- Greater efficiency and productivity
- Better use of NHS resources and social care resources, including limited clinical/non-clinical resource
- Reduced ED attendances and ambulance delays, and improved ED/ambulance performance against key targets
- Improved social care demand management through timely and appropriate response for people living with complex needs
- Reduced risk of deconditioning associated with conveyance, handover delays and admission and maximising opportunities to avoid these
- Alleviated pressure in general practise, allowing focus on people with complexity and continuity of care needs
- Reduced healthcare inequalities
- Increased efficiency in utilisation of financial resources.

This guidance will specifically support health boards to develop and implement a consistent SPoA and actively encourage closer working with the Welsh Ambulance Service (WAST) and Local Authority (LA) partners in how they can develop and implement the components of the SPoA to best serve the needs of their Integrated Urgent Care (IUC) system and of their local populations.

## 1.1 A Single Point of Access overview

A SPoA simplifies access to services by offering clinicians and other professionals involved in the care of a person, further timely assessment, treatment, advice, and/or guidance to support people to get the right care for their needs, efficiently and safely. The aim is to improve outcomes for people regardless of where they present or enter urgent care.

**The SPoA should be considered as a partnership between urgent and community care, WAST services and social care, bringing together a multi professional team that can optimise care closer to**

## **home, preventing avoidable conveyances and attendances at emergency departments.**

SPoA implementation is part of the Integrated Urgent Care (IUC) system approach aimed towards providing care closer to home and avoiding unnecessary hospital presentation or admission. A SPoA can also contribute to improving referrals to services providing Enhanced Community Care, bring an additional increase to the use of alternative pathways into specialised and Same Day Emergency Care and they can also contribute towards the management of urgent care by completing episodes of care using a remote assessment and treatment approach when appropriate to do so.

### **1.2 Key recommendations**

By September 2025, all health boards are required to have the following:

- A clearly defined SPoA in place seven days a week, 12 hours a day.
- Clearly defined pathways for the delivery of remote or face-to-face assessment, treatment, and advice (via the SPoA).
- Ambulance services to have agreed pathways from their remote and response care platforms to explore alternatives to conveyance with SPoA.
- 111 service enabled to identify people prior to attendance at ED and flow as agreed into the SPoA for provision of treatment or access to alternative pathways of care.
- Direct referral from the SPoA into local Information, Advice and Assistance (IAA) and associated integrated community services.
- A mechanism to provide priority access for ambulance (including ambulance clinicians at scene) and General Medical Services (GMS) staff in the first instance, but with consideration to expand to wider health and care professionals, providers, and services in the future.

## **2. Introduction**

The NHS is a complex system and having detailed knowledge and understanding of access into local services is inconsistent across health boards and organisational boundaries. Similarly, the same challenges apply to Local Authority services.

Having a Single Point of Access (SPoA)\* at a local level within organisations ensures a consistency of approach, allows local knowledge and associated skills to be applied, to assess a person's needs in one place and get them

to the right service in a timely manner, optimising their care closer to home.

When done well, it creates greater integration and streamlining of access into a range of services seven days a week.

*\*Note: SPoA is not intended as a care entry point for patient use.*

The development of similar models across the UK have been shown to have several benefits and prevent inappropriate conveyances/attendances to hospital. Development of SPoAs in Wales, whilst not yet as wide ranging or comprehensive in coverage, are showing similar benefits where they have been put in place by offering alternative options to manage a person's needs closer to home.

Across Wales, some health boards have started to develop a SPoA in the form of navigation, streaming and flow hubs. However, there are often differences in scope, geographical footprint, maturity and name. Models also vary in the range of clinicians or professionals who can access them, how and when they are staffed and which services they accept referrals from.

The National SPoA Framework will build upon the work already undertaken and enable health boards to further enhance and standardise access to pathways and services while improving consistency of service across seven days. It will also help to reduce variation locally, regionally and nationally.

### **3. Background**

The Six Goals for Urgent and Emergency Care (UEC) National Programme, co-designed by clinical and professional leads, spans the urgent and emergency care pathway and reflects the priorities in the Welsh Government Programme for Government 2021–2026. Our strategic aim is to prevent unnecessary escalation of care where possible, by providing proactive support and to enable access to the right care, first time for people who have a need for urgent or emergency care.

This approach aligns with the commitments of *A Healthier Wales (2018)*, the *Workforce Strategy for Health and Social Care (2020)*, the *Programme for Government (2021)* and the *National Clinical Framework (2021)*, to deliver:

- A whole system approach where seamless support, care or treatment is provided as close to home as possible

- Services designed around the individual and around groups of people, based on their unique needs and what matters to them, as well as quality and safety outcomes
- A system where people only present at, or are admitted to, a general hospital when it is essential, with hospital services designed to minimise the time spent in hospital
- A shift in resources to the community that enables hospital-based care (when needed) to be accessed more quickly
- The use of digital change and technology to support high quality services
- A motivated and engaged workforce with the right capacity, capability and confidence.

Our vision for urgent and emergency care is also founded on the *Wellbeing of Future Generations Act (2015)*, 'Five Ways of Working', setting out:

- A longer-term vision for designing a seamless urgent and emergency care model, along with short to medium term action requiring collaborative planning across health, social care and the third sector to optimise outcomes
- Public involvement which has been key to shaping the Six Goals and will remain fundamental to tackling health inequalities, the delivery of personalised care and the co-design of new models of care, with a strong focus on preventive activity aimed at keeping people well and maintaining independence.

## **4. Components of a Single Point of Access**

Health boards are required to implement the following components as a minimum for September 2025, expanding the scope and capacity thereafter. It is recognised that there is a requirement for some flexibility in the approach to take account of the different requirements in certain health board areas. Further detail can be seen in Appendix 1.

### **4.1 Operating model**

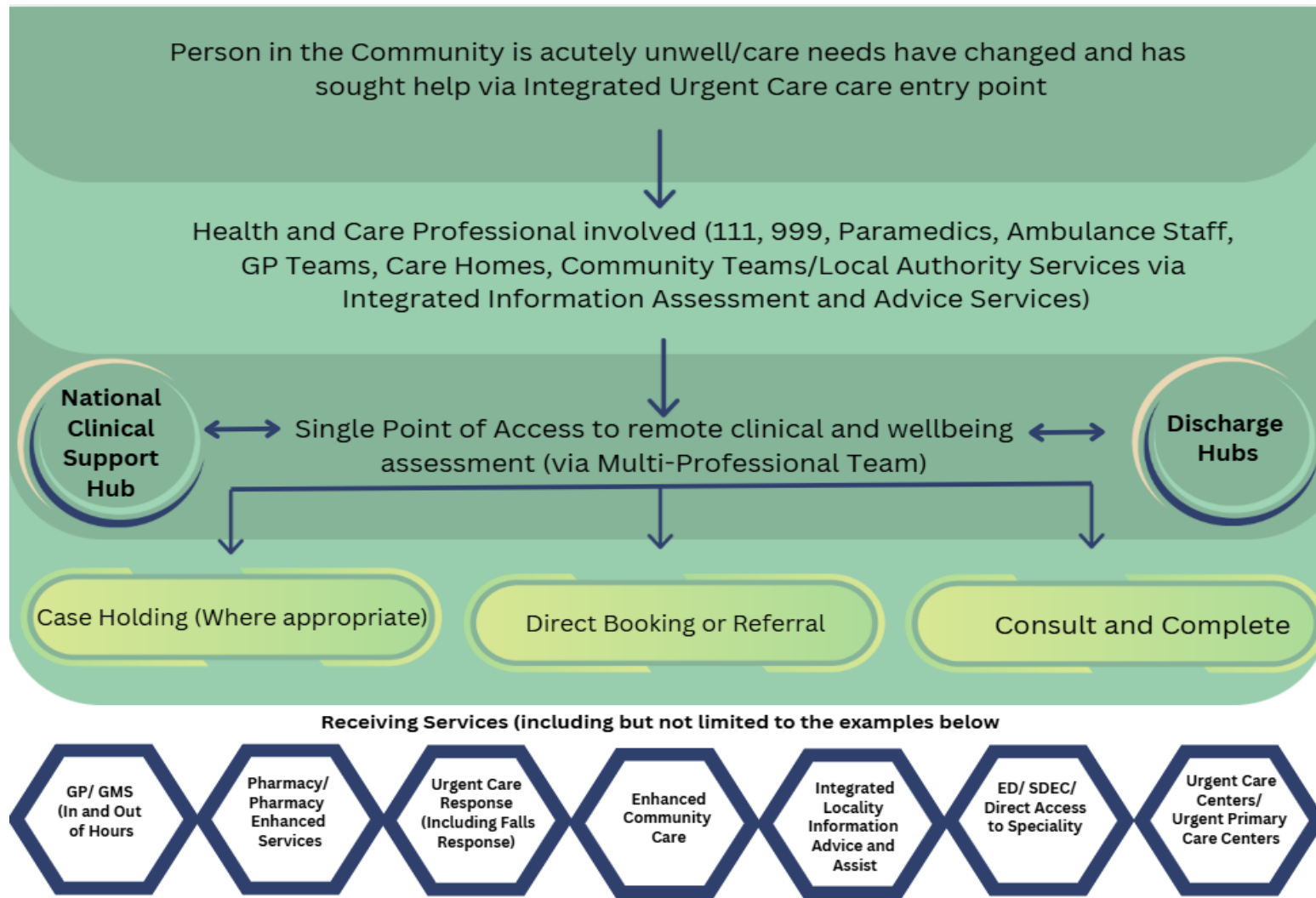
- Operates at a health board level.
- Seven days a week, 12 hours a day. Recognising this takes time to implement, a five day a week approach with support from the National Clinical Support Hubs (NCSH) could still enable a seven-day service to be provided whilst health boards are moving toward seven-day

implementation. In addition, links with the NCSH could also increase sustainability during times of high demand.

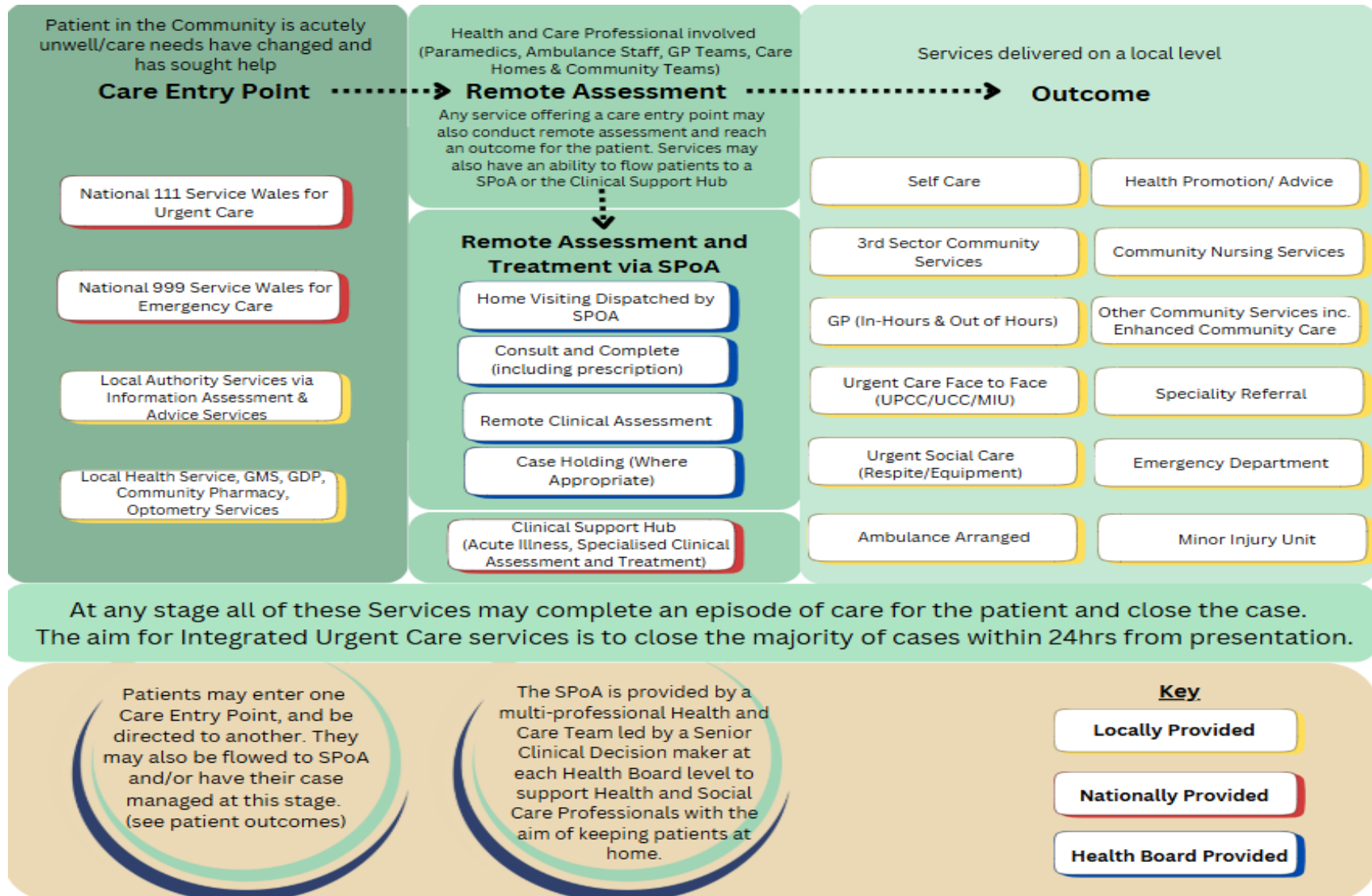
- Provides clinical assessment and has access to a senior clinical decision maker (in-person or virtually).
- Defined links into local IAA arrangements for assessment of wellbeing and services where appropriate, including on-call services where these are not available seven days a week.
- Referral into a range of receiving services with activity and outcomes captured. There is an expectation that development of receiving services has been considered as a priority and that these are in place (partially or wholly) before implementing a SPoA.
- The operating model/service should be designed on the principles of right service/pathway first time to reduce handoffs/delays in patient care. Patients should always be treated by the appropriate service. To reduce pressure on ED at the front door, many urgent care conditions would be better treated if redirected to Minor Injury Units (MIUs)/ Urgent Primary Care Centres (UPCC).
- System in place to monitor and act on referrals into receiving services that are rejected.
- Outreach services to enable assessment in a person's home.

## 4.2 The Single Point of Access Model for Wales

The SPoA approach is summarised in the model below:



SPoA in the context of the integrated urgent care system:



## 5. Impact

As a key service, emerging findings from across the UK indicates that a SPoA ensures the person/patient receives the correct and proportionate response once their needs have been assessed. If implementation of SPoAs is achieved across Wales, the impact on the wider system is as follows:

- **Appropriate ambulance dispatch:** increase in the number of appropriate or 'approved' dispatches for target patient cohorts and minimalise patients passed to the ambulance service. (*Note: target patient cohorts will be locally agreed but may include people who live in care homes, who are end-of-life, or who have complex frailty*)
- **Reduced ambulance conveyance:** reduction in the number of inappropriate conveyances to ED for target patient cohorts.
- **Urgent community response:** increase access to a two-hour holistic and personalised urgent care response, taking a shared approach across services.
- **Increase in the number of appropriate referrals** and in acceptance rates to wider community, ECC services, mental health (including 111 Press 2) and/or social care services. This would also include those people who could continue to be maintained within these services as opposed to being admitted to hospital (case holding).
- **Increase in the number of referrals/acceptance rates** for alternative acute services, for example, SDEC.
- **Reduction in the number of ED attendances** for target patient cohorts.

### **For our population this will mean:**

- Improved experience and satisfaction
- Increased access to same day urgent assessments where appropriate
- Faster access to the right care, resulting in improved patient outcomes
- Optimised care at home, or in their normal place of residence.

### **For systems this will mean:**

- Greater efficiency and productivity
- Better use of NHS resources and social care resources, including limited clinical/non-clinical resource
- Reduced ED attendances and ambulance delays, and improved ED/ambulance performance against key targets
- Improved social care demand management through timely and appropriate response for people living with complex needs

- Reduced risk of deconditioning associated with conveyance, handover delays and admission and maximising opportunities to avoid these
- Alleviated pressure in general practise allowing focus on people with complexity and continuity of care needs
- Reduced healthcare inequalities
- Increased efficiency in utilisation of financial resources.

## 6. Improvement targets for 2025/26

- A minimum 50% of calls managed (and closed) by the SPoA from 999, 111, and paramedics on scene where an alternative pathway to ED has been arranged.
- 50% increase from baseline in appropriate conveyances from care homes whilst reducing overall number of conveyances.
- 20% overall increase from baseline in utilisation of alternative pathways of care including referral to ECC.

## 7. Implementation of the specification

As part of the implementation of the specification, NHS Wales health boards are required to:

| <b>Essential activity</b>   |
|---|
| Undertake a baseline assessment using the tool provided to identify what elements of a SPoA are already in place, sources of referral into the SPoA, and what receiving services are in place. Additionally, identify other single points of access within the health board to determine if there are efficiencies to be gained from bringing them together |
| To identify gaps in sources of referral, receiving services and staffing  |
| Establish a minimum level of receiving services and associated pathways   |
| Ensure there is sufficient resource to operate the SPoA seven days a week, 12 hours a day   |
| Work with WAST to ensure as appropriate flow from 999 and 111 services into the SPoA and direct access for GMS/Community Nursing and care homes   |

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| Aim to achieve an urgent care response within two hours, in line with NICE guidelines |
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| Forge links with Local Authority IAAs and put in place agreed referral pathways |
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| Implement the SPoA data set and provide aggregate reports on activity and outcomes |
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In addition to the above essential tasks, health boards should refer to Appendix 2 which sets out some key design steps and questions to consider when developing the SPoA.

## 8. Appendices

### 8.1 Appendix 1

#### **Additional key principles and components of the SPoA**

The following describes in more detail the key principles and components of the SPoA that are expected to be considered in developing the model.

#### **Core multi-professional team**

- Senior clinical decision makers, for example: Advanced Practitioners - Nurse, Paramedic, Occupational Therapists, Consultant Nurse or Allied Health Professionals (AHPs) or Doctor.
- Clinical team from community, acute, ambulance, social care services and therapies.
- GP and/or COTE consultant to enable referral to most appropriate setting.

#### **Connected teams (in person/hybrid/virtual)**

- Co-located (where evidence has indicated this is valuable) or connected teams to maximise relationship building, skills/knowledge sharing, joint working, and referrals to partner services such as ECC and ambulance response. Physical/virtual links should be developed where appropriate with services such as NHS 111 Wales/Clinical Support Hubs and discharge hubs. Please note that a new IAA framework is being drafted and once published, should be used to guide the development of connected teams in the community.

## **System collaboration**

- System partnership/connected working across urgent and emergency care, hospitals, ambulance, primary care, community health and social care services to ensure full involvement in the multi-professional team and maximise referral opportunities.
- Clear leadership agreed with robust governance arrangements, risk management and patient safety detailed.

## **System integration/technology**

- All SPoAs should implement clinical systems that facilitate robust record keeping with an ability to link to other clinical systems for transfer of individuals and sharing of records.
- Ensures timely transfer of appropriate people from care entry points such as 111 and 999, as well as to receiving services such as Urgent Primary Care Centres (UPCC) and Urgent Care Centres (UCC).

This requires:

- Visibility of people waiting for an ambulance dispatch and those waiting for a clinical response in 111 (and appropriate lower acuity cases that may be on the 999 queues)
- Access to shared records
- Ability to transfer a case between multi-professional team members as required
- Visibility of appropriate waiting lists and real-time capacity
- Ability to book directly into and referral to key services.

Technological limitations should not be a barrier to practical solutions, for example, sharing of information among those working in the multi-professional team. Considering emerging technologies (e.g. video conferencing, TeleHealth, and TeleCare), health boards will need to consider future opportunities for the SPoA to expand its services to encompass these.

## **Established referral pathways**

- Locally agreed IAA and wider community and hospital discharge pathways (including trusted assessor models).
- Priority receiving services should include, as a minimum, urgent care response (including falls), ECC, District Nursing, Reablement (including community bedded facilities), Community Resource Teams (CRTs), Same Day Emergency Care (SDEC) and Urgent Care Centres (UCCs).

## **Senior clinical decision-makers**

Capability to manage clinical risk appropriately and 'hold' clinical risk while arranging appropriate diagnostics and/or follow-up and care for people, in collaboration with other services including CRTs, Reablement, ECC and Urgent Care Response (UCR).

- The SPoA should ensure that ambulance crews can handover the patient's case to the SPoA to manage and then leave the 'scene' when mutually agreed.
- The ability to take clinical responsibility for sub-acute patients in real-time marks the start of care co-ordination by the SPoA.

## **Improvement activities for SPoAs**

Once the initial components are in place, health boards should look to expand and develop their SPoA. As a minimum this should include:

- Supporting care homes and enhanced health in care homes by providing advice and management for patients with urgent and complex needs to avoid ambulance call outs and/or transfer to hospital
- Supporting general practice and locally integrated IAA teams by managing urgent escalation of care and avoiding ambulance call outs and planning for the inclusion of social care as an integral partner
- Reviewing opportunities to further reduce duplication between clinical teams; for example, alignment with, NCSH and 111/999 clinical teams.

## **SPoA learning and improvement cycles by:**

- Regularly reviewing emerging/changing urgent demand against available capacity
- Using a range of outputs (as detailed within the SPoA data set), develop a more detailed understanding of whole system demand and capacity
- Reviewing demand and capacity data for acceptance/referral rates of services and action improvements as required
- Using system knowledge and learning cycle outputs to inform future developments and transformation
- Audits, for example, hospital admissions within 48 hours and two weeks and RIP audits.

## **Technical development areas**

Secure visibility/full record sharing of appropriate patient details to enable proactive management (case management) and referral.

- Enabling review of eligible 111 and ambulance cases before transfer to a suitable receiving service.

- Having real-time visibility of capacity and demand in sending and receiving services.

### **Communication and engagement**

Robust communication and engagement plans developed to raise awareness of the SPoA and promote its use whilst ensuring demand rises in line with capacity and does not overwhelm the system.

- Plans for ongoing communication as new pathways and target cohorts are added.

## 8.2 Appendix 2

### **Key design steps for health boards**

The following sets out key considerations and questions to ask when developing the SPoA.

#### **Step 1: Patient presents as unwell with an urgent care need and contacts NHS 111 Wales, 999, GP, local IAA arrangements.**

- What cohort of patients will the SPoA accept? For example, what category of 999 calls, which NHS 111 Wales dispositions, e.g., frailty, complex needs, end-of-life care?
- Is there any baseline activity profile for the patient cohort to support benefits realisation, for example, rate of conveyance vs admission, rates of referral to ECC, SDEC, UCC/UPCC, UCR?

#### **Step 2: NHS 111 Wales/999 transfers the case to the SPoA (before ambulance dispatch) or the healthcare professional calls the SPoA (before conveyance).**

- Is the SPoA operating seven days a week, 365 days a year and typically for at least 12 hours a day? If not, has it linked with the NCSH to provide enhanced support across seven days?
- What will happen outside of these hours?
- Do the opening hours align with both demand and availability of services?
- Are the referral pathways into key services agreed?

#### **Step 3: SPoA facilitates a clinical conversation between the healthcare professional(s) and the multi-professional team to decide onward management of the patient.**

- Who are the senior clinical decision-makers?

- How is the ambulance service represented, and can they facilitate a shared view of the stack to enable review of eligible patients?
- How is the ECC/UCR team represented? Where are they represented i.e. this may be as part of the local IAA arrangements for population with complex needs?
- How is medical support from GPs, consultant geriatricians or ED consultants included?
- Are IAAs compliant with IAA framework for adults with complex needs, comorbidities and frailty?

**Step 4: Same day assessment or follow-up in the right place, (for example, through UCR response, ECC admission or SDEC booking) at the right time by the right person, first time.**

- Are services able to meet demand? For example, does ECC capacity align and is there capacity to manage patients in the community?
- Is the Directory of Services (DoS) used and up to date?
- What is the ongoing plan for keeping the DoS up to date?
- Can the SPoA book directly into receiving services?

**Key governance design questions:**

- Is there clear leadership and collaboration across partner services?
- Is clinical governance in place including the ability to case manage patients and 'hold the clinical risk'?
- Is there clinical quality safety and reporting?
- Is a system in place to monitor and act on referrals that receiving services reject and gather learning that exposes demand and capacity issues?
- Does the SPoA have a GP notification (Post Event Message) and feedback loop in place?

## **9. Further resources to support SPoA implementation**

Please contact [ABB.SixGoalsUEC@wales.nhs.uk](mailto:ABB.SixGoalsUEC@wales.nhs.uk) for further resources, including an assurance template and SPoA data collection tool.