

Open Agenda



Our Healthier South East London Joint Health Overview & Scrutiny Committee

Tuesday 11 October 2016
7.00 pm

Lewisham Town Hall, Committee Room 1, Civic Suite, Catford, SE6 4RU

Supplemental Agenda

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Date: 4 October 2016

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South East London: Sustainability and Transformation Plan

Briefing 3 October



What is a STP?

- In December 2015 Health and care systems were asked to come together to create their own ambitious local blueprint for implementing the 5YFV, covering Oct 2016 to Mar 2021.
- The STP will need to describe an overall local vision, and its approach to address three overarching areas:
 - The health and wellbeing gap
 - The care and quality gap
 - The funding and efficiency gap

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For us in SEL, the STP builds on the work of Our Healthier South East London and other transformation programmes

- It's a different way of working

What are we really trying to achieve?

Over the next five years we will:

- Support people to be in control of their physical and mental health and have a greater say in their own care
 - Help people to live independently and know what to do when things go wrong
 - Help communities to support each other
 - Make sure primary care services are sustainable and consistently excellent and have an increased focus on prevention
 - Reduce variation in outcomes and address inequalities by raising the standards in our health services
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- Develop joined up care so that people receive the support they need when they need it
 - Deliver services that meet the same high quality standards whenever and wherever care is provided
 - Spend our money wisely, to deliver better outcomes and avoid waste



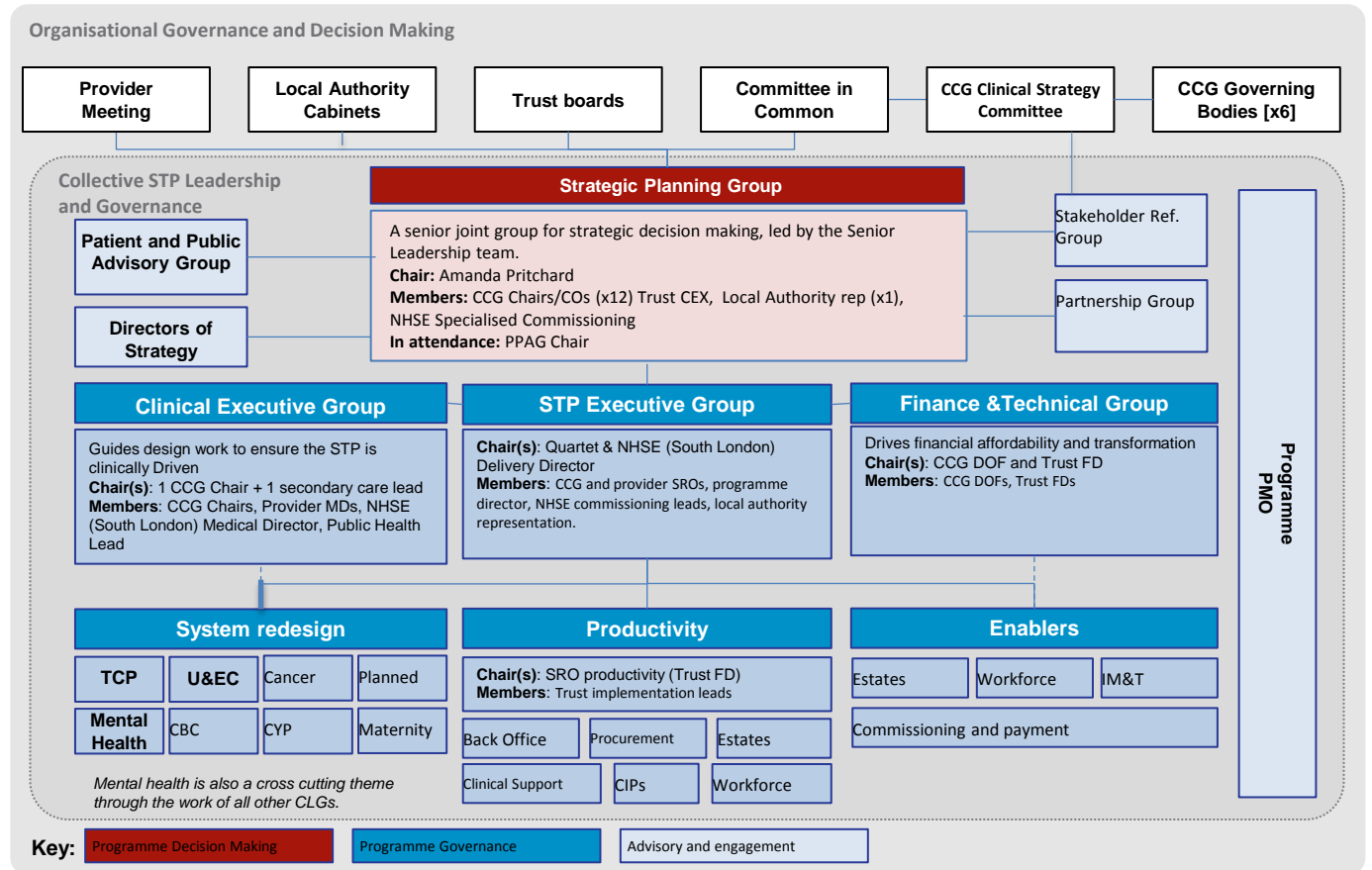
A partnership of NHS providers and Clinical Commissioning Groups serving the boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark, with NHS England

STP Governance

STP SRO and Leadership

- **SRO:** Amanda Pritchard, GSTT
- **CCG:** Andrew Bland, Southwark CCG
- **Council:** Barry Quirk, London Borough Lewisham
- **Clinical Lead:** Andrew Parsons, Bromley CCG

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SEL STP Plan on a Page

Our challenges

Demand for health and care services is increasing.

There is unacceptable variation in care, quality and outcomes across SEL.

Our system is fragmented resulting in duplication and confusion.

The cost of delivering health and care services is increasing.

Our five priorities and areas of focus

1 Developing consistent and high quality community based care (CBC), primary care development and prevention

2 Improve quality and reducing variation across both physical and mental health

3 Reducing cost through provider collaboration

4 Developing sustainable specialised services

5 Changing how we work together to deliver the transformation required

- Promoting self-care and prevention
- Improved access and co-ordination of care
- Sustainable primary care
- Co-operative structures across parts of the system
- Financial investment by the system
- Contracting and whole population budgets

- Integration of mental health
- Reduce pressure on and simplify A&E
- Implementation of standards, policies and guidelines
- Collaborate to improve quality and efficiency through consolidation (e.g. Elective Orthopaedics)
- Standardise care across pathways

- Standardise and consolidate non-clinical support services
- Optimise workforce
- Capitalise on collective buying power
- Consolidate clinical support services
- Capitalise on collective estate

- Joint commissioning and delivery models
- Strategic plan for South London
- London Specialised Commissioning Planning Board
- Managing demand across boundaries
- Mental health collaboration

- Effective joint governance able to address difficult issues
- Incorporation of whole commissioning spend including specialist
- Sustainable workforce strategy
- Collective estates strategy and management
- New models of collaboration and delivery

The impact of our plans

- Reduction in A&E attends and non-elective admissions
- Reduced length of stay
- Reduced re-admissions
- Early identification and intervention
- Delivery of care in alternative settings
(Net savings c.£119m)

Cross-organisation productivity savings from joint working, consolidation and improved efficiency.
(Net saving c. £232m)

- Increased collaboration
- Reduced duplication
- Management of flow
(Need to address £190m)

- Aligned decision-making resulting in faster implementation
- Increased transparency and accountability

STP Next Steps

- 16 September: finance submissions including more detail on capital, efficiency sources and investments for all STPs
- 20 September: publication of NHS planning guidance for 2017/18 and 2018/19
- 21 October: full STP submissions including an updated finance template and delivery templates
- End-November: CCGs and NHS providers to share first drafts of operational plans for 2017/18 and 2018/19
- End-December: CCGs and NHS providers to finalise two-year operational plans.

N.B. It is intended that two years of operational planning and contracts are agreed by end December with the expectation of alignment between the STP and operational plans

NHSE Feedback on SEL STP 30 June Submission

General Comments on STPs

- Have greater depth and specificity in your plans
- Provide year on year financial trajectories
- Articulate more clearly the impact on quality of care.
- Include stronger plans for primary care and wider community services
- Set out more fully your plans for engagement with local communities
- Capital is in very short supply

Specifically for SEL

- Set out what plans you have to strengthen your collective leadership towards an implementation focus, given the maturity of your STP and local leadership. This should include completing the work on and agreement of your MOU for inclusion in the October submission.
- Develop further the orthopaedic project
- Develop further the specialist services project
- Finalise agreement of the savings targets at organisational level for your collective productivity improvements.
- Further develop your oversight and analysis of activity data and CIP and QIPP.
- Strengthen further the clinical and financial business case for the proposed service transformations, including setting out year-on-year benefits.
- Include stronger plans for mental health drawing on the recent publication of the Forward View for Mental Health.

Key Messages

Our response to the national feedback letter is set out in the coming pages, focusing on the progress we've made since June and our trajectory to respond to the October STP refresh deadline. Since 2013, our STP has been working on a system-wide plan. Therefore, our October submission will not be changing

any of our workstream ambitions but rather setting the delivery trajectory & infrastructure.

To aide in transforming our strategic plan into implementation we have since June:



Started designing and developing the leadership and governance structure required to implement STP



Agreed to produce five collaborative productivity business cases for board approval in December



Maintained progress on Orthopaedic Elective Centre; the evaluation group has met and a preferred option will be presented to the Committee in Common in November



Collated our thoughts on the STP's role in delivering of CIP, QIPP and Performance measures



Worked with NHSE and SWL to establish the specialised services workstream

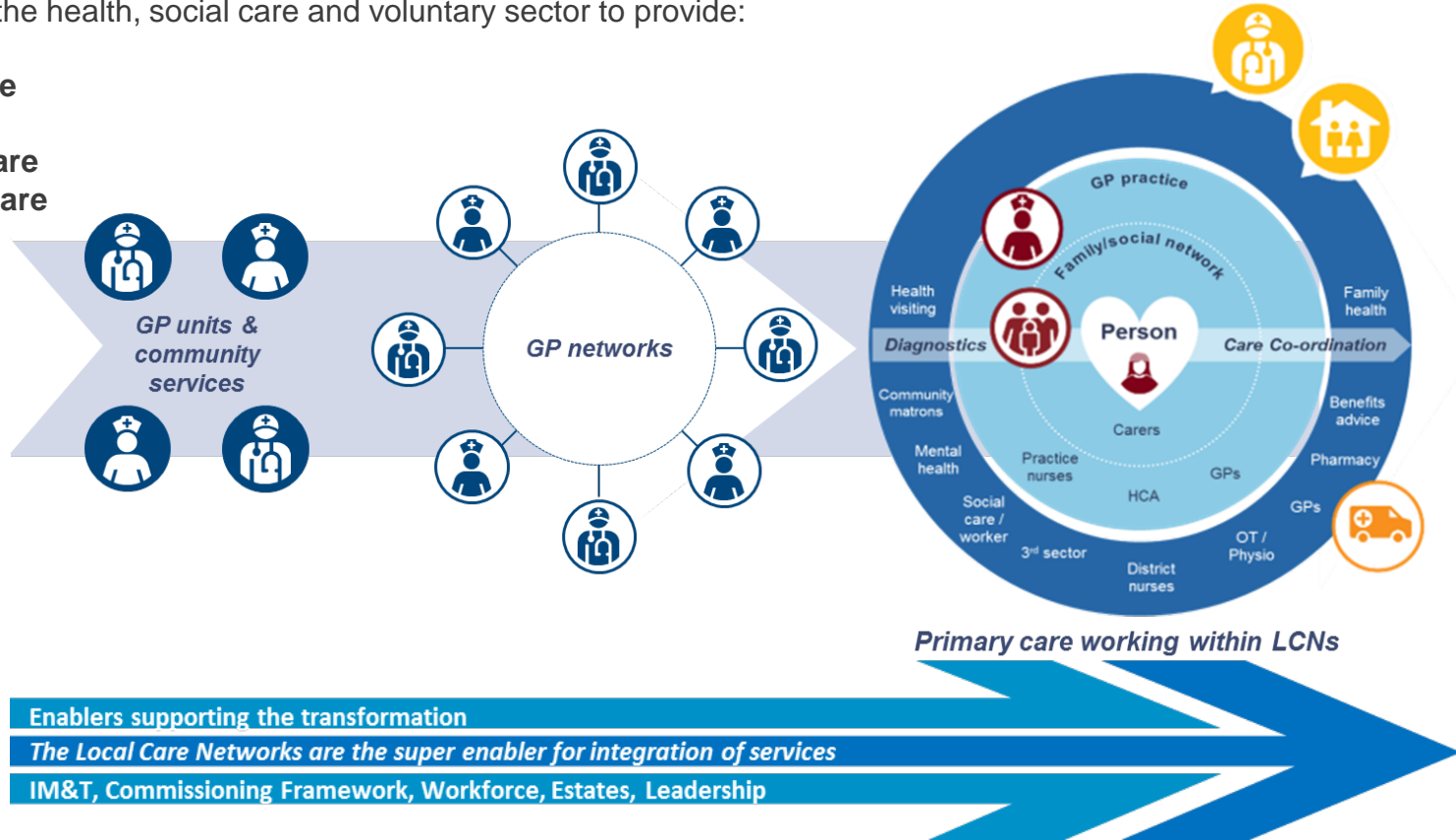


Set out proposals for aligning the STP and the planning round

1 Investment in Community Based Care is essential to transform our system and move towards lower cost, higher value care delivery

Primary and community care (defined in its broadest sense) will be provided at scale by Local Care Networks and drawing on others from across the health, social care and voluntary sector to provide:

- Accessible care
- Proactive care
- Coordinated care
- Continuity of care









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2 For each CLG we are finalising the commissioner and provider accountability of savings by intervention– each intervention with provider savings will have delivery plans in the October submission

We have programme plans by CLG which are being translated into detailed delivery plans. We have a Clinical Executive Group to advise on the clinical

interventions, their delivery, and to enable stronger clinical leadership to drive change.

Clinical Leadership Group	High level summary of the model of care
 Community based care	<ul style="list-style-type: none"> • Delivery of local care networks • Improving access in Primary Care
 Urgent and emergency care	<ul style="list-style-type: none"> • Community rapid response • Specialist advice and referral. • An enhanced single “front door” to the Emergency Department.
 Planned care	<ul style="list-style-type: none"> • Standardisation of planned care pathways. • Elective care centres.
 Children and young people’s care	<ul style="list-style-type: none"> • Children’s integrated community teams. • Short stay paediatric assessment units.
 Maternity	<ul style="list-style-type: none"> • Early assessment by the most appropriate midwife team. • Access to assessment clinics. • Culture of birthing units.
 Cancer	<ul style="list-style-type: none"> • Primary prevention including early detection. • Provider collaboration in treatment of cancer. • Enhanced end of life care.
<p style="text-align: right;">Net savings after 40% reinvestment £119m</p>	

We have received four provider submissions to be considered as a host site for one of two inpatient Orthopaedic Elective Centres across SEL



	Provider	Proposed Site
1	Guy's and St Thomas NHS Foundation Trust	Guy's Hospital
2	Lewisham and Greenwich NHS Trust	Lewisham Hospital
3	Dartford & Gravesham NHS Trust and Oxleas NHS Foundation Trust	Queen Mary's Hospital, Sidcup
4	Kings College Hospital NHS Foundation Trust	Orpington Hospital

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An evaluation panel was established to evaluate site options against financial and non-financial criteria developed by clinical and patient groups and agreed by a committee of the six south east London CCGs (known as the "Committee in Common") Once the evaluation is complete, the evaluation panel will make a recommendation to the Committee in Common (CiC), on what a

preferred option might be.

The evaluation panel recognised that the **Queen Mary's site option does not meet the agreed criteria for an inpatient elective orthopaedic centre**, and they will be recommending to the CiC that this site is not taken forward.

Our plans for mental health drawing on the recent publication of the Forward View for Mental Health

01

We have agreed to establish a sixth CLG for mental health to oversee the FYFV for MH



02

We are sourcing dedicated programme support



03

We have commissioned a “demand and supply” project



04

We are looking for a mental health “high impact change” drawing on the work of the Kings Fund

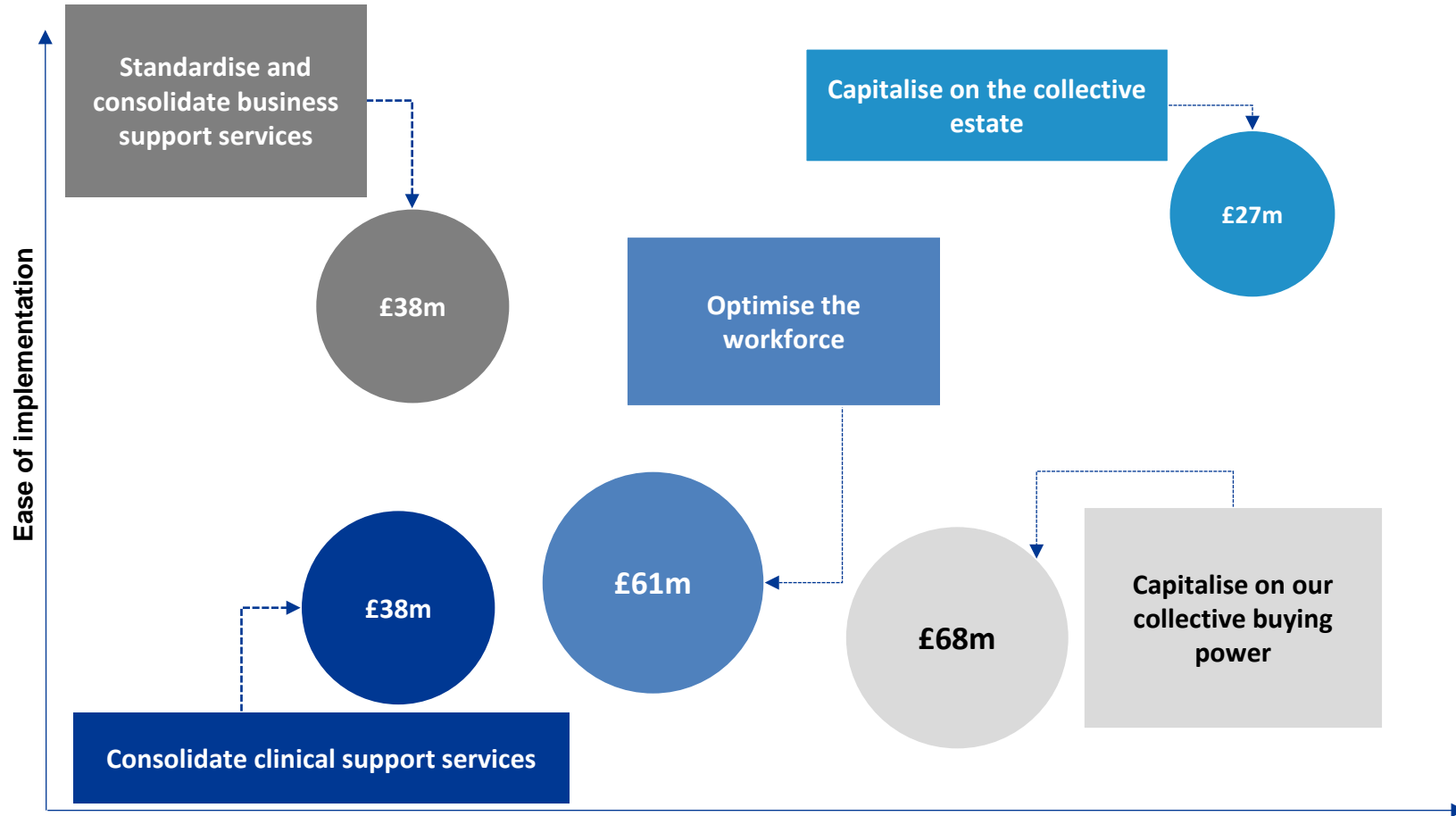


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Our providers are participating in the “transforming mental health” programme with NHSE returning high cost out of area placements



3 Our acute and mental health providers have identified opportunities for reducing the costs of delivering care in 5 priority areas



4 Review of specialist services across south London

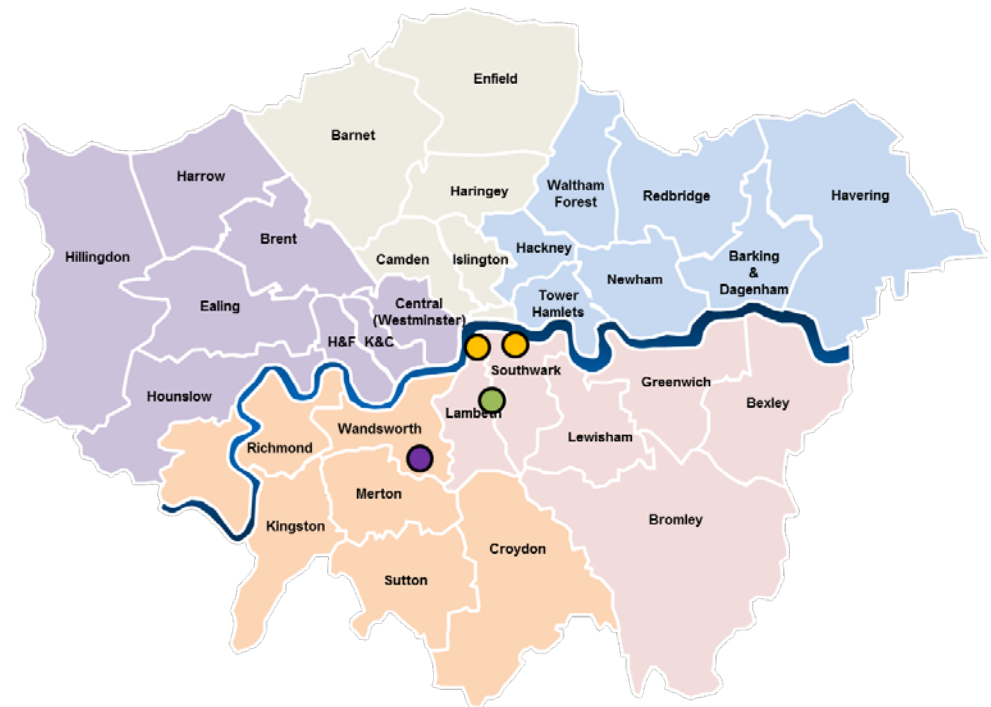
We have established a group with NHSE and SWL to look at the specialised services across south London

Transformation of specialised services needs to be undertaken on a large population basis. Across London, service review work has taken place to varying degrees (eg Cancer and cardiac) but little focus so far on South London.

Three **providers** provide the majority of acute specialised services in South London so they will form the focus of this report. These providers are geographically extremely close to one another; the furthest distance between them is just 7 miles.

We know there is significant duplication of services.

We also know there is significant growth pressure on services.



- Guy's and St Thomas' NHS Foundation Trust (GSTT)
- King's College Hospital NHS Foundation Trust (KCH)
- St George's University Hospital NHS Foundation Trust (SGH)

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A partnership of NHS providers and Clinical Commissioning Groups serving the boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark, with NHS England



5 We are strengthening our collective leadership towards an implementation focus

We will develop and agree a system-wide MOU between providers and commissioners setting out how we will work together to make decisions to improve patient care and outcomes. This will build on existing MOUs to confirm organisational commitment to our plans. It will also include a clear set of principles upon which decisions will be based.

Establishing a system wide MOU

Successful STP Implementation

Developing Clinical Leadership Group Accountability

We will build capability in our clinical leadership groups, enabling them to be the delivery vehicle for implementation. They will have clearly defined programme responsibilities for which they will be accountable and signed off by leadership.

Forming the Collaborative Productivity Board

We are developing proposals for a joint provider board to oversee the Collaborative Productivity Programme, providing leadership and oversight for implementation within the OHSEL strategy and to resolve strategic issues.

Defining the SEL leadership model

We need a collective leadership model that will remain cohesive and focussed in the pursuit of our shared collectives. The definition process will begin at October's leadership event.

Improving productivity and closing the local financial gap

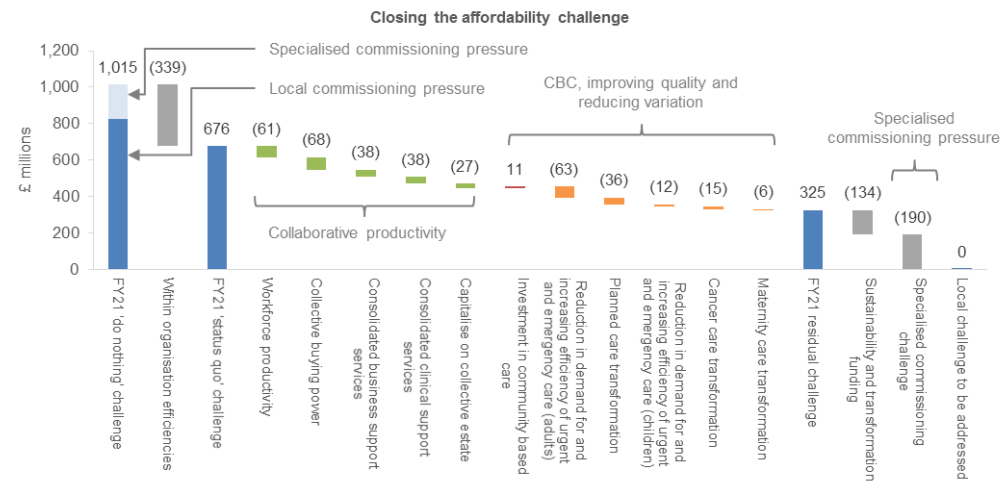
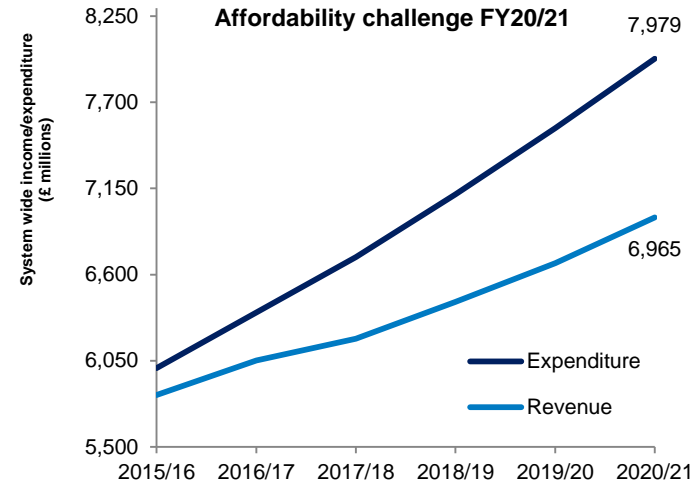
Our financial challenge

- The 'do nothing' affordability challenge faced by the south east London health economy is £1,015m by 2020/21. NHS England (Specialised) have estimated an indicative £190m five year affordability challenge for specialised commissioning.

Closing the affordability challenge

- 1.6% per annum CIPs across our five provider organisations contributes £339m
- Collaborative productivity contributes savings of £232m
- Service transformation leads to net savings of £119m
- Indicative Sustainability and Transformation Funding of £134m would reduce the challenge to £190m, with all of this relating to specialised commissioning for which savings plans have not yet been developed.

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If ongoing work is able to fully address this specialised commissioning pressure, then this would address the entire affordability challenge across south east London by 2020/21. This challenge translates into an **average annual 4.1% productivity improvement** –BAU CIPS (1.6%), Clinical Interventions (0.5%), Collaborative Productivity (1.1%) and NHSE (0.9%). Central funding support (£134m – 0.6%).



Improving the infrastructure for delivery by December 2016

Area of work	Description
1 Implementing shared information and performance monitoring	Developing the appropriate measures and tools for reviewing performance across SEL. This would demonstrate performance, quality and cost in order to support transparency and decision-making
2 Accelerating implementation through Clinical Leadership Groups	The delivery vehicle for clinical transformation is our clinical leadership groups. We will ensuring they have the authority, leadership, resources and information to deliver the STP
3 Agree a system wide MOU	We will develop and agree a system-wide MOU between providers and commissioners setting out how we will work together to make decisions to improve patient care and outcomes. This will build on the existing MOU for collaborative productivity to confirm organisational commitment to our plans. It will also include a clear set of principles upon which decisions will be based.
4 Scale up opportunities for provider collaboration	We have made significant progress in terms of back office / clinical support service collaboration. Following the recent letter from NHSI we have now initiated a process to explore further collaboration across acute, community and mental health providers.
5 Whole system financial strategy	Develop a shared investment strategy across organisations to support both collaborative productivity and service transformation
6 Strengthening the SEL leadership model	To deliver our STP we need collective leadership that can remain coherent and focused on our shared objectives through times of difficulty. We are exploring the requirements for our collective leadership model. Our first step is addressing this during a system-wide leadership event in September.

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Urgent and Emergency Care Facilities and System Specifications

November 2015

Introduction

The first stage of Professor Sir Bruce Keogh's national UEC review called for clarity and transparency in the offering of Urgent & Emergency Care (UEC) services to the public. It recommended the development of UEC Networks and the designation of UEC Facilities:

- Urgent care centres
- Emergency centres
- Emergency centres with specialist services

This document outlines specifications for these facilities in London.

The development of the specifications was led by the UEC Clinical Leadership Group with wide stakeholder engagement. The foundation of all of the specifications is the London Quality Standards which were developed in 2012 to address the variation that existed in service arrangements and patient outcomes in these services; following extensive engagement (during the development of the standards) broad support for their commissioning and implementation was gained across London. This was also reflected in more recent patient and public engagement where there was strong support for consistent services, seven days a week, with Londoners emphasising that they expect UEC services that:

- Are available with shorter waiting times, longer opening hours and efficient coordinated systems;
- Are consistent in their service offering and across the seven days of the week; and
- Are clear and instil confidence by being seen by the right clinical expertise at the right time.

Through more recent clinical engagement there was also strong support for the inclusion of the London Quality Standards as the basis for the facilities specifications. This engagement also highlighted the need to ensure parity of esteem for those in mental health crisis. Integral to all UEC facilities specifications is therefore the inclusion of the London Mental Health Crisis Care standards, developed in 2014 in response to the crisis care concordat to ensure equity between physical and mental health across London.

In addition to the individual facilities specifications the UEC system specification has been developed and agreed; this specification describes the arrangements to be in place across UEC facilities and with other parts of the UEC system including general practice, NHS 111, GP out-of-hours and Clinical Hubs, to ensure pathways across facilities and services are seamless. Critical to ensuring the system operates safely is the adherence to the clinically developed Inter-Hospital Transfer standards; these standards outline clinical protocols and timeframes for different levels of transfers: critical, immediate, clinical and non-urgent.

The facilities and system specifications complement the Commissioning Standards for Integrated Urgent Care for integrated 111 and GP OOH care.

London Urgent and Emergency Care System Specification

Developed based on stakeholder feedback and drawing on a number of existing service standards, the UEC System specification seeks to formalise the clinical interdependences between the UEC facilities (UCCs, ECs, ECSSs) and with other UEC services including General Practices (GP), Integrated Urgent Care (NHS111, GP out-of-hours (OOH)), ambulance services and community pharmacy. It also outlines the consistencies within the system that are required for equitable, high quality UEC provision regardless of whether initially accessed via 111, self-presentation or 999. It aligns with the *Commissioning Standards for Integrated Urgent Care* for integrated 111 and GP OOH care.

The specification applies to all UEC facilities (UCCs, ECs, and ECSSs). It specifies:

- Aspects that should be consistent across all of these facilities
- How the UEC facilities should link together and with other UEC services

Domain	Specification	Adapted from source
1. System operating hours and access	<ul style="list-style-type: none"> i. Telephone and in-person UEC services are available 24 hours a day, 7 days a week, at a System Resilience Group (SRG) level. ii. All UEC facilities are able to receive adults and children and young people. iii. All UEC facilities are able to receive patients that self-present or arrive by ambulance service. iv. All UEC facilities are able to receive referrals and direct bookings from registered health and social care professionals with responsibility for a patient. This includes staff from other UEC facilities, ambulance services, GPs (including out-of-hours), NHS 111, pharmacy and dental assessment. 	<ul style="list-style-type: none"> • – iv. Draft National guidance
2. Clinical governance	<ul style="list-style-type: none"> i. All facilities are part of the regional UEC network they are situated within. ii. Nested integrated clinical governance arrangements, under strong clinical leadership and with clear lines of accountability to commissioners, are in place joining all facilities within a SRG (e.g. a UCC provider and EC provider within a SRG having integrated clinical governance) to assure provider clinical quality and safety across facilities and ensure issues are identified and service improvements made. It will feed into the UEC network for whole system accountability. 	<ul style="list-style-type: none"> i. – iii. Draft National guidance iv. – vi. Commissioning Standards for Integrated Urgent Care

	<ul style="list-style-type: none"> iii. All UEC facilities report all patient safety incidents to the National Reporting and Learning System and they are reviewed locally to identify and implement learning. All National Patient Safety Alerts should be implemented in full and in the spirit they are intended. iv. A policy setting out the way in which adverse and serious incidents are identified and managed across UEC facilities in a SRG is in place to ensure that the clinical leadership of the services plays an appropriate role in understanding, managing and learning from these events at a system level. v. Co-operation is in place between all UEC facilities to undertake audit, case review and incident investigation regularly with the aim of shared learning. vi. A local integrated clinical governance lead (CGL) is in place. This lead should be appropriately skilled and suitably experienced for the role. <ul style="list-style-type: none"> a. The CGL role involves the development of relationships across the whole UEC network, and the individual should be clinically credible in order to work effectively in this complex environment. b. The CGL must have clearly defined links to the regional and national NHS clinical governance structures, particularly the SRGs and UEC networks. 	
<p>3. Patient experience and outcomes</p>	<ul style="list-style-type: none"> i. Patient experience and outcomes data is captured, recorded and routinely analysed and acted on (e.g. utilisation of the Friends and Family test). Review of data is a permanent item of the board agenda and integrated clinical governance meetings. It is routinely disseminated to all staff and patients. ii. Clear and well-publicised routes for both patients and health professionals to feedback their experience of the services are in place, ensuring prompt and appropriate response to that feedback with shared learning between organisations. iii. Regular review of the ‘end-to-end’ patient journey occurs, with the involvement of other partner organisations, especially where outcomes have proved problematic. 	<ul style="list-style-type: none"> i. – ii. Draft National guidance; Urgent Care (UC) LQS; Emergency Department (ED) LQS iii. Commissioning Standards for Integrated Urgent Care
<p>4. Safeguarding</p>	<ul style="list-style-type: none"> i. Safeguarding governance arrangements for children and young people and vulnerable adults are in place including regular system meetings, IT system flags and processes to share additional information (including Child Protection information sharing (CPIS)). A safeguarding lead is in place within each facility to take ownership of safeguarding 	<ul style="list-style-type: none"> i. Draft National guidance and UC LQS

	<p>governance and link into system-wide arrangements.</p> <p>ii. All children and young people, children’s social care, police and health teams have access to a paediatrician with child protection experience and skills (of at least Level 3 safeguarding competencies) available to provide immediate advice and subsequent assessment, if necessary, where there are safeguarding concerns. The requirement is for advice, clinical assessment and the timely provision of an appropriate medical opinion, supported with a written report.</p>	<p>ii. Paediatric Emergency Services LQS</p>
<p>5. Clinical assessment and onward care</p>	<p>i. Regardless of the initial service accessed, patients are able to access the same integrated clinical pathways across the health and social care system. This is achieved through the enablement of all registered health and social care professionals within UEC system, following telephone consultation or clinical review of a patient, to make direct referrals and/ or direct appointments with:</p> <ul style="list-style-type: none"> a. The patient’s registered general practice or corresponding OOH service; b. UCCs; c. EDs in ECs and ECSSs; d. Assessment units and ambulatory care units; e. Mental health crisis services and community mental health teams; f. Specialist services/ clinicians, if the patient is under the active care of that specialist service for the condition which has led to them accessing the UEC system. <p>These include referrals/ appointments for patients that require:</p> <ul style="list-style-type: none"> • Escalated clinical assessment and treatment; • Access to diagnostics that are not currently available within the current setting; • Access to continued care including primary care, community care and social services. <p>ii. Within a network, when a patient requires transfer from one UEC facility to another to complete their episode of care, the continuation of care should be seamless and they should not be required to register and queue again.</p> <p>iii. Exact pathway protocols are defined and agreed within each network region and used by</p>	<p>i. – v. Improving referrals between UEC service in England guidance</p> <p>vi. Commissioning Standards for Integrated Urgent Care</p>

	<p>UEC facilities. This includes direct community and acute specialist referral pathways to enable safe and effective onward care to be achieved as an alternative to via an ED. The pathways should be subject to regular audit and review and discussed at integrated governance forums.</p> <p>iv. A minimum data set of information on initial assessment should be agreed and accompany a referral or direct booking.</p> <p>v. A feedback loop should be in place for a clinician/ services receiving referrals to feedback to the clinician/ service making the referral. A senior member of clinical staff with clinical governance responsibilities should be nominated in each referring service to act as a point of contact for collating and responding to feedback and initiating any education or system changes that are required in response to the feedback.</p> <p>vi. All UEC facilities should have access to advice from clinical hubs including for dental and pharmacy services.</p>	
<p>6. Mental Health Crisis care</p>	<p>i. With appropriate partners, all UEC facilities providing care for adults and children and young people experiencing mental health crisis, or who present as a result of self-harm or overdose, should co-design an integrated care pathway in their locality. This should focus on patient/carer experience and streamline the number of professional contacts, reduce waiting time and demonstrate a joined up response to mental and physical health care needs.</p>	<p>i. London Mental health Crisis Standards</p>
<p>7. Managing information</p>	<p>i. All UEC facilities should have access to the Directory of services (including a mobile Directory of services) and direct booking facility. Facilities are responsible for informing updates to the DoS when appropriate.</p> <p>ii. All UEC facilities should have the ability to receive patient information from NHS 111 via the inter-operability toolkit.</p> <p>iii. All UEC facilities should have access to core general practice information including summary care record, special patient notes (including any red flags and crisis care and end of life care plans), medicines and contra-indications, allergies and other SPINE based records. Patients with a specific care plan should be treated according to that plan and, where patients have specific needs, are transferred to the appropriate professional or specialist service.</p> <p>iv. All UEC facilities should adhere to the Data Protection Act in relation to patient records.</p>	<p>i. – iv. Commissioning Standards for Integrated Urgent Care and Safer, Faster, Better guidance</p> <p>v. Draft National guidance</p> <p>vi. Draft National guidance and UC LQS</p>

	<ul style="list-style-type: none"> v. All UEC facilities should collect and return anonymised data relating to patients attending the service, in accordance with nationally specified standards. vi. At every UEC facility, all patients should have an episode of care summary communicated to the patient’s GP practice by 08.00 the next day. For children the episode of care should also be communicated to their health visitor or school nurse, where known and appropriate, no later than 08.00 the second day. All episode of care summaries, including any change in medicines, are communicated with patient’s community pharmacist if they have one. All communication should take place electronically. vii. All UEC facilities should adhere to the Health and Social Care Information Centre (HSCIC) formal standard of data collection (ISB 1594) to ensure consistent information sharing with the Metropolitan Police, full compliance with the Data Protection Act and active support to the Information Commissioners Office when required. 	<p>vii. Information Standards Board</p>
<p>8. Provision of information to patients</p>	<ul style="list-style-type: none"> i. All patients, including children and young people, should be supported to understand their diagnosis, relevant treatment options, ongoing care and support by an appropriate clinician. Patients, and where appropriate families and carers, must be actively involved in shared decision making and supported by clear information from health and social care professionals to make fully informed choices about investigations, treatment and on-going care that reflect what is important to them. ii. All UEC facilities should provide advice to patients to support self-care and advise of other providers of care e.g. pharmacy, dental or social care. iii. Where appropriate, all patients, including children and young people and carers should be provided with health and wellbeing advice and sign-posting to local community services where they can self-refer (for example, smoking cessation services and sexual health, alcohol and drug services). iv. All patients should be provided with written information in regards to any medicines prescribed. v. Information should be provided in a format which patients understand. 	<p>i. – v. Draft National guidance; UC LQS; ED LQS</p>
<p>9. Integrated Capacity</p>	<ul style="list-style-type: none"> i. Integrated capacity management protocols should be in place across the system, including access to real-time capacity information. 	<p>i. Safer, Faster, Better Guidance</p>

Management		
10. Training	<ul style="list-style-type: none"> i. All UEC facilities should provide training for all clinical and non—clinical staff ii. Staff rotations should be in place across the UEC system. iii. Staff should have completed all nationally agreed Mandatory and Statutory requirements for training (MAST) (e.g. information governance, adult and child safeguarding, manual handling) and training in cultural competence. iv. All those involved in the delivery of acute care must participate in the review of patient outcomes to drive care quality improvement. The duties, working hours and supervision of trainees in all healthcare professions must be consistent with the delivery of high- quality, safe patient care, seven days a week. 	<ul style="list-style-type: none"> i. – iii. Safer, Faster, Better Guidance ii. ED LQS
11. Clinical Decision Support systems (CDSS)	<ul style="list-style-type: none"> i. For registered clinicians, UEC facilities must determine the need of any CDSS based on the scope of practice, competences and educational level of clinicians concerned. ii. Where occurring, any Health Advisers and non-registered clinicians must use approved clinical assessment tools/clinical content to assess the needs of patients. iii. UEC facilities must ensure that they adhere to any licensing conditions that apply to using their system of choice. This must include the ability to link with the wider urgent and emergency care system. Commissioners should also ensure that providers deploy any relevant CDSS upgrade/version, associated business changes, training and appropriate profiling changes to enable Access to Service Information (DoS) within any specified deployment windows for the chosen system(s). 	<ul style="list-style-type: none"> i. – iii. Commissioning Standards for Integrated Urgent Care

London Urgent Care Centre Specification

The aspiration is to provide a *consistent* urgent care walk-in offering for the public. This specification therefore applies to *all* Urgent Care Centres. This includes both co-located and standalone centres. It specifies the minimum level of care that should be provided by any healthcare provider which is able to receive patients that walk-in with an undifferentiated health need and without an appointment. The service should also be able to receive referrals/ direct bookings from NHS 111 and registered health and social care professionals. As agreed through UEC network designation processes, this will include services previously known as Walk-in-Centres, Minor Injury Units and GP-led health centres. If necessary, local protocols should be in place during the transition from current service provision to the level set out within this specification.

Domain	Specification	Adapted from source
1. System	i. UCCs will adhere to the UEC system specification.	i. UEC system specification
2. Governance	<p>i. Each UCC should have a formal written policy for providing urgent care, and clear pathways of care for all common conditions. The policy is to adhere to the UCC facility specification and is to be ratified by the service's provider board and the UEC Network annually.</p> <p>ii. Each UCC should have an identified clinical lead, and participate in clinical and non-clinical audit, demonstrating effective engagement in a programme of continuous quality improvement.</p>	i. – ii. Draft National guidance and UC LQS
3. Location	i. Where possible, UCCs should be co-located with ECs, however, standalone centres will also exist.	i. Draft National guidance
4. Operating hours	<p>i. All UCCs to be open for a minimum of 16 hours per day.</p> <p>ii. Each site that a UCC is located on must provide urgent care from 08:00 to midnight (If the UCC is co-located with an EC then the EC may provide urgent care for part of this time period but the UCC should still be open for at least 16 hours).</p> <p>iii. All UCCs should be consistent in staffing and service provision throughout days and weeks.</p> <p>iv. During the hours that they are not open, UCCs should provide immediate access to the UEC</p>	i. – iv. Draft National guidance

	Network for persons contacting the UCC by phone (e.g. through 111, out of hours general practice, the ambulance service, or similar arrangements) or arriving in person.	
5. Access <i>(in addition to UEC system specification)</i>	i. All UCCs should be able to receive patient referrals from differentiated ambulances within network agreed protocols and pathways of care.	i. Draft National guidance
6. Staffing	<p>i. During the hours that they are open, UCCs should be staffed by multidisciplinary teams, including: at least one registered medical practitioner (either a registered GP or doctor with appropriate competencies (reflected below) for primary and emergency care, and mental health crisis care), and at least one other registered healthcare practitioner.</p> <p>ii. All registered healthcare practitioners working in UCCs should have a minimum level of competence in caring for adults and children and young people including: (a) Basic life support; (b) Recognition of serious illness and injury; (c) Pain assessment; (d) Identification of vulnerable patients; (e) ability to recognise that someone may be experiencing a mental health problem and to respond appropriately and (f) awareness of safeguarding. At any time the service is open at least one registered healthcare practitioner is to be trained and competent in advanced life support and paediatric advanced life support.</p> <p>iii. All UCCs should have arrangements in place for staff to access support and advice from experienced doctors (ST4 and above or equivalent) in both adult and paediatric emergency medicine and other specialties including surgery, mental health and paediatrics within their network without necessarily requiring patients to be transferred to an ED or other service.</p> <p>iv. All UCCs should have arrangements in place for staff to access advice and support in relation to medicines.</p> <p>v. All UCCs should have a medical or non-medical prescriber present throughout the hours of operation. Patient Group Direction (PGD) services to support the treatment of common injuries and illnesses may be used until sufficient staff are qualified as prescribers.</p>	i. – v. Draft National guidance and UC LQS
7. Assessment & Treatment	i. Co-located UCCs and ECs should have a single front door to access UEC, with one reception team under the same governance.	i. – ii. Safer, Faster, Better Guidance

	<ul style="list-style-type: none"> ii. Co-located UCCs and ECs should have a single point of initial appropriate clinical assessment. iii. An escalation protocol should be in place to ensure that seriously ill/high risk patients presenting to an UCC are seen immediately by a registered healthcare practitioner, and where treatment in an EC or ECSSs is required this is facilitated by attendance from the ambulance service within agreed timescales. All patient notes go with patient to ensure treatment is rapid. The escalation protocol should be sufficient to cover extreme conditions including adult or paediatric cardiac arrest, and should be thoroughly trained and tested. iv. All patients are to be seen and receive an initial clinical assessment by a registered healthcare practitioner within 15 minutes of the time of arrival at the urgent care service. v. Within 90 minutes of the time of arrival at the urgent care service 95 per cent all patients are to have a clinical decision made that they will be treated in the urgent care service and discharged or arrangements made to transfer them to another service. vi. At least 95 per cent of patients who present at an urgent care service to be seen, treated if appropriate and discharged in under 3 hours of the time of arrival at the urgent care service (where clinically appropriate). vii. Internal access or arrangements in place to safely access all medicines a patient needs in relation to the consultation at the time they need it. If required, these medicines are to be provided in a clinically and cost effective pack to a patient for at least a 24 hour period. 	<ul style="list-style-type: none"> iii. UC LQS and Draft National guidance iv. – vi. UC LQS vii. Safer, Faster, Better Guidance
<p>8. Diagnostics</p>	<ul style="list-style-type: none"> i. Access to the following diagnostics for adults and children and young people during hours the UCC is open, with real time access to images and results: <ul style="list-style-type: none"> - Plain film x-ray: immediate on-site access with formal report within 24 hours of examination - Blood testing: immediate access with formal results received within one hour of the sample being taken <p>Clinical staff to have the competencies to assess the need for, and order, diagnostics and imaging, and interpret the results.</p> <p><i>(During transition to this specification where this is not currently available, local protocols should specify alternate routes of access and reporting standards).</i></p>	<ul style="list-style-type: none"> i. Draft National guidance and UC LQS

<p>9. Equipment and physical environment</p>	<p>i. Appropriate equipment to be available onsite (with sizes available for adults and children):</p> <ul style="list-style-type: none"> - a full resuscitation trolley - an automated external defibrillator - oxygen high flow - suction and - emergency drugs - Monitoring equipment to calculate a National Early Warning Score (NEWS) score <p>All urgent care service to be equipped with a range of appropriate medicines necessary for immediate treatment.</p> <p>ii. Training, audit, testing and quality assurance mechanisms to be in place for all equipment.</p> <p>iii. UCCs should have appropriate waiting rooms, treatment rooms and equipment according to the workload and patient’s needs, including a suitable place for mental health assessment and observation for those in crisis when necessary. The environments should be child and young person friendly.</p> <p>iv. Appropriate environment and policy in place to accommodate children and young people including audio-visual separation and availability of chaperone.</p>	<p>i. – iv. UC LQS; Draft National guidance; London Acute standards for Children and Young People</p>
<p>10. Mental Health Crisis Care</p>	<p>i. Single point of access for mental health referrals to be available during hours the UCC is open, with a maximum response time of 1 hour.</p> <p>ii. Dedicated area for mental health assessments which reflects the needs of people experiencing a mental health crisis and in accordance with RCPsych standards.</p> <p>iii. Arrangements in place to ensure Mental Health Act assessments take place promptly and reflect the needs of the individual concerned.</p> <p>iv. Access to all the information required to make decisions regarding crisis management including self-referral.</p> <p>v. Direct line of communication with local mental health service and knowledge of local out of hours mental health services.</p> <p>vi. Single call access for children and adolescent mental health (CAMHS) (or adult mental health services with paediatric competencies for children over 12 years old) referrals to be available 24 hours a day, seven days a week with a maximum response time of 30 minutes.</p>	<p>i. UC LQS</p> <p>ii. – v. London Mental Health Crisis standards</p> <p>vi. – vii. Paediatric Emergency Services LQS</p>

	<p>Psychiatric assessment to take place within four hours of call.</p> <p>vii. Staff should have access to both telephone consultation and an on-site response from a dedicated pool of CAMHS professionals known to the local hospital during and out of hours. Staff should not be in the position of having to speak with someone who has no direct knowledge of their clinical environment and staffing skills in dealing with psychiatric emergency and managing the risk of young people who self-harm or attempt suicide.</p>	
11. Referral/ Direct Booking	<p>i. UCCs should be able to directly refer to a pharmacy that is commissioned to provide urgent repeat medicines as a local NHS service.</p> <p>ii. UCCs should be accountable for having and monitoring robust and cohesive policies for inter-hospital transfers (IHTs) that encompass the agreed pan-London standards. All hospitals to be linked into networks for clinically indicated IHTs.</p>	<p>i. Commissioning Standards for Integrated Urgent Care</p> <p>ii. Inter-hospital transfer standards</p>
12. Patient information	<p>i. During all hours that the UCC is open it is to provide guidance and support on how to register with a local GP and how to access or self-refer to other services including mental health crisis services.</p>	<p>i. Draft National guidance and UC LQS</p>
13. Training	<p>i. UCCs to provide appropriate supervision for training purposes including both educational supervision and clinical supervision of both medical and non-medical personnel.</p> <p>ii. All healthcare practitioners to receive training in the principles of safeguarding children, vulnerable and older adults and identification and management of child protection issues. All registered medical practitioners working independently to have a minimum of safeguarding training level 3.</p> <p>iii. Unregistered staff should have completed a course of training specific to the setting and undergone a period of competence assessment before carrying out delegated tasks including level 1 safeguarding training as a minimum.</p>	<p>i. – ii. Draft National guidance and UC LQS</p> <p>iii. Health Education England Care Certificate Framework</p>

London Emergency Centre Specification

This specification applies to hospital facilities that are able to receive, assess, treat and refer all patients with emergency care needs. The entire hospital is designated as an Emergency Centre, including the Emergency Department (ED) that is located within it.

Domain	Specification	Reference
1. System	i. ECs will adhere to the UEC system specification.	i. UEC system specification
2. Governance	<p>i. ECs have a formal written policy for providing emergency care, and clear pathways of care, including acceptance and referral criteria, for all common emergency conditions within the over-arching Network. The policy is to adhere to the EC facility specifications and will be ratified by the service's provider board and the UEC Network annually.</p> <p>ii. Emergency Departments (EDs) and all hospital based settings seeing paediatric emergencies, including short-stay paediatric units, should have a policy to identify and manage an acutely unwell child. Trusts are to have local policies for recognition and escalation of the critical child and to be supported by a resuscitation team. All to be able to provide initial stabilisation for acutely unwell children in level 2 HDU pending retrieval to an appropriate facility.</p>	<p>i. Draft National guidance</p> <p>ii. Paediatric Emergency Services LQS</p>
3. Location	i. Contains an ED that operates structurally and functionally within a supporting acute hospital.	i. Draft National guidance
4. Operating hours	<p>i. Open 24 hours a day, 7 days a week.</p> <p>ii. Adheres to the clinical Service Dependency Framework which outlines a set of clinically agreed service dependencies and the the degree to which a service should depend on the availability of others in order to be clinically safe and effective</p>	<p>i. Draft National guidance</p> <p>ii. Service Dependency Framework</p>
5. Access	i. All ECs will receive patient referrals from undifferentiated ambulances.	i. Draft National guidance

<p>6. Staffing</p>	<ul style="list-style-type: none"> i. EDs are under the continuous supervision and accountability of one or more consultants in Emergency Medicine. ii. A trained and experienced doctor (ST4 and above or doctor of equivalent competencies) in emergency medicine to be present in the ED 24 hours a day, seven days a week. iii. A consultant in emergency medicine to be scheduled to deliver clinical care in the ED for a minimum of 16 hours a day (matched to peak activity), seven days a week. Outside of these 16 hours, a consultant will be on-call and available to attend the hospital for the purposes of senior clinical decision making and patient safety within 30 minutes. iv. A designated nursing shift leader (Band 7) to be present in the ED 24 hours a day, seven days a week with provision of nursing and clinical support staff in EDs to be based on ED-specific skill mix tool and mapped to clinical activity v. There must be immediate availability of someone of appropriate airway maintenance skills for resuscitation, with prompt access to advanced airway management for all ages of patient, and who is on site with sufficient support and backup by other staff to be able to respond to ED emergency calls. vi. All EDs to have a named paediatric consultant with designated responsibility for paediatric care in the ED either on-site or via networked arrangements that include robust, safe transfer protocols for the acutely unwell child. All EDs are to appoint a consultant with sub-specialty training in paediatric emergency medicine. EDs to have in place clear protocols for the involvement of an on-site paediatric team. vii. EDs and all hospital based settings seeing paediatric emergencies, including short-stay units, to have a minimum of two paediatric trained nurses on duty at all times, (at least one of whom should be band 6 or above) with appropriate skills and competencies for the emergency area. viii. Timely access, seven days a week to, and support from, dentally qualified staff within the UEC network which may include oral and maxillofacial teams, to support assessment and management of patients presenting with oro-facial symptoms. ix. Arrangements in place for staff to access advice and support in relation to medicines. Including pharmacist presence in ED depending on local demand. 	<ul style="list-style-type: none"> i. Draft National guidance ii. – iv. ED LQS v. Royal College of Anaesthetists Guidelines for the provision of anaesthetic services vi. – vii. Paediatric Emergency Services LQS viii. London Dental Assessment Service Specification ix. Draft National guidance and ED LQS
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<p>7. Assessment / Treatment</p>	<ul style="list-style-type: none"> i. Co-located UCCs and ECs should have a single front door to access UEC, with one reception team under the same governance. ii. Co-located UCCs and ECs should have a single point of initial appropriate clinical assessment. iii. Triage to be provided by a qualified healthcare professional and registration is not to delay triage. iv. 95% of patients wait less than 4 hours from arrival to admission, discharge or transfer. v. A clinical decision/ observation area is to be available to the ED for patients under the care of the emergency medicine consultant that require observation, active treatment or further investigation to enable a decision on safe discharge or the need for admission under the care of an inpatient team. vi. All ECs must have 24 hour access to blood products. vii. Internal access or arrangements in place to safely access all medicines a patient needs in relation to the consultation at the time they need it. If required, these medicines are to be provided in a clinically and cost effective pack to a patient for at least a 24hour period. 	<ul style="list-style-type: none"> i. – ii. Safer, Faster, Better Guidance iii. ED LQS iv. Department of Health v. ED LQS vi. – vii. Draft National guidance
<p>8. Diagnostics</p>	<ul style="list-style-type: none"> i. 24/7 access to, with staff trained to use and interpret, the following minimum key diagnostics for adults and children and young: <ul style="list-style-type: none"> - X-ray: immediate access with formal report received by the ED within 24 hours of examination - CT: immediate access with formal report received by the ED within one hour of examination - Ultrasound: immediate access within agreed indications with definitive report received by the ED within one hour of examination - Lab sciences: immediate access with results received by the ED within one hour of the sample being taken <p>When hot reporting of imaging is not available, all abnormal reports are to be reviewed within 24 hours by an appropriate clinician and acted upon within 48 hours.</p>	<ul style="list-style-type: none"> i. ED LQS and Draft National guidance

9. Equipment	i. The ED must include a resuscitation area with appropriate equipment to provide advanced paediatric, adult and trauma life support (where a trauma unit) prior to transfer to definitive care.	i. ED LQS and Draft National guidance
10. Mental Health Crisis care	<p>i. ECs should adhere to the Mental health crisis standards, including:</p> <ul style="list-style-type: none"> - Dedicated area for mental health assessments which reflects the needs of people experiencing a mental health crisis and in accordance with RCPsych standards - Have access to on-site liaison psychiatry services 24 hours a day, 7 days a week - Liaison Psychiatry services to see service users within 1 hour of ED referral - Arrangements in place to ensure Mental Health Act assessments take place promptly and reflect the needs of the individual concerned - Access to all the information required to make decisions regarding crisis management including self-referral <p>ii. Single call access for children and adolescent mental health (CAMHS) (or adult mental health services with paediatric competencies for children over 12 years old) referrals to be available 24 hours a day, seven days a week with a maximum response time of 30 minutes. Patient ED episode to be completed including initial psychiatric assessment within four hours of arrival.</p> <p>iii. Staff should have access to both telephone consultation and an on-site response from a dedicated pool of CAMHS professionals known to the local hospital during and out of hours. Staff should not be in the position of having to speak with someone who has no direct knowledge of their clinical environment and staffing skills in dealing with psychiatric emergency and managing the risk of young people who self-harm or attempt suicide.</p>	<p>i. London Mental Health Crisis standards</p> <p>ii. – iii. Paediatric Emergency Services LQS</p>
11. Transfer	<p>i. Following initial stabilisation some patients who require specialist care will be transferred to another EC or an ECSS; this transfer capability is integral to the functioning of an EC and the network in which it operates.</p> <p>ii. ED patients who have undergone an initial assessment and management by a clinician in the ED and who are referred to another team, to have a management plan (including the decision to admit or discharge) within one hour from referral to that team. When the decision</p>	<p>i. Draft National guidance</p> <p>ii. ED LQS and General Provision of Intensive Care</p>

	<p>is taken to admit a patient to a ward/ unit, actual admission to a ward/ unit to take place within one hour of the decision to admit. This should include adult and paediatric critical care areas, which should be planned for sufficient capacity to allow admission within one hour, and to obviate the need to transfer intensive care patients inter-site for non-clinical reasons. If admission is to an alternative facility the decision maker is to ensure the transfer takes place within timeframes specified by the London inter-hospital transfer standards.</p> <p>iii. Timely access, seven days a week to, and support from, onward referral clinics and efficient procedures for discharge from hospital.</p> <p>iv. Trusts to be accountable for having and monitoring robust and cohesive policies for inter-hospital transfers (IHTs) - including repatriations – that encompass the agreed pan-London standards for adult and paediatrics. All hospitals to be linked into networks for clinically indicated IHTs. The standards include:</p> <ul style="list-style-type: none"> - All IHT will occur according to the relevant type of transfer: Critical, Immediate, Clinical and Non-urgent - All IHT agreements to be made between senior clinicians (at least ST4 or equivalent) at both the sending and receiving hospitals. For critically ill patients requiring intensive care, involvement is required from consultants at both the sending and receiving hospitals - The receiving hospital is to inform the sending hospital whether it can accept a proposed IHT within the agreed timeframes - The sending hospital retains clinical responsibility for the patient until handover at the receiving hospital has taken place. Handover should take place within 15 minutes of arrival. - The sending hospital is to ensure the patient is accompanied by an appropriate clinical escort(s) during the transfer, who is ready for transfer when LAS or PTS arrive. Prior to the IHT of any patient a risk assessment must be undertaken by a suitably competent member of clinical staff to determine the level of anticipated risk during transfer and identify the patient’s minimum clinical escort requirements. - All hospitals to have an escalation process in place which is instigated where 	<p>Services (2015)</p> <p>iii. ED LQS</p> <p>iv. – v. Inter-hospital transfer standards</p>
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	<p>timescales are not met for all IHTs.</p> <p>v. Critically ill patients undergoing inter-site transfer are at physiological risk and should be transferred according to local Critical Care Network protocols, and escorted for by suitably transfer-trained staff of appropriate seniority.</p>	
12. Clinical support services	<p>i. All ECs must have 24 hour access to care or advice from all specialties, including mental health, directly or through the Network (in some cases this may be provided remotely, for example using telemedicine).</p> <p>ii. EDs to have a policy in place to access support services seven days a week including: - Alcohol liaison - Mental health - Older people’s care - Safeguarding - Social services- Drug abuse.</p> <p>iii. Timely access, seven days a week to, and support from, community nursing services including rapid response services integrated with social care provision, physiotherapy and occupational therapy teams to support discharge.</p>	<p>i. Draft National guidance</p> <p>ii. – iii. ED LQS</p>
13. Inpatient	<p>i. ECs should adhere to the following LQs (the LQs fully congruent with national seven day services standards). These evidence-based standards are applicable across 7 days a week and represent the minimum quality of care that patients admitted as an emergency in every acute hospital in London or women who give birth in every maternity unit in London should expect to receive.</p> <ul style="list-style-type: none"> - Acute medicine and emergency general surgery - Paediatric Emergency Services - Critical care - Fractured neck of femur pathway - Maternity services <p>ii. Adhere to the Acute Care and Asthma Standards for Children and Young people.</p> <p>iii. Adhere to the London Clinical Service Dependency framework.</p> <p>iv. All ECs must include facilities for ambulatory care, admission avoidance, early supported discharge and a frailty pathway.</p>	<p>i. LQS</p> <p>ii. Acute Care and Asthma Standards for Children and Young people</p> <p>iii. London Clinical Dependency Framework</p> <p>iv. Draft National guidance</p>

14. Patient information	i. ECs should have a IT system for tracking patients, integrated with order communications. A reception facility with trained administrative capability to accurately record patients into the ED is to be available 24 hours a day, seven days a week. Attendance and admission record and discharge summaries to be immediately available in case of re-attendance and monitored for data quality.	i. ED LQS
15. Patient experience	i. Patients, and where appropriate families and carers, must be actively involved in shared decision making and supported by clear consultant-led communication and information including the provision of patient information leaflets to make fully informed choices about investigations, treatment and on-going care that reflect what is important to them.	i. ED LQS
16. Training	<p>i. The EC to provide a supportive training environment and all staff to undertake relevant ongoing training.</p> <p>ii. Organisations have the responsibility to ensure that staff involved in the care of children and young people are appropriately trained in a supportive environment and undertake ongoing training.</p> <p>iii. All nurses looking after children to be trained in acute assessment of the unwell child, pain management and communication, and have appropriate skills for resuscitation and safeguarding. Training to be updated on an annual basis.</p> <p>iv. Unregistered staff should have completed a course of training specific to the setting and undergone a period of competence assessment before carrying out delegated tasks.</p>	<p>i. ED LQS</p> <p>ii. – iii. Paediatric Emergency Services LQS</p> <p>iv. Health Education England Care Certificate Framework</p>

London Emergency Centre with Specialist Services Specification

This specification applies to Emergency Centres with additional specialist facilities features. The additions are outlined below. The full Emergency Centre specification applies to ECSS facilities also.

Domain	Specification	Reference
1. System and Emergency Centre	<ul style="list-style-type: none"> i. ECSSs will adhere to the UEC system specification. ii. ECSSs will adhere to the Emergency Centre (EC) specification. 	<ul style="list-style-type: none"> i. UEC system ii. EC specification
2. Governance	<ul style="list-style-type: none"> i. Provide support and coordination to the whole Network for patients with specialist emergency care needs, and work in partnership with the other system components to ensure that patients are able to access specialist care in a timely way. ii. Protocols across networks should be in place with London Ambulance Service in regards to who should be conveyed to an ECSS. 	i. – ii. Draft National guidance
3. Staffing	<ul style="list-style-type: none"> i. Provide consultant presence over extended hours in line with agreed specialist specifications. 	i. Draft National guidance
4. Assessment/ Treatment	<ul style="list-style-type: none"> i. Receive patients identified with specialist needs, either from ambulances that have bypassed an EC or patients transferred from UCCs or ECs in line with agreed protocols. 	i. Draft National guidance
5. Diagnostics	<ul style="list-style-type: none"> i. Provide 24/ 7 immediate access to enhanced diagnostics such as CT and MRI scanning and interventional radiology, and a wider range of facilities. ii. Provide the ability to undertake bedside focused ultrasound scanning, including echocardiography, within the ED from appropriately trained staff when clinically indicated. 	i. – ii. Draft National guidance and ED LQS
6. Transfer	<ul style="list-style-type: none"> i. Patients should not need to be transferred between similar ECSSs for the same condition other than for recovering patients being returned to community based settings of care, closer to patients' homes or based on agreed protocols for specialist services (i.e. a patient may need transfer from a ECSS without neurosurgery to one with neurosurgery, but should not need transfer between neurosurgery units on grounds of capacity at the 	<ul style="list-style-type: none"> i. Draft National guidance ii. Inter-hospital Transfer standards

	<p>transferring unit).</p> <p>ii. As per the Inter-hospital Transfer standards for adults and paediatrics:</p> <ul style="list-style-type: none"> - If a specialist centre is unable to accept an IHT on clinical grounds clear reasons for the decision and targeted advice on further care must be provided to the sending hospital. The name of the specialist giving advice should be recorded in the patient’s medical notes at the sending hospital. - Where a specialist centre within a network lacks capacity to take an IHT within appropriate timescale, the specialist centre is responsible for finding an alternative destination for the patient - The specialist centre receiving a patient is to inform the sending hospital with the estimated date of discharge/repatriation as soon as possible, and no later than 48 hours from admission. 	
7. Specialist care	i. ECSS contains one of more specialist facilities and expertise (outlined below).	i. Draft National guidance
a) Major Trauma	i. Adhere to standards for Major Trauma Centres.	i. Major Trauma Centre standards
b) Hyper-Acute Stroke Units	i. Adhere to standards for Hyper-Acute Stroke Units.	i. Hyper-Acute Stroke Unit standards
c) Heart Attack Centres	i. Adhere to standards for Heart Attack Centres.	i. Heart Attack Centre standards
d) Vascular Centres	i. Adhere to standards for Specialised Vascular Services.	i. Vascular Services standards

Sources

- Draft National guidance - *to be published 2015*
- Commissioning Standards for Integrated Urgent Care - <https://www.england.nhs.uk/ourwork/pe/nhs-111/resources/>
- London Quality Standards
 - Urgent Care - www.londonhp.nhs.uk/services/quality-and-safety-programme/urgent-care-services
 - Emergency Department - www.londonhp.nhs.uk/services/quality-and-safety-programme/emergency-departments
 - Acute medicine and emergency general surgery - www.londonhp.nhs.uk/services/quality-and-safety-programme/acute-medicine-and-emergency-general-surgery
 - Paediatric Emergency Services - www.londonhp.nhs.uk/services/quality-and-safety-programme/paediatric-emergency-services/
 - Critical care - www.londonhp.nhs.uk/services/quality-and-safety-programme/critical-care/
 - Fractured neck of femur pathway - www.londonhp.nhs.uk/services/quality-and-safety-programme/fractured-neck-of-femur-pathway
 - Maternity services - www.londonhp.nhs.uk/services/quality-and-safety-programme/maternity-services/
 - Inter-Hospital Transfers - www.londonhp.nhs.uk/wp-content/uploads/2014/12/FINAL-Adult-IHT-standards_updated.pdf
 - London clinical dependency framework - www.londonhp.nhs.uk/services/quality-and-safety-programme/clinical-dependencies-framework/
- Acute Care Standards for Children and Young people - www.londonscn.nhs.uk/publication/acute-care-standards-for-children-and-young-people/
- Major Trauma Centres - www.londonhp.nhs.uk/services/major-trauma/
- Hyper-Acute Stroke Units - www.londonhp.nhs.uk/services/stroke/
- Heart Attack Centres - www.england.nhs.uk/wp-content/uploads/2013/06/a09-cardi-prim-percutaneous.pdf
- Specialised Vascular services - www.england.nhs.uk/wp-content/uploads/2013/06/a04-spec-vascu-adult.pdf
- Mental health crisis standards - www.crisiscareconcordat.org.uk/inspiration/nhs-london-strategic-clinical-networks-london-mental-health-crisis-commissioning-standards/
- Mental Health Crisis Care Concordat - www.crisiscareconcordat.org.uk/
- Safer, Faster, Better Guidance - www.england.nhs.uk/wp-content/uploads/2015/06/trans-UEC.pdf
- Improving referrals between UEC service in England Guidance - *to be published 2015*
- Guidelines for the provision of anaesthetic services - <http://rcoa.ac.uk/news-and-bulletin/rcoa-news-and-statements/guidelines-the-provision-of-anaesthetic-services-gpas>
- Information Standards Board - <http://www.hscic.gov.uk/isce/publication/isb1594>
- Care certificate framework - www.hee.nhs.uk/work-programmes/talent-for-care-3/workstreams/get-on/the-care-certificate-new/

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