Healthy London Partnership

Coordinated, consistent and clear urgent and emergency care

Implementing the urgent and emergency care vision in London

November 2017

Contents

For further information, please contact england.serviceredesign@nhs.net
or visit www.myhealth.london.nhs.uk/healthy-london/urgent-emergency

Foreword

Professor Sir Bruce Keogh's national Urgent and Emergency Care Review called for the transformation of services to address the unsustainable pressures on the urgent and emergency care system and offered recommendations to deliver transformation. In London, we have made significant strides in improving urgent and emergency services. We now need to build on these efforts and draw from the Keogh review to accelerate transformation and deliver high quality, safe urgent and emergency care, seven days a week.

Londoners have told us that the current Urgent and Emergency Care system is confusing to navigate and characterised by queues. Our vision is therefore to improve patient outcomes and experience through high quality and consistent urgent and emergency care services that are available seven days a week. This means responding to Londoners and ensuring services are clear, consistent, coordinated and instil confidence, by connecting patients to the appropriate clinical expertise.

For people with urgent care needs, continuing to develop an integrated service is vital to help them get the right advice in the right place, first time. It is therefore important that we do not just focus on accident and emergency departments, but a much broader system of services that include NHS 111 and primary care. This will allow people requiring urgent care to be seen or receive advice close to home, improving satisfaction and reducing confusion, while reducing pressure on our accident and emergency departments. For those with more serious needs we must ensure access to high quality care in appropriate facilities with the right expertise. This document complements ongoing work to transform NHS 111 and primary care and outlines the Urgent and Emergency Care Facilities and System specifications, another piece of the jigsaw to deliver the vision for Urgent and Emergency Care. Developed by the London Clinical Leadership Group, the Urgent and Emergency Care facilities and system specifications represent the minimum standard of care that patients can expect when they access face-to-face urgent and emergency care services.

The recently developed Urgent and Emergency Care Networks in London will play a vital role in taking this vision forward and making it a reality for Londoners. As part of wider strategic planning, Networks will be responsible for overseeing the development of plans to deliver services in line with these specifications and provide a forum for clinicians, commissioners, and other stakeholders to collaborate in sharing responsibility and finding solutions for the pressures that our urgent and emergency care system faces in London.

It is recognised that this transformation won't happen overnight, but with the commitment and collective effort shown in developments to date we're confident that the aspiration made in Better Health for London, the report published by the London Health Commission, to create the best health and care services of any world city and close the gap in care between those admitted to hospital on weekdays and at weekends by 2020 can be achieved.

Conor Burke
UEC Transformation Programme Co-Chair
Chief Officer, Barking and Dagenham, Havering and Redbridge CCGs

Dr Andy Mitchell
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Medical Director, NHS England (London)

Exceptional work has occurred across London over recent years to improve care for those with life threatening emergency care needs. Our specialist emergency care services, such as stroke, heart attack and major trauma care, are now some of the best in the world. It is clear, however, that we need to build on this success across the rest of the urgent and emergency care system.

In responding to Londoners' vision for urgent and emergency care we have developed specifications for services to meet their expectations: services that are available and coordinated, clear and consistent, and that instil confidence. To do this we started with the clinically agreed London Quality Standards. These standards were developed to address the variation that existed in service arrangements and patient outcomes and through engagement with our clinical colleagues we heard broad support for the standards to be the foundation of the facilities specifications for Urgent Care Centres, Emergency Centres and Emergency Centres with Specialist Services.

The development of the specifications has been widely contributed to by patients and the public and colleagues across London. The overriding aim has been to develop specifications for London that outline a level of care that is consistently high quality, safe and equitable, seven days a week.

Engagement also highlighted the need to ensure parity of esteem for those patients in mental health crisis. Unacceptable variation exists in the quality and accessibility of services for individuals who experience a mental health crisis; integral to all Urgent and Emergency Care facilities specifications is therefore the inclusion of the Mental Health Crisis Care standards, developed in response to the crisis care concordat to ensure equity between physical and mental health across London.

With the aspiration to provide a coordinated, consistent and clear urgent and emergency care offering for the public, the specifications are to apply to all facilities offering urgent and emergency care. Through their delivery plans, Networks will work towards designating facilities according to the specifications by the end of 2016. We recognise system wide change and collaboration is needed to implement the specifications fully and, aligning with the national urgent and emergency care review, it is anticipated progress will be seen by autumn 2017 with completion by 2020.

Importantly, the specifications are part of a broader programme of work covering the spectrum of urgent and emergency care in London including NHS 111 and primary care highlighting the importance of the system specification. This specification describes the arrangements to be in place across the system to ensure pathways across facilities and services are seamless regardless of whether a patient accesses care by calling 111 or 999, or if they walk in to an Urgent and Emergency Care facility.

We would like to thank all those that have contributed to the development of the specifications and the broader programme of work. We have experienced a strong commitment to the delivery of better, more consistent care for Londoners and believe this will be vital throughout implementation to ensure we realise the justifiable expectations of Londoners.

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National context

In 2013, NHS Medical Director Professor Sir Bruce Keogh announced a comprehensive review of the Urgent and Emergency care (UEC) system in England. The review set out to address the growing and unsustainable pressures the system faced: an ageing population with increasingly complex needs leading to more people needing urgent or emergency care; and a confusing and inconsistent array of urgent care services provided outside of hospital. The review acknowledged that people struggle to navigate and access these services and therefore often default to accident and emergency (A&E) departments. The review also highlighted the recruitment and retention challenges across a range of services and clinical disciplines; and economic pressures within all organisations.

The review called for system wide transformation to develop a sustainable solution to meet these challenges and meet two overarching aims:

- To provide highly responsive, effective and personalised services outside of hospital for those with urgent but non-life threatening needs; and
- To ensure those with more serious or life threatening emergency needs are treated in centres of excellence with the very best expertise and facilities to maximise chances of survival and a good recovery.

To implement these aims and ensure patients receive consistently high quality care in the future, the review's subsequent reports[1 2], outlined five key elements to be taken forward:

1. Provide better support to self-care
2. Help people to get the right advice or treatment in the right place, first time
3. Provide a highly responsive urgent care service outside of hospital
4. Ensure that those people with more serious or life threatening emergency needs receive treatment in centres with the right facilities and expertise
5. Connect the whole UEC system together through networks

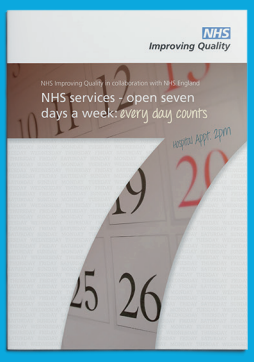
The *NHS Five Year Forward View* [3] reiterated the importance of the Review's findings and set out new models of care to redesign and integrate UEC services in England for people of all ages with physical or mental health problems.

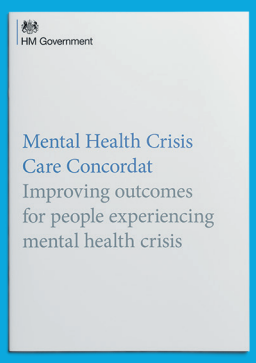
A number of other developments nationally further support the review's aims:

The NHS Services Seven Days a Week Forum's [4] ten clinical standards describe the minimum level of service that patients admitted to hospital as an emergency should expect to receive on every day of the week.

A range of national bodies involved in health, policing, social care, housing, local government and the third sector have come together to develop and sign a Mental Health Crisis Care Concordat[5]. It sets out how organisations should work together better to make sure that people get the help they need when they are having a mental health crisis.

Transforming Primary Care [6], a joint plan between the Department of Health and NHS England, outlines intentions to provide safe, personalised, proactive care for people who need it most. The plan builds on the role of primary care in keeping patients well and independent and describes how this can help avoid unnecessary emergency hospital stays.





London context

London often faces many of the national challenges in a heightened way. It has the highest rate of emergency attendances across England[7] and also has particular challenges with primary care with many practices performing worse than the England average for access scores and patient satisfaction rates[8]. This limited GP access is linked to an increase in A&E attendances[9].

Surveys of Londoners also reveal varied awareness and confusion of alternatives to A&Es. 46% of Londoners have not heard of GP out-of-hours services[10]; and three in five Londoners find urgent care services confusing and don't know the difference between 'Urgent Care Centres', 'Walk in Centres', 'Minor Injury Units' and 'GP led health centres'[11]. This is summarised by Londoners description of the UEC system as 'Confusing, 'Delayed', and characterised by 'Queues' (Figure one).

Despite these challenges, London has achieved significant improvements in care for those with more serious and life-threatening emergency care needs in recent years. Specialist services for major trauma, stroke and heart attack care now offer rapid and effective treatment in highly specialised centres of excellence resulting in a reduction in mortality across all specialties. These developments have saved lives and improved the quality of care with one in five patients who would have died from severe injuries now surviving[12 13].

Evidence suggests that a minimum of 500 Londoners' lives could be saved each year by addressing the variation in care for those admitted during the week and those admitted at the weekend.

Figure 1. Londoners description of the current UEC system

Improvements have also been made to emergency acute care more broadly. The London Quality Standards promote improvement and consistency of care across all providers and between care at the weekend and during week days and implementation of these standards is underway, although London still has some way to go to ensure full implementation.

Delivering the London Quality Standards was reinforced by the London Health Commission's *Better Health for London* report[14] which highlighted the key role the standards play in supporting the capital's providers to achieve a more consistent quality of care across all seven days of the week. The vision of transformed UEC is also consistent with Better Health for London's vision for more personalised care, with a greater emphasis on self-care, care planning, and patient engagement in service redesign.

This was reinforced by *Better Health for London: Next Steps,* with far-reaching commitment by health and care organisations across the capital to commit to the aspiration of creating the best health and care services of any world city, throughout London and on every day. This is supported by the shared commitment to close the gap in care between those admitted to hospital on weekdays and at weekends by 2020.

What Londoners want from urgent and emergency care

Figure 2. Londoners' description of the desired UEC system

To transform UEC services, we have undertaken extensive patient and public engagement to understand the perceptions and expectations of Londoners[15]. This has included a survey of 1,000 Londoners and over 800 interviews with people attending A&Es across London[16] to define the vision for the future UEC system in London.

Londoners emphasised 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
- Instil confidence by being seen by the right clinical expertise at the right time.

It is notable that these are the qualities often attributed to A&Es, rather than an urgent care centre or GP. There are currently a plethora of alternatives to A&E with different names and inconsistencies in the services they offer, the patients they are able to see and treat and the times they are open. It is therefore unsurprising that the public often default to A&E.

Healthcare access and utilisation behaviours are learnt over time in response to the perceptions of offerings currently available. This means that there are two tasks ahead: to transform the UEC system so that it meets the expectations and needs of the populations and also to instil confidence in Londoners so that they seek UEC in the appropriate locations, rather than defaulting to A&E.

Responding to Londoners

In response to what we have heard, over the last 12 months commissioners and clinical leaders across health and social care in London have been working together – and with Londoners – to shape a vision for UEC:

1. Developing responsive, effective and personalised urgent care with 111 as the 'front door' of the UEC system providing the public with access to the right advice in the right place, first time – any hour of the day and any day of the week.
2. Developing a facility specification for consistent Urgent Care Centres to reduce public confusion and developing specifications for Emergency Centres and Emergency Centres with Specialist Services for those with more serious or life-threatening emergency needs to ensure access to the best expertise and facilities to reduce risk and maximise chances of survival and good recovery.
3. Developing UEC Networks to provide overarching coordination and accountability for the system around all UEC services.

76% of patients said that their or their families past experience had guided them to attend A&E

1. Right advice in the right place, first time

Developing responsive, effective and personalised urgent care with 111 as the 'front door' of the UEC system providing the public with access to the right advice in the right place, first time – any hour of the day and any day of the week

The recently published Commissioning Standards for Integrated Urgent Care aim to support efforts to address the urgent care needs of the public[17].

Some parts of the NHS are already a long way towards integrating urgent care across NHS 111, GP out-of-hours services and other urgent care services, but elsewhere there remain areas that have entirely separate working arrangements. Londoners tell us that this makes accessing urgent advice and treatment very confusing.

The national standards seek to enable the delivery of a fully functionally integrated 24/7 urgent care service with 111 as the 'front door' of the UEC system providing access to the right advice in the right place, first time at any hour of the day and any day of the week.

Integrated Urgent Care

This new functionally integrated service includes NHS 111 and GP Out-of-hours services, as well as linking to face-to-face services such as general practice, community services, social care, ambulance services, urgent care centres and emergency departments. This means that anyone with an urgent care need can phone a single number (111) and either be given advice or, if necessary, be directed to see or speak to a GP or other appropriate health professional earlier in their urgent care journey. Relationships will also be made with the 999 call service to ensure seamless transition between services where necessary.

The service will also provide, where appropriate, direction and support for callers to self-care. This will be enhanced through the development of a digital 111 platform to enable the public to access advice, including self-care, online.

To help facilitate an improved flow of patients and information within the UEC system, all health and social care professionals within physical and mental health, will be empowered to make direct referrals and/or appointments for patients across the range of services.

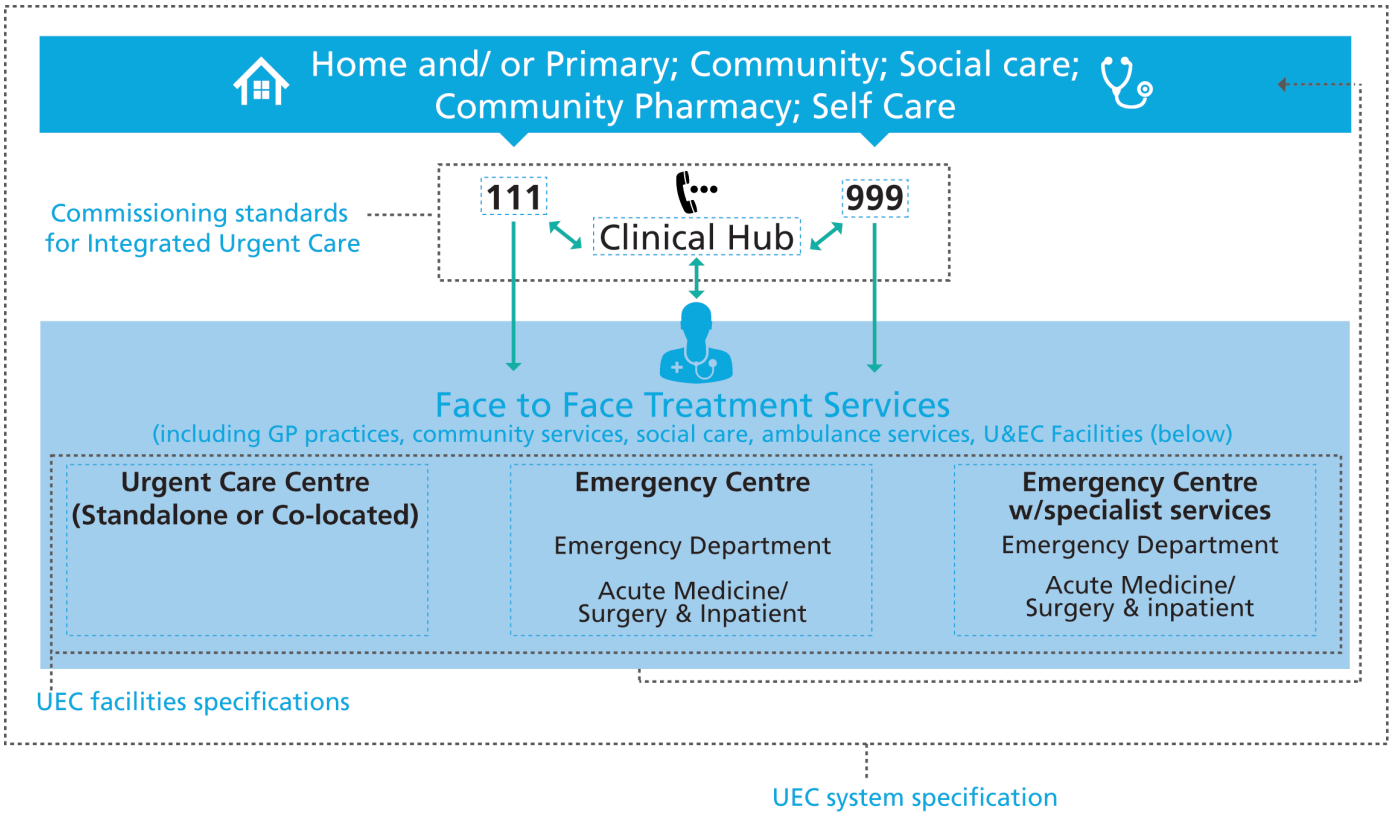


Figure 3. Overview of UEC system

Clinical assessment, advice and treatment

Central to the delivery of functional Integrated Urgent Care is the development of a 'Clinical Hub'; offering patients access to a wide range of clinicians, both experienced generalists and specialists. This will be a telephone service and will support decisions in regards to ongoing care as well as providing self-care advice to patients. It will also offer advice to health professionals in the community, such as paramedics and emergency technicians, so that no decision needs to be taken in isolation. This aims to address the strong steer from Londoners that services need to instil confidence by being seen by the right clinical expertise at the right time.

London's pharmacy and dental specifications are key components to support the development of the Clinical Hub in the new model. It is intended that the Pharmacy Hub service will be expanded to include a broader case mix and accept electronic referrals directly. The referrals process to community pharmacists for urgent repeat prescriptions will be streamlined and the coverage of pharmacies in London will be expanded. A new out-of-hours Dental Nurse Triage service will also be fully integrated into the Clinical Hub.

Face to face treatment services

The Commissioning Standards for Integrated Urgent Care focus on NHS 111, GPOOHs and the Clinical Hub and sets out the links within the system to develop a seamless system of services. Alongside this, individual services that provide face to face treatment for those that need it are also being transformed across London to ensure highly responsive and consistent urgent care services outside of hospital are available so people no longer choose to queue in Emergency Departments.

Primary care

The Primary Care Strategic Commissioning Framework[18] outlines service descriptions for more coordinated, proactive and accessible primary care.

Over the next five years, primary care will be transformed to deliver this care, which includes same day and some 7 day access to general practice for those with urgent care needs:

- **Increased patient choice:** Patients will be given a choice of access options and should be able to decide on the consultation most appropriate to their needs.
- **Improved ease of contacting the practice:** One call, click or contact in order to make an appointment.
- **Extended opening hours:** Access to a GP or other primary care professional seven days per week, 12 hours per day (8am to 8pm or equivalent based on local need).
- **Improved response to UEC needs:** Skilled staff to ensure patients with UEC needs are effectively identified and responded to appropriately.

Community and social care services

Community health and social care services are critical to the effective functioning of an UEC system. Transformation in London has been driven through the *Declaration of the Foundations of Community Services*[19]. The declaration is a picture of what excellent community services look like and is a collaborative effort of more than 1,000 people, including patients and carers; academics and opinion formers; commissioners and front-line practitioners from across London. It is intended to be a tool to support and inspire local service improvements in the delivery and commissioning of health and social care services in the community.

2. Facilities and System Specifications

Developing a facility specification for consistent Urgent Care Centres and developing specifications for Emergency Centres and Emergency Centres with Specialist Services for those with more serious or life-threatening emergency needs

In London, led by the UEC Clinical Leadership Group, UEC facilities specifications have been developed to drive care that is clear, consistent, coordinated and based on evidence based standards. Outlined in the first stage of the national UEC review, UEC facilities refer to Urgent Care Centres (UCC), Emergency Centres (EC) and Emergency Centres with Specialist Services (ECSS) (Appendix two) (Figure three).

A wide range of stakeholders across London have been engaged in the development of these specifications. The specifications build on national guidance and incorporate clinical standards agreed in London, including:

- London Quality Standards
- Major Trauma, Heart Attack, Vascular and Stroke Care Standards
- Inter-hospital Transfer Standards
- Mental Health Crisis Care Standards

London is major urban conurbation and does not include rural UEC services; it has the need and ability to deliver a consistently high quality of care across all facilities. This is reflected in the specifications by including the full London Quality Standards[20] as recommended by the London UEC Clinical Leadership Group and supported through extensive engagement.

The London Quality Standards were developed to address the variation that existed in service arrangements and patient outcomes in these services between hospitals and within hospitals, between weekdays and weekends, following multiple reports from professional bodies (including the National Confidential Enquiry into Patient Outcome and Death and Royal Colleges) which identified issues relating to the provision of emergency care services over a number of years. Messages had been consistent, namely that there is often inadequate involvement of senior medical staff in the assessment and subsequent management of many acutely ill patients. Evidence suggested a minimum of 500 lives could be saved a year by addressing this variation in care[21].

The development of the standards was clinically-led with over 90 clinicians from across London forming multidisciplinary expert panels. Patient and service user panels were also formed to provide input and ensure that patient expectations were reflected in all developments.

The majority of the standards are national recommendations from Royal Colleges and other clinical bodies and together represent the minimum quality of care that patients attending an urgent care centre, emergency department or admitted as an emergency should expect to receive from services in London, every day of the week. They are congruent with the national Seven Day Services Clinical Standards[22].

Through extensive engagement during the development of the standards broad support for their commissioning and implementation across London was achieved. This was also reflected in more recent public engagement where there was strong support for consistent services, seven days a week and through recent clinical engagement where there was strong support for the inclusion of the London Quality Standards as the basis for the facilities specifications.

94% of Londoners think UEC services should be consistent across the whole week

Engagement also highlighted the need to ensure parity of esteem for those in mental health crisis. Integral to all UEC facilities specifications is the inclusion of the Mental Health Crisis Care Standards[23], developed in response to the crisis care concordat to ensure equity between physical and mental health across London.

With the aspiration to provide a coordinated, consistent and clear UEC offering for the public, these UEC facilities specifications apply to all services offering UEC care that are able to receive patients that can walk-in or arrive by ambulance without an appointment and with an undifferentiated health need. Any such service must be designated as an UCC, EC or ECSS and comply with the associated specification. This includes both co-located and standalone centres.

For UCCs the aim is to reduce confusion by creating a single consistent service offering that the public can be confident can deal with their urgent care need wherever they are in London. As determined through UEC network designation processes, UCCs will include services previously known as Walk-in-Centres, Minor Injury Units and GP-led health centres. For ECs, the specifications will apply to emergency departments (ED) and the acute hospital they are part of. For ECSSs, specifications will apply to ECs with one or more of a Major Trauma Centre, Hyper-Acute Stroke Unit, Heart Attack Centre and Specialised Vascular Service.

In addition, an 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[24]. 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 out of hours (OOH) care.

A small number of sites, for specific indications, may develop formal networked arrangements to ensure safety and access for A&Es to a full Emergency Centre. Designation guidance is under development to support U&EC Networks in this decision making process.

Urgent Care Centre	Emergency Centre	Emergency Centre for Specialist Services
- Encompass Walk-in Centres, Minor Injuries Units, GP-led Health Centres and all other similar facilities – but now referred to as Urgent Care Centres - Open and staffed consistently for at least 16 hours a day - Where appropriate, co-located with emergency centres on hospital sites - Have access to X-Ray and blood tests	- Hospital facilities that receive, assess, treat and refer all patients with emergency care needs, including the Emergency Department (ED) - A consultant in emergency medicine is scheduled to deliver clinical care in the ED for a minimum of 16 hours a day, seven days a week. - Consistent consultant presence and earlier review across seven days a week in acute and surgical assessment units	- Hospital based facilities with all the features of an EC, but also specialist facilities. - Include one or more of the following specialist services: > Major Trauma Centres > Hype-acute Stroke Units > Heart Attack Centres > Specialised vascular Services
UEC System		
- Access for all ages and to the same integrated clinical pathways - Integrated clinical governance across facilities - Common transfer standards between services		

Table 1. Overview of U&EC facilities and system specifications

3. Urgent and emergency care networks

Developing UEC Networks to provide overarching coordination and accountability for the system around all UEC services

Closely aligned to patient preferences, commissioners and providers of healthcare want to optimally deliver clinically effective services that provide value for money and are sustainable. A system that reliably meets the needs of patients but offers more appropriate services in both terms of clinical and economic effectiveness will not only ensure appropriate care but also reduce the pressure on emergency departments across London and improve patient experience. To help achieve this five UEC networks have been established in London.

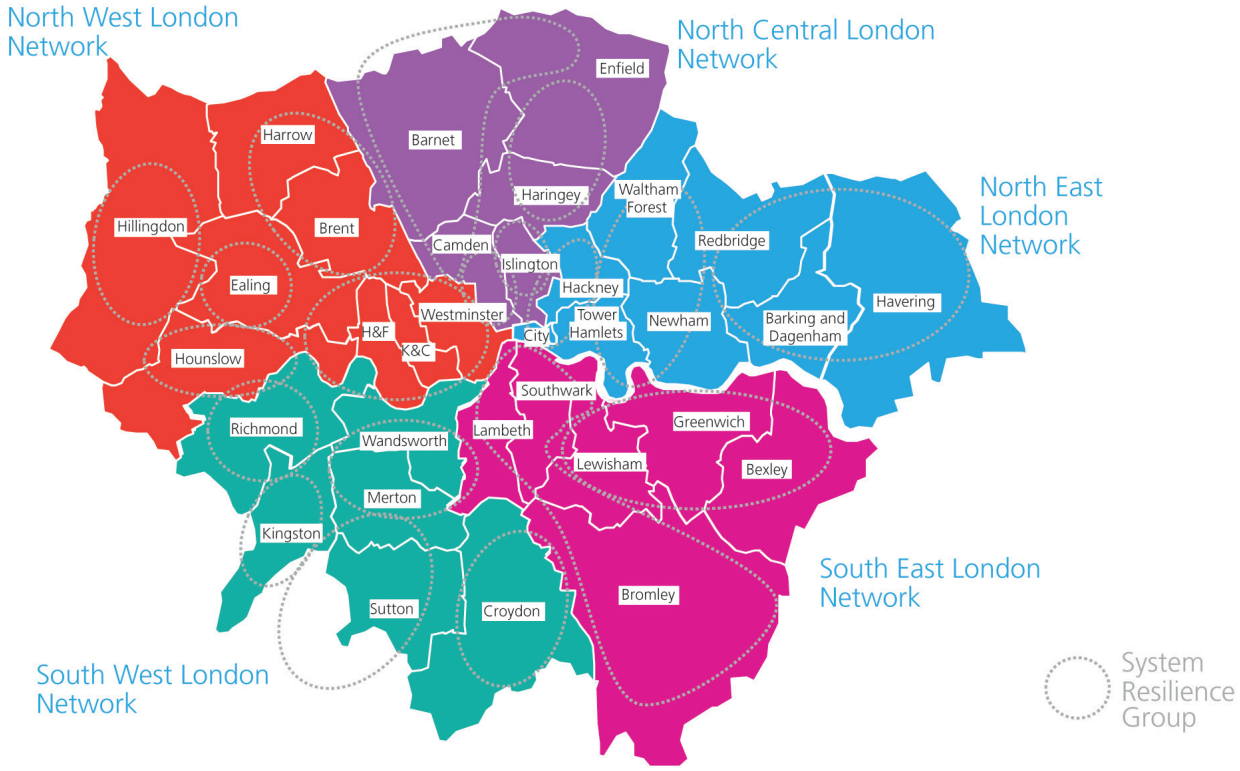


Figure 4. London's U&EC Networks and System Resilience Groups

The overall purpose of UEC Networks is to operate strategically to improve the consistency and quality of UEC by bringing together constituent System Resilience Groups (SRGs) and other stakeholders to address challenges in the UEC system that are difficult for single SRGs to address in isolation. They will ensure all patients within the network can access high quality and consistent UEC services 24 hours a day, seven days a week in line with agreed standards and specifications.

The core objectives of UEC Networks include:

- Creating and agreeing an overarching network delivery plan to deliver the Urgent and Emergency Care vision in London;
- Designating UEC facilities in line with the agreed London specifications and defining consistent pathways of care and equitable access to services for both physical and mental health;
- Coordinating workforce and training needs and ensuring the building of trust and collaboration throughout the network and spreading best practice.

The UEC Networks in London will have robust links with existing clinical networks in London including Trauma Networks, Stroke Networks, Heart Attack Networks and Paediatric Repatriation Networks.

Enablers

Workforce

It is widely recognised that UEC services face some of the biggest challenges in workforce across health and social care. Through evidence gathered and engagement to date with UEC Clinical and Network Leads, National UEC representatives and London's Strategic Planning Groups' Workforce Leads, a number of priority areas of focus have been identified to address within and across networks in London:

- A coordinated approach to ensure sufficient numbers of trained UEC staff are available at the right grade and in the right part of the system, to meet existing patient demand, maintain expected service quality standards and to reduce the reliance on agency use.
- To address factors that hinder the retention of the UEC workforce, and impact significantly on their Health & Wellbeing.
- A cultural shift for all members of UEC Networks, including the clinical workforce, to participate and deliver change collaboratively rather than as individual organisations.
- Investment in frontline workforce personal development such as developmental rotations and more clearly defined and communicated career pathways. Low pay, anti-social working hours and limited personal development are identified as reasons for a high attrition rate of this workforce.
- Greater multidisciplinary and cross organisational boundary working across health and social care settings.
- Make working in and out of hospital UEC models more integrated, such as portfolio career options and further placements in NHS111 and the community for training clinicians.
- Specific skills across the system such as the ability to recognise a patient that presents in mental health crisis and promoting appropriate self-care for patients.

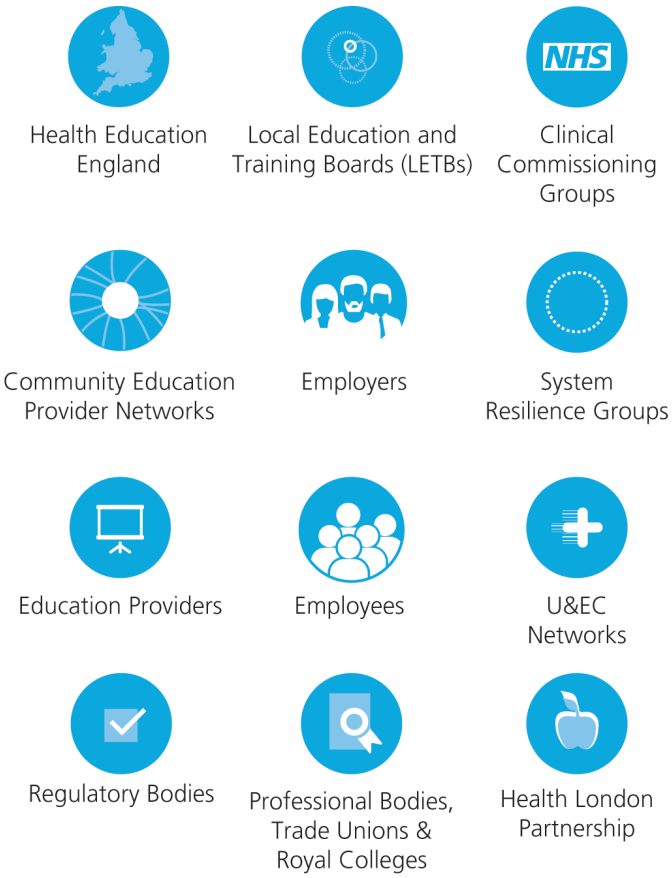
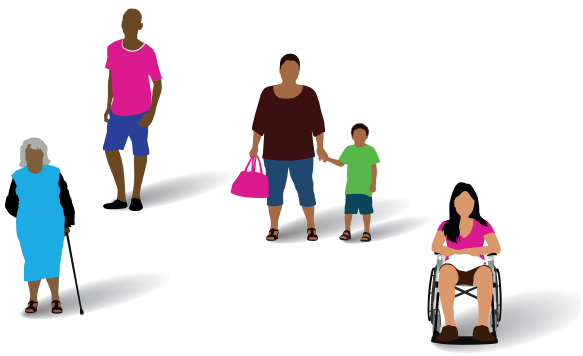


Figure 5. Stakeholders involved in the London UEC workforce system

A number of stakeholders are involved in the London UEC workforce system. Relating to these priorities, specific roles and interactions will transform the workforce across the capital.

Action is needed across each of these workforce priorities in London, and will require a coordinated approach across a wide range of UEC system stakeholders. The next phase will look to capture those actions that will deliver the most value to UEC system stakeolders locally.



Roles and responsibilities:

Employees

- Maintain professional qualifications for their role, and undertaking continuing professional development to ensure practice is current and quality is maintained.

Employers

- Develop a supportive environment for their staff to work within and investing in education and training.
- Develop and implement appropriate recruitment and retention packages.
- Contribute to the regional workforce planning process by providing robust and financially-sound workforce plans that align with the Integrated Urgent Care and UEC facilities specifications, including identification of skills and role gaps in their current workforce.

Employers together

- Streamline human resources and organisational design functions where appropriate to facilitate workforce working across UEC settings.

Community Education Provider Networks (CEPNs)

- Deliver improved workforce planning and workforce development, including identification of new roles and skill-mix changes required to deliver the Integrated Urgent Care and UEC facilities specifications.
- Understand the development requirements of the workforce to meet the local population UEC health needs.

Local Education & Training Boards (LETBs)

- Working with commissioners and employers to understand the workforce implications of their UEC service plans and develop new roles that will be required to deliver the service vision for the locality.

Health Education England (HEE)

- Develop a workforce strategy that will support the NHS to deliver its vision for UEC service transformation.

Clinical commissioning groups (CCGs)

- Support providers to develop an appropriate workforce to deliver the standards and specifications and meet the health population needs of their locality.
- Support UEC Networks to develop their workforce supporting strategies with the providers, incorporating the needs of the local population and aligned with designation decisions.

UEC Networks

- Work with employers to understand the workforce implications of the service visions they have developed, and develop supporting strategies.
- Horizon scan for changing commissioning requirements.

Healthy London Partnership

- Gain consensus on London's UEC workforce challenges/ priorities and facilitate and lead the coordinated actions that need to be taken to address them in the short and longer term.

Regulatory bodies

- Protect patient interests by improving education for professionally qualified staff through training and practice standards.
- Ensure that members keep skills and knowledge up to date and uphold professional standards.

Education providers

- Work with the regulatory and professional bodies to ensure that curricula for professional training meet professional requirements.
- Work with HEE and LETBs to ensure training is fit for purpose and reflects future service provision.

Interoperability

86% of Londoners think the ability for healthcare professionals to access their up-to-date health information is important.

The exchange of critical information across UEC improves the patient journey and experience. Interoperability is a key enabler to continuity of care and supports effective clinical decision making across the capital, with critical patient information exchanged between organisations along with triage information and sharing of crisis records/plans.

The communication process, including referring patients electronically and the booking of appointments, should be seamless across UEC with providers communicating with one another for the patients' benefit. Services across UEC should be able to receive and consume information and data should be collated as the patient touches UEC points, meaning they only have to consent once as part of UEC episode.

National standards for interoperability in UEC are in development to support transformation and address this problem. Change will be required in primary care, integrated urgent care and in the UEC facilities, however common standards and a coordinated approach across all services is required which includes the response of community nursing and mental health crisis services. For London, an interoperability framework for UEC systems will be developed – in line with national standards – which will include a specification for connecting UEC services and sharing patient information. Support will be provided to assist networks in designing services alongside this and procuring and implementing new systems.

Specific areas of development, in addition to the specification, are shown on page 17.

What?	How?
Ability for patient information to be communicated between services. This includes core general practice information such as summary care records, special patient notes for crisis care and end of life care plans, medicines and other relevant records.	The piloting of Patient Relationship Manager (PRM), a pioneering cloud based technology solution, has enabled NHS 111 services to retrieve care and crisis plan information from multiple information systems for use during clinical decision-making. Its use means that patients calling back 111 will no longer need to repeat information and ambulance crews will be able to view key crisis information from 111 referrals, en route or at scene. The scope of the PRM pilot will expand based on learnings from the first phases. This will include incorporating patient relevant data from additional partners, refining the crisis information available to 999 ambulance crews, and developing automatic and individualised patient routing based on caller's crisis information and profiles. The overall aim is for the PRM to facilitate London UEC Network's compliance with the interoperability requirements of the Commissioning Standards for Integrated Urgent Care. In parallel to the PRM pilot, London GP OOH providers have been supported to align over 48,000 Special Patient Notes to restructured standard templates to allow 111 to electronically forward key crisis data to the LAS and wider UEC services.
Ability for services to make direct bookings between one another so that patients that require an escalated level or ongoing care do not need to present as a newcomer.	To further enhance information sharing between organisations the referral methods within Interoperability Toolkit, a set of national standards, frameworks and implementation guides to support interoperability within local organisations and across local health communities, will be extended. In addition, improvements to Post Event Messaging from Clinical Hub services will be made and a cross hub solution enhanced.
Ability for services to access up-to-date information of the range of services available to refer or direct patients towards	The London Directory of Service (DoS) contains clinical profiles for over 7,000 London UEC Services. Further work will be undertaken to expand the number of services that can receive a 111 referral ensuring a streamlined handover between clinicians and services. Work will continue to enhance the information available on the DoS such as the inclusion of GP bypasses numbers, 111 Pharmacy Urgent Repeat Medication (PURM) pharmacies, mental health and rapid response community services. A Mobile DoS platform, providing an online search tool, has also been rolled out and is available in over 130 UEC services across London including integrated urgent care services, Urgent Care Centres, Emergency Departments, and the London Ambulance Service. Efforts will continue to improve the consistency, coverage and access to the Directory of Services, extend the rollout and usage of the mobile DoS search tool, and continue work on integrating the DoS with other directories (e.g. local authority).
Offer the public digital access points to UEC	Working with the National Digital Futures Team, an Urgent Care Digital Platform will be piloted in London during 2016. This will support the future integrated urgent care model in London, offering the choice of either calling 111 or accessing urgent care services online.

Table 2. Interoperability development areas for UEC in London

Payment mechanisms

The current forms of payment mechanisms for UEC create a barrier to the coordination and collaboration of organisations to achieve the UEC vision for London. NHS England and Monitor have recognised this and produced proposals for a new approach to payment to enable a networked model of care [25]. In London, Monitor and NHS England are supporting vanguards and other pilots adopt this approach.

Key features of the proposed approach

The proposed new approach to payment (figure 6) is intended to be coordinated and consistent across all parts of an UEC network and incorporates the following features:

- **a substantial proportion of fixed core payment,** to reflect the 'always-on' nature of services and to concentrate providers' and commissioners' attention on planning capacity across the system to the agreed specifications;
- **a proportion of volume based payment,** to make it possible for individual providers to meet differences in expected and actual demand, and to enablemore efficient allocation of financial risk across a network; and
- **network-wide outcomes and performance metrics** operating throughout payment to encourage coordination, deliver improved patient flow across the network and promote quality improvement.

Applied to all services and providers within the network, these features are intended to support the transition to, and operation of, the new networked model of care for UEC and the facilities and system specifications. Currently, each patient handover carries disparate financial as well as assessment delay consequences. Payment reforms therefore aim to better align payment across all services.

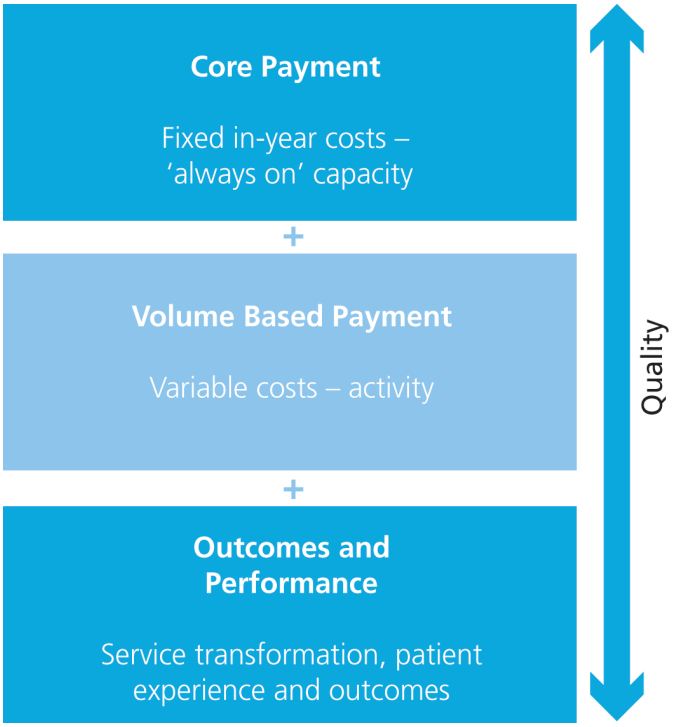


Figure 6. Three-part payment approach

Key payment design steps

In formulating a coherent and comprehensive payment approach that incorporates the desirable features set out above, a number of key design steps have also been proposed, as shown in Figure 7 on page 19. They are intended as possible starting points for testing to inform the approach(es) that could be taken.

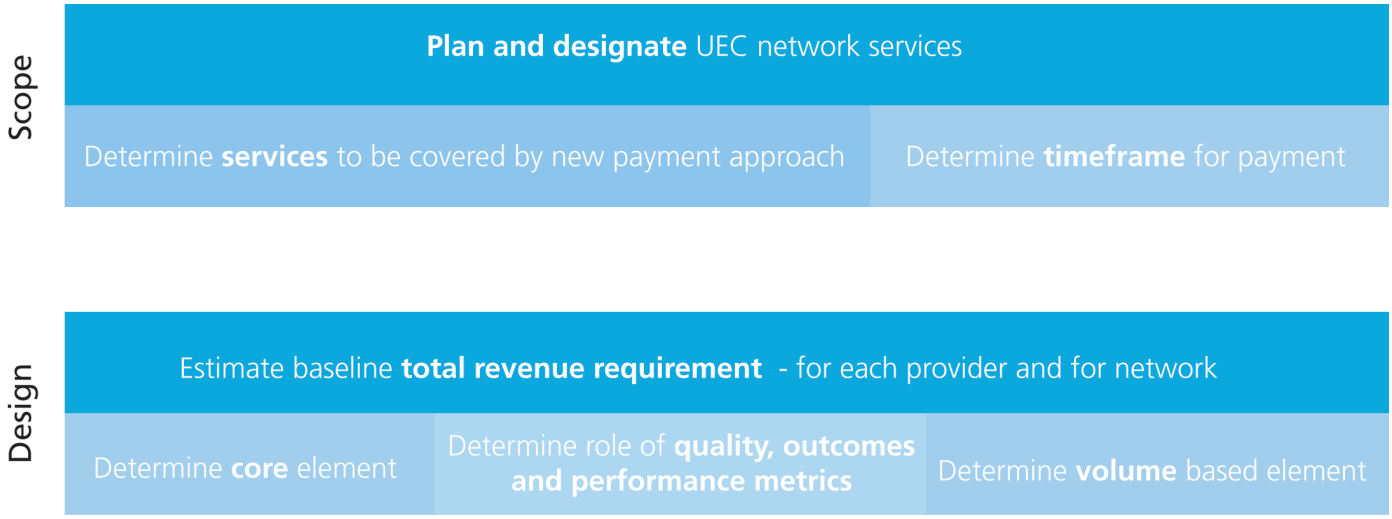


Figure 7. Payment design steps

A number of possible options are available at each step and at this stage a single preferred answer from them has not been identified. Instead, high level options for each step have been set out. This provides a 'tool box of options' from which local areas can construct a three-part payment approach that best meets their local needs and vision for service change.

The success of the approaches will be determined by their support in delivering new models of UEC care. They must support continuous improvement and incentivise coordination across a UEC network to provide the right care, first time, in the most cost effective setting. They should also ensure organisation and system level accountability for activity & costs and be robust to unexpected case mix and volume of demand whilst being practical to implement and operate.

Adopting this approach in London

The proposals permit flexibility for local health economies to develop payment models that fit with local strategies. This provides an opportunity to develop and test different payment models across local health economies, evaluate models to understand the impact and learning. To do this, NHS England and Monitor have agreed to support further pilots in London in addition to Barking and Dagenham, Havering and Redbridge Vanguard in Northeast London.

As care models evolve payment models will also evolve and local health economies will be considering payment models that build on the approach outlined above, for example capitation under an accountable care model. It will be important to share learning across London from all new approaches and build on successes.

Appendix 1 - Glossary

A&E	Accident and Emergency Departments
CCGs	Clinical Commissioning Groups
CEPNs	Community Education Provider Networks
DoS	Directory of Services
ED	Emergency Departments
EC	Emergency Centres
ECSS	Emergency Centres with Specialist Services
GP	General Practitioner
HEE	Health Education England
LETB	Local Education and Training Board
LQS	London Quality Standards
NHS	National Health Service
OOH	Out of hours
PURM	Pharmacy Urgent Repeat Medication
SRG	System Resilience Group
UCC	Urgent Care Centre
UEC	Urgent and Emergency Care

Appendix 2 - References

1 NHS England (2013) *Urgent and Emergency Care Review - End of Phase 1 Report*

2 NHS England (2014) *Urgent and Emergency Care Review - Update on progress*

3 NHS England (2014) *Five Year Forward View*

4 NHS England (2013) *NHS Services Seven Days a Week Forum Clinical Standards*

5 Department of Health (2014) *Mental Health Crisis Concordat*

6 Department of Health and NHS England (2014) *Transforming Primary Care*

7 Health and Social Care Information Centre (2014) *www.hscic.gov.uk/article/3875/Attendance-rates-at-major-AE-departments-highest-in-London*

8 London Health Commission (2014) *Improving the quality and consistency of general practice – Technical Pack*

9 T.E. Cowling et al. (2013) *'Access to Primary Care and Visits to Emergency Departments in England: A Cross-Sectional, Population-Based Study' available at: www.journals.plos.org/plosone/article?id=10.1371/journal.pone.0066699 (accessed on 20 January 2015)*

10 House of Commons Committee of Public Accounts (2014) *Out of Hours GP Services Report*

11 Healthy London Partnership (2015) *London UEC transformation programme survey*

12 London Health Programmes (2012) *www.londonhp.nhs.uk/services/*

13 Trauma Audit and Research Network (TARN) (2013) *National Audit*

14 London Health Commission (2014) *Better Health for London*

15 Healthy London Partnership (2015) *London UEC transformation programme survey*

16 Healthy London Partnership (2015) *Behavioural insights of people attending Emergency Departments in London*

17 NHS England (2015) *Commissioning Standards for Integrated Urgent Care*

18 Healthy London Partnership (2015) *Primary Care Commissioning Framework*

19 TransformLDN project, NHS England (2014) *Declaration of the Foundations of Community Services*

20 London Health Programme (2013) *London Quality Standards*

21 London Health Programme (2012) *Case for change for London Quality Standards*

22 NHS England (2013) *NHS Services Seven Days a Week Forum Clinical Standards*

23 NHS England (London) Strategic Clinical Networks (2014) *Mental Health Crisis Commissioning Standards*

24 London Health Programme (2013) *Inter-Hospital Transfer Standards*

25 NHS England and Monitor (2015) *Urgent and emergency care: a potential new payment model*

Appendix 3 – U&EC Facilities and System Specification

Introduction

The first stage of Professor Sir Bruce Keogh's national UEC review called for clarity and transparency in the offering of Urgent and 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

In November 2015 London released 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 clinical engagement there was also strong support for the inclusion of the London Quality Standards as the basis for the 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.

In July 2017, NHS England published ‘Urgent Treatment Centres – Principles and Standards’ setting out the principles and standards which Sustainability and Transformation Partnerships and local commissioners should achieve when establishing Urgent Treatment Centres as part of their local integrated urgent and emergency care system.

Two years on, and with further information released, London has reviewed its UCC facility specifications against national Urgent Treatment Centre (UTC) guidance and updated these facility specifications as a result.

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	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.	• – iv. Draft National guidance
2. Clinical governance	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.	i. – iii. Draft National guidance iv. – vi. Commissioning Standards for Integrated Urgent Care

	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. 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.	
3. Patient experience and outcomes	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.	i. – ii. Draft National guidance; Urgent Care (UC) LQS; Emergency Department (ED) LQS iii. Commissioning Standards for Integrated Urgent Care
4. Safeguarding	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	i. Draft National guidance and UC LQS

	governance and link into system-wide arrangements. 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.	ii. Paediatric Emergency Services LQS
5. Clinical assessment and onward care	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: 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. These include referrals/ appointments for patients that require: • 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. 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. iii. Exact pathway protocols are defined and agreed within each network region and used by	i. – v. Improving referrals between UEC service in England guidance vi. Commissioning Standards for Integrated Urgent Care

	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. iv. A minimum data set of information on initial assessment should be agreed and accompany a referral or direct booking. 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. vi. All UEC facilities should have access to advice from clinical hubs including for dental and pharmacy services.	
6. Mental Health Crisis care	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.	i. London Mental health Crisis Standards
7. Managing information	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. ii. All UEC facilities should have the ability to receive patient information from NHS 111 via the inter-operability toolkit. 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. iv. All UEC facilities should adhere to the Data Protection Act in relation to patient records.	i. – iv. Commissioning Standards for Integrated Urgent Care and Safer, Faster, Better guidance v. Draft National guidance vi. Draft National guidance and UC LQS

	v. All UEC facilities should collect and return anonymised data relating to patients attending the service, in accordance with nationally specified standards. i. 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 and GP if they have one. All communication should take place electronically. GPs are encouraged to then reflect accurate data into their local systems and update the patient's SCR or local record following an UCC attendance. ii. 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.	vii. Information Standards Board
8. Provision of information to patients	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.	i. – v. Draft National guidance; UC LQS; ED LQS

9. Integrated Capacity Management	i. Integrated capacity management protocols should be in place across the system, including access to real-time capacity information.	i. Safer, Faster, Better Guidance
10. Training	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.	i. – iii. Safer, Faster, Better Guidance ii. ED LQS
11. Clinical Decision Support systems (CDSS)	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).	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	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. 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. iii. Each UCC should have an identified lead for safeguarding and children and young people.	i. – ii. Draft National guidance and UC LQS
3. Location	i. UCCs should be co-located with ECs, however, standalone centres will also exist.	i. Draft National guidance
4. Operating hours and scope	i. Opening hours will be locally determined but all UCCs will be open for a minimum of 12 hours a day. All UCCs should be consistent in staffing and service provision throughout days and weeks. ii. During the hours that they are not open, UCCs should provide immediate access to the UEC Network for persons contacting the UCC by phone (e.g. through 111, out of hours general	i. – ii. Draft National guidance iii. National UTC guidance

	practice, the ambulance service, or similar arrangements) or arriving in person. iii. The scope of practice in UCCs must include minor illness and injury in adults and children of any age, including wound closure, removal of superficial foreign bodies and the management of minor head and eye injuries.	
5. Access *(in addition to UEC system specification)*	i. All UCCs should accommodate direct access to patient referrals from differentiated ambulances within network agreed protocols and pathways of care.	i. Draft National guidance
6. Staffing	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. UCCs should have a specified clinical lead; this can be co-led with a GP. 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 a co-located UCC service is open, it should have access to healthcare practitioners in the ED trained and competent in advanced life support and paediatric advanced life support. Non-co-located UCCs should ensure attendance by an ambulance is facilitated within agreed timescales if seriously ill/high risk patients attend who need treatment in an EC or ECSS. 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. iv. All UCCs should have arrangements in place for staff to access advice and support in relation to medicines.	i. – v. Draft National guidance and UC LQS

	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.	
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 or joint governance. 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. Each STP should look at how they provide adequate support to standalone UCCs to account for this. 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 of 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. Appointment slots should not be more than 2 hours after the time of arrival. 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.	i. – ii. Safer, Faster, Better Guidance iii. UC LQS and Draft National guidance iv. – vi. UC LQS v. National UTC guidance vii. Safer, Faster, Better Guidance
8. Diagnostics	i. Access to the following diagnostics for adults and children and young people during hours	i. Draft National guidance and UC

	the UCC is open, with real time access to images and results: - 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 - Clear governance protocols should be developed with consideration of how to discourage patients re-attending the acute site to access investigations and blood tests over their own GP. - Clinical staff to have the competencies to assess the need for, and request, diagnostics and imaging, and interpret the results. *(During transition to this specification where this is not currently available, local protocols should specify alternate routes of access and reporting standards).*	LQS
9. Equipment and physical environment	i. Appropriate equipment to be available onsite (with sizes available for adults and children): - a full resuscitation trolley to include those items which the Resuscitation Council (UK) recommends as being immediately available in its guidance 'Quality standards for cardiopulmonary resuscitation practice and training' - an automated external defibrillator - oxygen high flow - suction - emergency drugs - Monitoring equipment to calculate a National Early Warning Score (NEWS) score All urgent care service to be equipped with a range of appropriate medicines necessary for immediate treatment, including 24 hour emergency contraception. ii. Training, audit, testing and quality assurance mechanisms to be in place for all equipment. 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. iv. Appropriate environment and policy in place to accommodate children and young people including audio-visual separation and availability of chaperone.	i. – iv. UC LQS; Draft National guidance; London Acute standards for Children and Young People

	v. Access to the NHS Spine Portal should be available on every desktop within UCCs vi. All clinical staff within the UCCs must have and use NHS smartcards with the relevant role-based access control (RBAC) codes on them. Examples include: EPS, SCR, and CP-IS	
10. Mental Health Crisis Care	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. ii. Dedicated area for mental health assessments which reflects the needs of people experiencing a mental health crisis and in accordance with RCPsych standards. iii. Arrangements in place to ensure Mental Health Act assessments take place promptly and reflect the needs of the individual concerned. iv. Access to all the information required to make decisions regarding crisis management including self-referral. v. Direct line of communication with local mental health services and knowledge of local out of hours mental health services. 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. Psychiatric assessment to take place within four hours of call. 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.	i. UC LQS ii. – v. London Mental Health Crisis standards vi. – vii. Paediatric Emergency Services LQS
11. Referral/ Direct Booking	i. UCCs should be able to directly refer to a pharmacy that is commissioned to provide urgent repeat medicines as a local NHS service. 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. iii. Where available, systems interoperability should make use of nationally-defined	i. Commissioning Standards for Integrated Urgent Care ii. Inter-hospital transfer standards

	interoperability and data standards; clinical information recorded within local patient care records should make use of clinical terminology (SNOMED-CT) and nationally-defined record structures. iv. There must be the ability for other services (such as NHS 111) to electronically book appointments at the urgent treatment centre directly, and relevant flags or crisis data should be made available for patients. v. UCCS should make use of the Emergency Care Data Set (ECDS)	
12. Patient information	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. This should include supporting patients to self-care and use community pharmacy wherever it is appropriate to do so. UCCs should promote and record the numbers of patients offered self-care management and patient education. ii. The Summary Care Record (SCR) Additional Information (AI) should also be promoted and patients should be given the option to request AI to be added to their core SCR. It is recommended the SCR is used for medicines reconciliations, even if a local solution is in place iii. Information should be provided in a format which patients understand and UCCs should provide the necessary range of services to enable people with communication challenges to access British Sign Language, interpretation and translation services.	i. Draft National guidance and UC LQS ii. National UTC guidance
13. Training	i. UCCs to provide appropriate supervision for training purposes including both educational supervision and clinical supervision of both medical and non-medical personnel. 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. 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.	i. – ii. Draft National guidance and UC LQS iii. Health Education England Care Certificate Framework

	iv. All UCC staff should have child protection information sharing (CPIS) training	

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	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. 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.	i. Draft National guidance ii. Paediatric Emergency Services LQS
3. Location	i. Contains an ED that operates structurally and functionally within a supporting acute hospital.	i. Draft National guidance
4. Operating hours	i. Open 24 hours a day, 7 days a week. 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	i. Draft National guidance ii. Service Dependency Framework
5. Access	i. All ECs will receive patient referrals from undifferentiated ambulances.	i. Draft National guidance

6. Staffing	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.	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

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 or joint 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.	i. – ii. Safer, Faster, Better Guidance iii. ED LQS iv. Department of Health v. ED LQS vi. – vii. Draft National guidance
8. Diagnostics	i. 24/7 access to, with staff trained to use and interpret, the following minimum key diagnostics for adults and children and young: - 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 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.	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	i. ECs should adhere to the Mental health crisis standards, including: - 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 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. 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.	i. London Mental Health Crisis standards ii. – iii. Paediatric Emergency Services LQS
11. Transfer	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. 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	i. Draft National guidance ii. ED LQS and General Provision of Intensive Care

	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. iii. Timely access, seven days a week to, and support from, onward referral clinics and efficient procedures for discharge from hospital. 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: - 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	Services (2015) iii. ED LQS iv. – v. Inter-hospital transfer standards

	timescales are not met for all IHTs. 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.	
12. Clinical support services	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). 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. 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.	i. Draft National guidance ii. – iii. ED LQS
13. Inpatient	i. ECs should adhere to the following LQSs (the LQSs 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. - Acute medicine and emergency general surgery - Paediatric Emergency Services - Critical care - Fractured neck of femur pathway - Maternity services ii. Adhere to the Acute Care and Asthma Standards for Children and Young people. iii. Adhere to the London Clinical Service Dependency framework. iv. All ECs must include facilities for ambulatory care, admission avoidance, early supported discharge and a frailty pathway.	i. LQS ii. Acute Care and Asthma Standards for Children and Young people iii. London Clinical Dependency Framework iv. Draft National guidance

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	i. The EC to provide a supportive training environment and all staff to undertake relevant ongoing training. 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. 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. 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.	i. ED LQS ii. – iii. Paediatric Emergency Services LQS iv. Health Education England Care Certificate Framework

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	i. ECSSs will adhere to the UEC system specification. ii. ECSSs will adhere to the Emergency Centre (EC) specification.	i. UEC system ii. EC specification
2. Governance	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	i. Provide consultant presence over extended hours in line with agreed specialist specifications.	i. Draft National guidance
4. Assessment/ Treatment	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	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	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	i. Draft National guidance ii. Inter-hospital Transfer standards

	transferring unit). ii. As per the Inter-hospital Transfer standards for adults and paediatrics: - 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

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- Draft National guidance - *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
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  - 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/
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- 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 - *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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