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JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE - OUR HEALTHIER SOUTH EAST LONDON

Date: TUESDAY, 11 OCTOBER 2016 at 6.30 pm

Committee Room 1
Civic Suite
Catford
SE6 4RU

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The public are welcome to attend our committee meetings, however occasionally committees may have to consider some business in private. Copies of reports can be made available in additional formats on request.

Our Healthier South East London Joint Health Overview & Scrutiny Committee

Tuesday 11 October 2016
7.00 pm
Lewisham Town Hall, Committee Room 1, Civic Suite, Catford, SE6 4RU

Supplemental Agenda

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9.	**London Urgent and Emergency Care - follow up** The Urgent and Emergency Care Facilities and System Specifications is enclosed.	18 - 40

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Date: 4 October 2016

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NHS

South East London: Sustainability and Transformation Plan

Briefing 3 October

What is a STP?

- In December 2015 Health and care systems were asked to come together to create their own ambitious local blueprint for implementing the 5YFV, covering Oct 2016 to Mar 2021.

- The STP will need to describe an overall local vision, and its approach to address three overarching areas:
  - The health and wellbeing gap
  - The care and quality gap
  - The funding and efficiency gap

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

- It's a different way of working

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What are we really trying to achieve?

Over the next five years we will:

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

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STP Governance

STP SRO and Leadership

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

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Organisational Governance and Decision Making

Provider Meeting | Local Authority Cabinets | Trust boards | Committee in Common | CCG Clinical Strategy Committee | CCG Governing Bodies [x6]

Collective STP Leadership and Governance

Patient and Public Advisory Group

Directors of Strategy

Strategic Planning Group

A senior joint group for strategic decision making, led by the Senior Leadership team.
Chair: Amanda Pritchard
Members: CCG Chairs/COs (x12) Trust CEX, Local Authority rep (x1), NHSE Specialised Commissioning
In attendance: PPAG Chair

Stakeholder Ref. Group

Partnership Group

Programme PMO

Clinical Executive Group

Guides design work to ensure the STP is clinically Driven
Chair(s): 1 CCG Chair + 1 secondary care lead
Members: CCG Chairs, Provider MDs, NHSE (South London) Medical Director, Public Health Lead

STP Executive Group

Chair(s): Quartet & NHSE (South London) Delivery Director
Members: CCG and provider SROs, programme director, NHSE commissioning leads, local authority representation.

Finance &Technical Group

Drives financial affordability and transformation
Chair(s): CCG DOF and Trust FD
Members: CCG DOFs, Trust FDs

System redesign

TCP | U&EC | Cancer | Planned
Mental Health | CBC | CYP | Maternity

Mental health is also a cross cutting theme through the work of all other CLGs.

Productivity

Chair(s): SRO productivity (Trust FD)
Members: Trust implementation leads

Back Office | Procurement | Estates
Clinical Support | CIPs | Workforce

Enablers

Estates | Workforce | IM&T
Commissioning and payment

Key: Programme Decision Making | Programme Governance | Advisory and engagement

4

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If we don't succeed, we will have to have to build the equivalent of another hospital in south east London to cope with the increase in activity.

SEL STP Plan on a Page

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Our challenges

Demand for health and care services is increasing.

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

Our system is fragmented resulting in duplication and confusion.

The cost of delivering health and care services is increasing.

Our five priorities and areas of focus

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

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

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

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

3 Reducing cost through provider collaboration

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

4 Developing sustainable specialised services

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

5 Changing how we work together to deliver the transformation required

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

The impact of our plans

Priorities 1 and 2:

- Reduction in A&E attends and non-elective admissions
- Reduced length of stay
- Reduced re-admissions
- Early identification and intervention
- Delivery of care in alternative settings

(Net savings c.£119m)

Priority 3:

Cross-organisation productivity savings from joint working, consolidation and improved efficiency.

(Net saving c. £232m)

Priority 4:

- Increased collaboration
- Reduced duplication
- Management of flow

(Need to address £190m)

Priority 5:

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

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STP Next Steps

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

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

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NHSE Feedback on SEL STP 30 June Submission

General Comments on STPs

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

Specifically for SEL

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

Key Messages

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

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

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

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

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

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

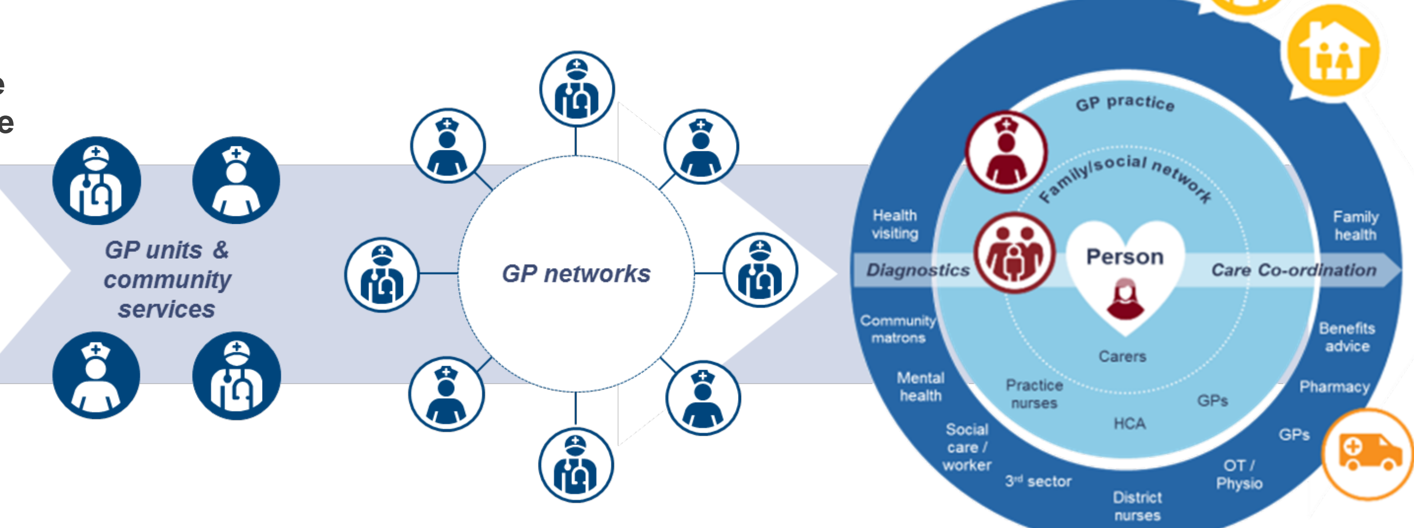
Worked with NHSE and SWL to establish the specialised services workstream

Set out proposals for aligning the STP and the planning round

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

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

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



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

We have programme plans by CLG which are being translated into detailed delivery plans. We have a Clinical Executive Group to advise on the clinical interventions, their delivery, and to enable stronger clinical leadership to drive change.

Clinical Leadership Group	High level summary of the model of care
Community based care	• Delivery of local care networks • Improving access in Primary Care
Urgent and emergency care	• Community rapid response • Specialist advice and referral. • An enhanced single "front door" to the Emergency Department.
Planned care	• Standardisation of planned care pathways. • Elective care centres.
Children and young people's care	• Children's integrated community teams. • Short stay paediatric assessment units.
Maternity	• Early assessment by the most appropriate midwife team. • Access to assessment clinics. • Culture of birthing units.
Cancer	• Primary prevention including early detection. • Provider collaboration in treatment of cancer. • Enhanced end of life care.
	Net savings after 40% reinvestment **£119m**

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

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

An evaluation panel was established to evaluate site options against financial and non-financial criteria developed by clinical and patient groups and agreed by a committee of the six south east London CCGs (known as the "Committee in Common")
Once the evaluation is complete, the evaluation panel will make a recommendation to the Committee in Common (CiC), on what a preferred option might be.
The evaluation panel recognised that the **Queen Mary's site option does not meet the agreed criteria for an inpatient elective orthopaedic centre**, and they will be recommending to the CiC that this site is not taken forward.

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

01
We have agreed to establish a sixth CLG for mental health to oversee the FYFV for MH

02
We are sourcing dedicated programme support

03
We have commissioned a "demand and supply" project

04
We are looking for a mental health "high impact change" drawing on the work of the Kings Fund

05
Our providers are participating in the "transforming mental health" programme with NHSE returning high cost out of area placements

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

Ease of implementation

- Standardise and consolidate business support services — £38m
- Capitalise on the collective estate — £27m
- Optimise the workforce — £61m
- Consolidate clinical support services — £38m
- Capitalise on our collective buying power — £68m

4 Review of specialist services across south London

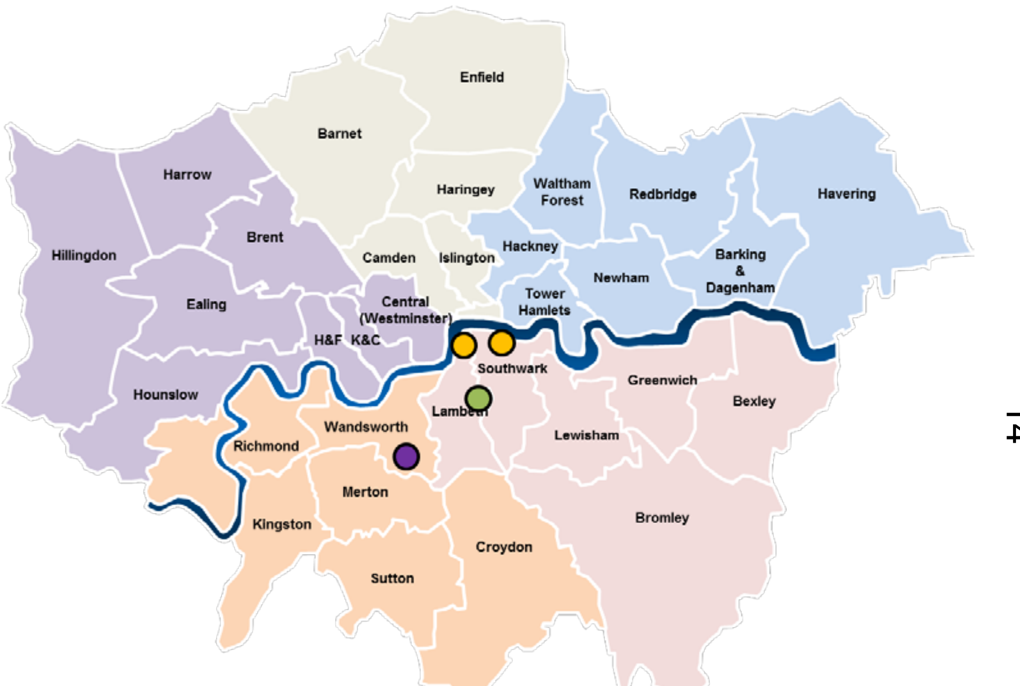
We have established a group with NHSE and SWL to look at the specialised services across south London

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

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

We know there is significant duplication of services.

We also know there is significant growth pressure on services.



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

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5 We are strengthening our collective leadership towards an implementation focus

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

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

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

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

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Improving productivity and closing the local financial gap

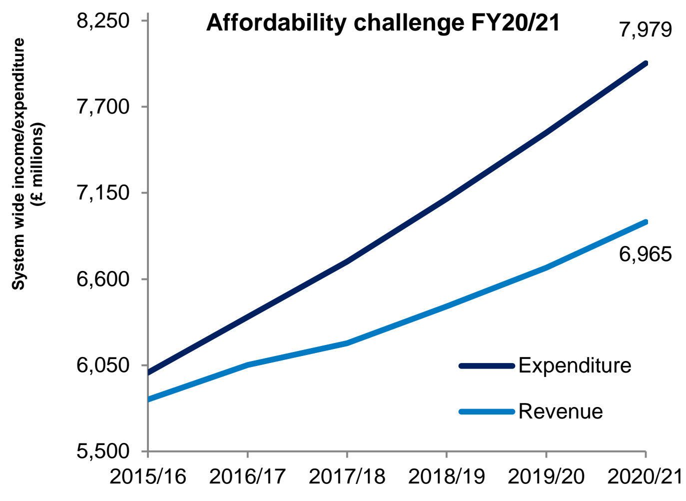
Our financial challenge

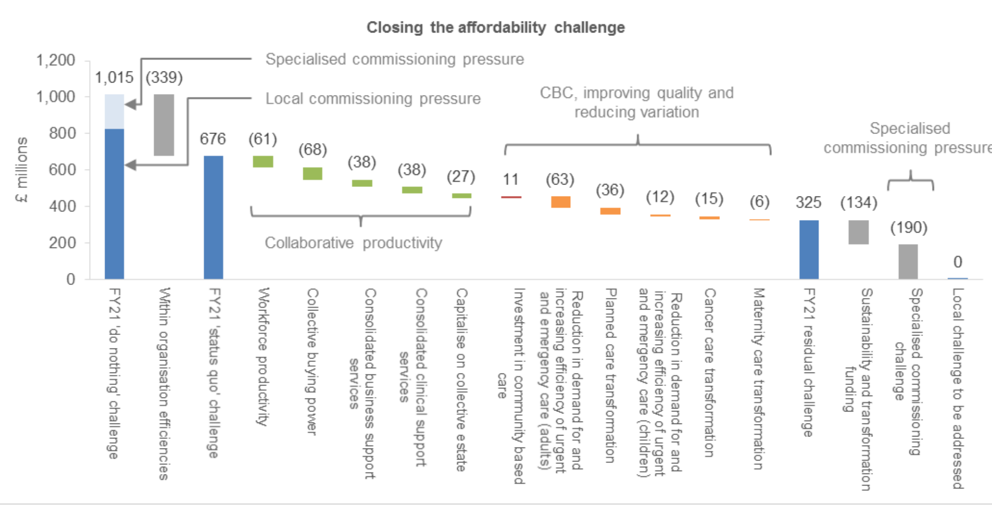
- The ‘do nothing’ affordability challenge faced by the south east London health economy is £1,015m by 2020/21. NHS England (Specialised) have estimated an indicative £190m five year affordability challenge for specialised commissioning.

Closing the affordability challenge

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

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





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Improving the infrastructure for delivery by December 2016

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

Urgent and Emergency Care Facilities and System Specifications

November 2015

Introduction

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

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

This document outlines specifications for these facilities in London.

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

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

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

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

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

London Urgent and Emergency Care System Specification

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

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

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

Domain	Specification	Adapted from source
1. System operating hours and access	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. vi. At every UEC facility, all patients should have an episode of care summary communicated to the patient’s GP practice by 08.00 the next day. For children the episode of care should also be communicated to their health visitor or school nurse, where known and appropriate, no later than 08.00 the second day. All episode of care summaries, including any change in medicines, are communicated with patient’s community pharmacist if they have one. All communication should take place electronically. vii. All UEC facilities should adhere to the Health and Social Care Information Centre (HSCIC) formal standard of data collection (ISB 1594) to ensure consistent information sharing with the Metropolitan Police, full compliance with the Data Protection Act and active support to the Information Commissioners Office when required.	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	i. Integrated capacity management protocols should be in place across the system, including access to real-time capacity information.	i. Safer, Faster, Better Guidance

Management		
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.	i. – ii. Draft National guidance and UC LQS
3. Location	i. Where possible, UCCs should be co-located with ECs, however, standalone centres will also exist.	i. Draft National guidance
4. Operating hours	i. All UCCs to be open for a minimum of 16 hours per day. ii. Each site that a UCC is located on must provide urgent care from 08:00 to midnight (If the UCC is co-located with an EC then the EC may provide urgent care for part of this time period but the UCC should still be open for at least 16 hours). iii. All UCCs should be consistent in staffing and service provision throughout days and weeks. iv. During the hours that they are not open, UCCs should provide immediate access to the UEC	i. – iv. Draft National guidance

	Network for persons contacting the UCC by phone (e.g. through 111, out of hours general practice, the ambulance service, or similar arrangements) or arriving in person.	
5. Access *(in addition to UEC system specification)*	i. All UCCs should be able to receive patient referrals from differentiated ambulances within network agreed protocols and pathways of care.	i. Draft National guidance
6. Staffing	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. ii. All registered healthcare practitioners working in UCCs should have a minimum level of competence in caring for adults and children and young people including: (a) Basic life support; (b) Recognition of serious illness and injury; (c) Pain assessment; (d) Identification of vulnerable patients; (e) ability to recognise that someone may be experiencing a mental health problem and to respond appropriately and (f) awareness of safeguarding. At any time the service is open at least one registered healthcare practitioner is to be trained and competent in advanced life support and paediatric advanced life support. 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. 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.	i. – v. Draft National guidance and UC LQS
7. Assessment & Treatment	i. Co-located UCCs and ECs should have a single front door to access UEC, with one reception team under the same governance.	i. – ii. Safer, Faster, Better Guidance

	ii. Co-located UCCs and ECs should have a single point of initial appropriate clinical assessment. iii. An escalation protocol should be in place to ensure that seriously ill/high risk patients presenting to an UCC are seen immediately by a registered healthcare practitioner, and where treatment in an EC or ECSSs is required this is facilitated by attendance from the ambulance service within agreed timescales. All patient notes go with patient to ensure treatment is rapid. The escalation protocol should be sufficient to cover extreme conditions including adult or paediatric cardiac arrest, and should be thoroughly trained and tested. iv. All patients are to be seen and receive an initial clinical assessment by a registered healthcare practitioner within 15 minutes of the time of arrival at the urgent care service. v. Within 90 minutes of the time of arrival at the urgent care service 95 per cent all patients are to have a clinical decision made that they will be treated in the urgent care service and discharged or arrangements made to transfer them to another service. vi. At least 95 per cent of patients who present at an urgent care service to be seen, treated if appropriate and discharged in under 3 hours of the time of arrival at the urgent care service (where clinically appropriate). vii. Internal access or arrangements in place to safely access all medicines a patient needs in relation to the consultation at the time they need it. If required, these medicines are to be provided in a clinically and cost effective pack to a patient for at least a 24 hour period.	iii. UC LQS and Draft National guidance iv. – vi. UC LQS vii. Safer, Faster, Better Guidance
8. Diagnostics	i. Access to the following diagnostics for adults and children and young people during hours the UCC is open, with real time access to images and results: - 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 Clinical staff to have the competencies to assess the need for, and order, 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).*	i. Draft National guidance and UC LQS

9. Equipment and physical environment	i. Appropriate equipment to be available onsite (with sizes available for adults and children): - a full resuscitation trolley - an automated external defibrillator - oxygen high flow - suction and - emergency drugs - Monitoring equipment to calculate a National Early Warning Score (NEWS) score All urgent care service to be equipped with a range of appropriate medicines necessary for immediate treatment. 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
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 service 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.	i. UC LQS ii. – v. London Mental Health Crisis standards vi. – vii. Paediatric Emergency Services LQS

	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.	
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.	i. Commissioning Standards for Integrated Urgent Care ii. Inter-hospital transfer standards
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.	i. Draft National guidance and UC LQS
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

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 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

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

Agenda Item 14

Our Healthier South East London
Joint Health Overview & Scrutiny Committee
MUNICIPAL YEAR 2016-17
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Dated: October 2016	

Open Agenda

Our Healthier South East London Joint Health Overview & Scrutiny Committee

Tuesday 11 October 2016
7.00 pm
Lewisham Town Hall, Committee Room 1, Civic Suite, Catford, SE6 4RU

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	• Equalities analysis – online only	

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Date: 4 October 2016

Equalities Analysis

NHS South East London

Scoping report

September 2016

Review and approvals

Revision	Date	Originator	Checker	Approver	Description
A	25 July 2016	Hannah Grounds Katy Field Frances Parrott	Frances Parrott	Kerry Scott	Draft scoping report for internal review.
B	28 July 2016	Hannah Grounds Katy Field Frances Parrott	Frances Parrott	Kerry Scott	Scoping report for client issue.
C	16 August 2016	Frances Parrott	Kerry Scott	Kerry Scott	Updated scoping report following client comments.
D	5 September 2016	Frances Parrott	Kerry Scott	Kerry Scott	Second update following equalities steering group feedback

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1. Our Healthier South East London

NHS commissioners and providers are working in partnership with local authorities on a five-year plan for services across six boroughs in south east London: Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark collectively known as 'Our Healthier South East London' (OHSEL).

The approach undertaken by OHSEL has been to look in detail at a number of clinical areas where significant challenges are faced. One of these areas is planned care, of which elective orthopaedic services has been identified as an area for potential reconfiguration.

Elective orthopaedic surgery is currently carried out at eight different sites in south east London. OHSEL has identified the following reasons for improving the care currently available:

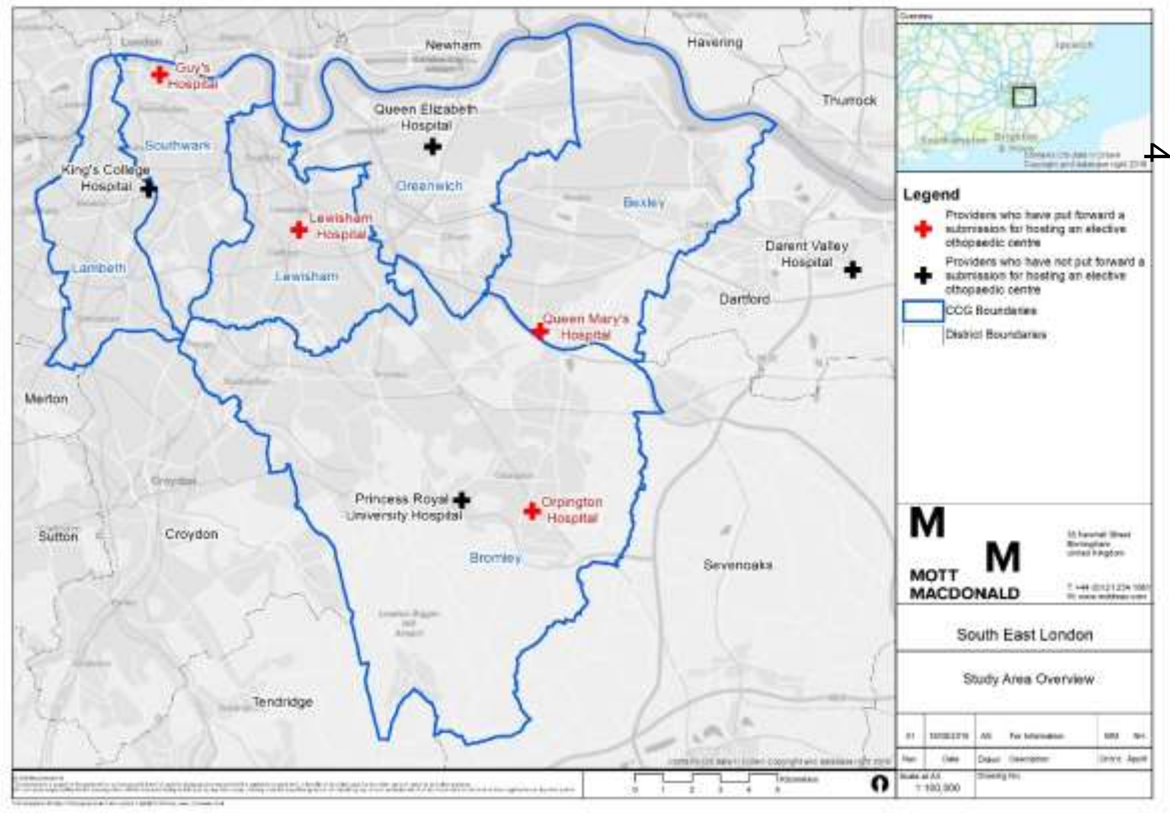
- Quality of care and outcomes for patients accessing orthopaedic care varies across south east London.
- Too many procedures are cancelled and there are unnecessary delays in the patient journey.
- Demand is increasing; the report by Professor Tim Briggs 'Getting it right first time' published in March 2015 shows that by 2030 over 15.3 million people in the UK will be over the age of 65 and consequently, the need for planned care including orthopaedic procedures is likely to increase.
- OHSEL wants to find a more reliable and consistently high standard of care for patients while increasing capacity to care for larger numbers of people.

OHSEL is exploring the benefits and feasibility of a consolidated elective orthopaedic service for inpatient operations in south east London. It is proposed that some elective operations should be provided from two centralised centres in future, while outpatient and emergency services remain at local hospitals as is the structure currently.

Seven sites currently offer inpatient elective orthopaedic care to patients from south east London. Through the submission process, four providers have come forward to describe sites that could host an elective orthopaedic centre within the model.

The sites are; Guy's Hospital, Lewisham Hospital, Queen Mary's Hospital and Orpington

The map below shows the sites that currently provide elective orthopaedic care to south east London residents, it should be noted that at present Queen Mary's Hospital provides elective orthopaedic day case surgery not inpatient surgery for south east London patients. Sites in red are those which providers have put forward submissions for hosting an elective orthopaedic centre.



2. Equalities analysis overview

Equalities analysis
To support the public consultation and to fulfil the need to ensure that OHSEL has considered the potential impacts on those characteristics protected under the Equality Act 2010[1], those classified as deprived and carers. Mott MacDonald was appointed to undertake an equalities analysis of the proposals for elective orthopaedic services.

It is important to note that the purpose of this work is not to determine the decision about which option is selected by OHSEL; rather this analysis is to assist decision-makers by giving them better information on how best they can promote and protect the well-being of the local communities that they serve.

Scope and objectives
The objectives of this equalities analysis are to:

- Identify the positive and any negative impacts for the population of OHSEL as a result of the proposed reconfiguration.
- Identify which (if any) of the protected characteristics groups are more likely to be affected by the proposals due to their propensity to require different types of health services.
- Set out conclusions about the extent to which proposals accord with the three aims of the Public Sector Equality Duty (PSED): (to eliminate unlawful discrimination; advance equality of opportunity; and to foster community good relations).
- Develop conclusions on the comparative advantages and disadvantages of the different options.
- Provide recommendations on ways in which positive impacts can be maximised and ways in which to mitigate or minimise any adverse effects.

The equalities analysis has been designed to be an iterative process that can be revisited and take on board evidence over the course of the option-development and consultation process. Work is structured around three principal stages.

The table overleaf sets out each stage of the equalities analysis.

1. The protected characteristics are; age, disability, pregnancy and maternity, race and ethnicity, sexual orientation, gender reassignment, religion and belief, marriage and civil partnership and gender.

2. Equalities analysis overview

Stage	Description and deliverables
One: Scoping	**Description** • Desk research into demand for elective orthopaedic services by each protected characteristic group and deprivation and carers. • Socio-demographic profiling of all six CCG localities. • Strategic and community stakeholder engagement through one-to-one telephone interviews. • Confirmation of issues, geographical areas and population groups on which to focus during the next stage of work. **Deliverables** • Interim presentation delivered to the OHSEL Equalities Steering Group. • Scoping report.
Two: Consultation	**Description** • Expert equality advice provided to OHSEL during the public consultation. • Continuing engagement with community stakeholders either through engagement fora or focus groups, to be decided. • Staff engagement through one-to-one telephone interviews. • Equalities training workshop delivered to NHS staff on data required to fulfil Public Sector Equality Duty (PSED). **Deliverable** • Interim report.
Three: Post consultation	**Description** • Review of public consultation findings. • Re-engagement with strategic and community stakeholders through a final workshop. **Deliverable** • Final report.

Please note that the phrase community stakeholders refers to community groups and representatives. Strategic stakeholders include CCG and Trust equality leads, clinical and project leads and directors of public health. A list of stakeholders contacted and invited to share their views is included in appendix A1.

3. Overview of the scoping report

The objectives of the scoping report are to:

- Identify existing health inequalities, access barriers and equality issues to be considered.
- Identify which of the 11 groups have a higher need for orthopaedic services and therefore more likely to experience positive or negative impacts.
- Provide recommendations about key groups to target during consultation.
- Provide advice on equalities questions for inclusion in public consultation.

Evidence for the scoping report has been gathered through:

1. Demographic analysis which sets out the characteristics of the south east London population, and particularly the distribution of residents from different equality groups.
2. An evidence review of available literature which identifies population groups who may have a disproportionate need for services.
3. Strategic and community engagement.

Please note that this report is not inferring that social groups not scoped in have no need for elective orthopaedic services, rather it suggests that there does not presently exist a body of clinical evidence indicating a disproportionate need amongst groups not presently scoped in. This scoping opinion will be supplemented as further evidence is gathered throughout stages two and three.

4. South East London population profile

The total population and the density of population provide a baseline from which to break down the key socio-demographic trends in the study area.

Total population

The table below shows the total population of each of the six CCGs, as well as wider area comparators[2].

Area	Total population
Bexley	239, 900
Bromley	321, 300
Greenwich	268, 700
Lambeth	318,200
Lewisham	291,900
Southwark	302, 500
South East London	1,742,500
Greater London	8,538,700

Source: ONS, mid-year population estimates, 2014

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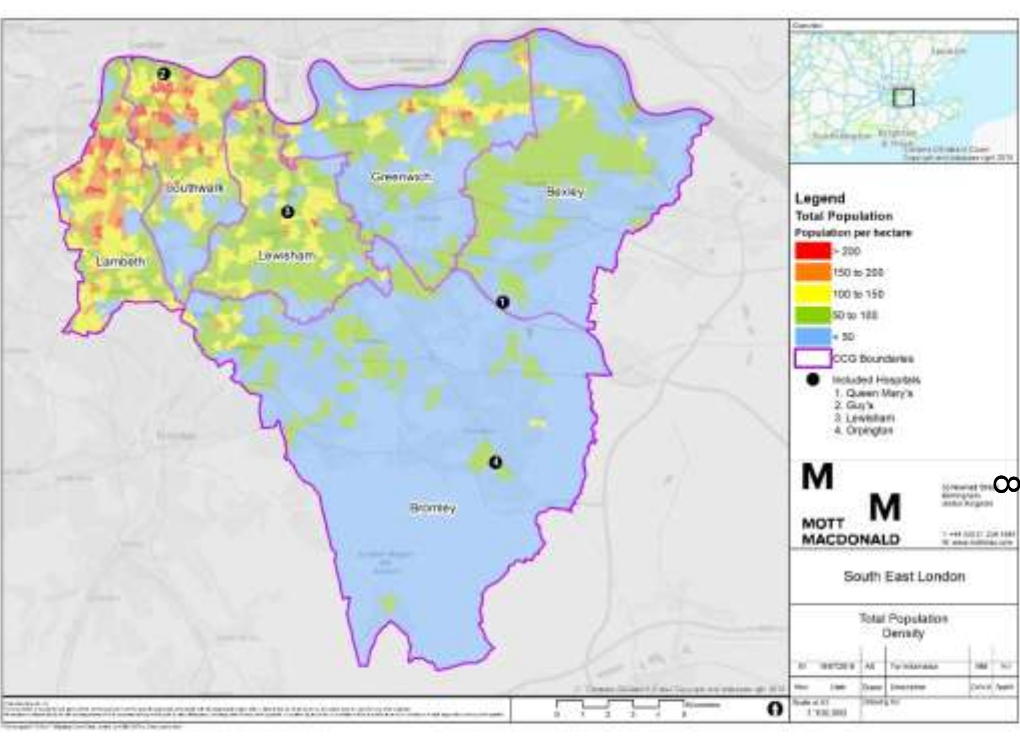
The table indicates that the largest numbers of people live in the boroughs of Bromley (with 321,300 people) and Lambeth (with 318,200) while the least populated is Bexley (with 239,900). The total population of the study area is over 1.7 million.

The map indicates that there are higher densities of population in the inner London Boroughs of Lambeth and Southwark. Bromley has much lower density of population, despite being the most populated CCG.

Population density



2. Population figures have been rounded to the nearest one hundred.

5. Breakdown of protected characteristic groups

This section of the report considers each of the nine ‘protected characteristic’ groups in turn, as well considering other disadvantaged groups specifically deprived communities and carers. This includes:

- Age
- Disability
- Pregnancy and maternity
- Race and ethnicity
- Gender
- Sexual orientation
- Gender reassignment
- Religion and belief
- Marriage and civil partnership
- Deprived communities
- Carers.

For each group, it is noted whether there is evidence of disproportionate or differential need for elective orthopaedic services and a summary of this evidence is provided. By differential need, that is to say there is evidence that different sub sections of a protected characteristic group have different needs. For example, females and males have different needs to access a service, but there is no evidence to suggest that either females or males have a disproportionate need.

At the beginning of analysis for each scoped in characteristic, tables on the left hand side of the page are provided to show the total number of that characteristic in each CCG area and the percentage of the total population. On the right hand side of the page, socio-demographic maps are used to demonstrate the density (or distribution) of these population groups across south east London.

Larger versions of these maps and are available in appendix A2.

In the final sections, a summary of the in-scope groups is provided alongside a commentary as to the profile of these population groups across south east London. Other equality impacts are explored and an overview of the next steps provided.

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5.1 Age (Older people)

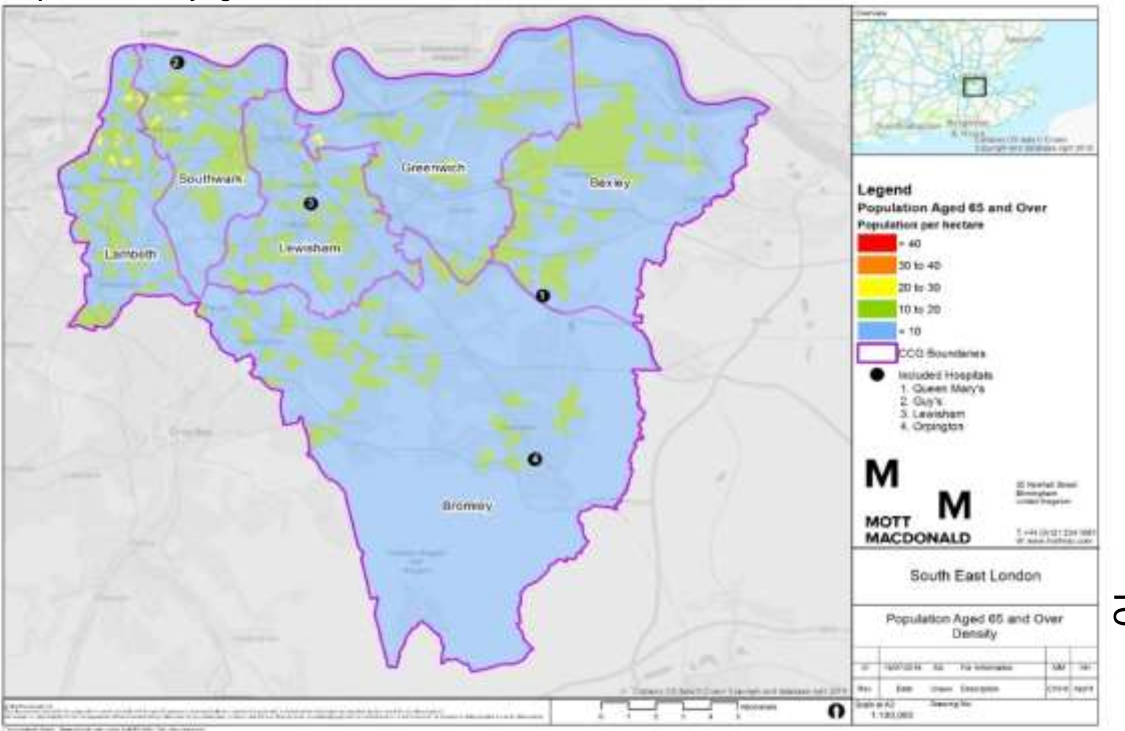
Population aged 65 or over and 75 or over

Area	Aged 65 and over	%	Aged 75 or over	
Bexley	39,800	17	19,600	8
Bromley	56,300	18	27,300	8
Greenwich	28,200	10	12,700	5
Lambeth	24,800	8	11,400	4
Lewisham	27,400	9	12,900	4
Southwark	24,000	8	10,800	4
South East London	200,500	12	94,700	5
Greater London	982, 900	12	459,100	5

Source: ONS, Mid-year Population estimates, 2014

The analysis shows that Bromley has the highest volume of those aged 65 and over and those aged 75 and over. Bromley has significantly more older people than any of the other CCGs. Bexley also has high volumes and proportions of older people.

Population density aged 65 or over



Source: ONS, Mid-year Population estimates, 2014

Evidence to demonstrate disproportionate need for elective orthopaedic care

Osteoporosis, a condition treated with elective orthopaedic care, becomes more likely the older that people get. Around 50% of people over the age of 75 are affected by the condition, and after the age of 50 one in two women and one in five men will break a bone as a result of poor bone health arising from osteoporosis *(Age UK (No date): Osteoporosis: Could you be at risk?).*

Evidence surrounding specialised orthopaedics services in adults also points towards older people having a disproportionate need for revision joint procedures in later life, thereby increasing the demand for elective orthopaedic care with older people . This is because the average age for arthroplasty procedures is falling, and so people are likely to need revision procedures as they are having initial surgery younger. The average age for knee arthroplasty has fallen from 70.6 in 2004 to 67.5 in 2010, and from 68 in 2004 to 6.2 in 2010 for hip arthroplasty patients. It is worth noting that these figures come in a time when the population is ageing. *NHS England (2013): NHS Standard Contract for Specialised Orthopaedics (Adults).*

5.1 Age (Older people) - Continued

Examples of evidence to demonstrate disproportionate need for elective orthopaedic care[3]

Older people are more predisposed to osteomyelitis than the general population as they disproportionally suffer from associated disorders (such as diabetes). *(Biomed Central, 2010: Osteomyelitis in elderly patients).*

Bursitis also disproportionately effects older people due to the joints, muscles and tendons near the bursae being overused *(NHS Choices 2014, Causes of bursitis) .*

The NHS website reports that most people who have a total knee replacement are over 65 years old. The most common reason for knee replace surgery is osteoarthritis. *NHS Choices 2015*

Changing population trends of older people

In line with the national trends, all CCGs will experience an increase in the number of people aged 65 or over. Southwark will experience a doubling of its aged 65 or over population by 2039. Lambeth, Lewisham and Greenwich will also experience increases for the aged 65 or over greater than the OHSEL or Greater London average. Bexley and Bromley will experience an increase of less than the OHSEL or greater London average. However, it is important to note that Bexley and Bromley will still have higher numbers of older people overall .The CCGs with the greatest numbers of people aged 65 or over in 2014 remain the same CCGs in 2039. For further information, please see appendix A3.

3. Please note, that the although we are seeing a significant increase in joint replacement in the young population, it continues to be the older population that is most reliant on orthopaedic services and driving the increasing workload. *Briggs , T (2015)* ‘Getting it right first time’

5.2 Disability

Population with long term illness or disability.

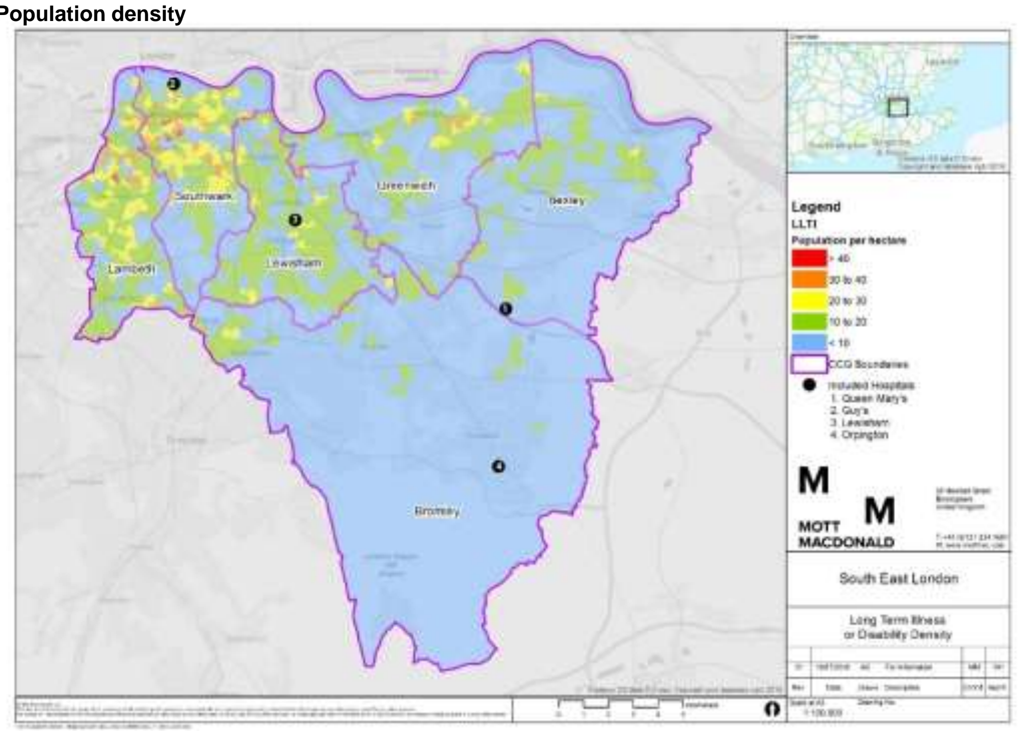
Area	Long term illness or disability	%
Bexley	37,100	16
Bromley	46,300	15
Greenwich	38,400	15
Lambeth	38,700	13
Lewisham	39,700	14
Southwark	39,000	14
South East London	239,200	14
Greater London	1,157,200	14

Source: ONS, Census 2011

Bromley has the most people living with a long term illness or disability. There is relative consistency across the other CCG areas in terms of overall numbers of people with a long term illness or disability.

Lambeth and Southwark have higher densities of those with a long term illness of disability.

Population density



Source: ONS, Census 2011

Additional data on the number of people living in each borough with a learning disability has been gathered using disability living allowance data. This is detailed in appendix C1.

Examples of evidence to demonstrate disproportionate need for elective orthopaedic care

A UK report supported by the Department of Health states that people with learning disabilities may have increased prevalence of osteoporosis and lower bone density than the general population. Contributory factors include their possible lack of weight-bearing exercise, delayed puberty, entering menopause at an earlier-than-average age for women, poor nutrition, being underweight and use of anti-epilepsy medication. The report notes that people with learning disabilities have a greater prevalence of some of the risk factors associated with osteoporosis than other people *(Emerson, E. et al. (2012): Health Inequalities & People with Learning Disabilities in the UK: 2012).*

Examples of evidence to demonstrate disproportionate need for elective orthopaedic care

Studies have suggested that people who take epilepsy medicine for long periods of time are at higher risk of thinning and breaking bones than those who do not take epilepsy medicine. In 2009, the Medicines, Healthcare Products Regulatory Authority (MHRA) advised that people still taking the following older epilepsy medicines on a long-term basis were at risk of osteoporosis or broken bones; Carbamazepine, Phenytoin, Primidone and Sodium valproate. However, there is little research exploring whether some of the newer types of epilepsy medicines can cause bone problems (*Epilepsy Action (2013): Bone health).*

Epilepsy is also more common in people with a learning disability than in the general population. It is estimated that 1 in 3 people who have a mild to moderate learning disability also have epilepsy, and around 1 in 5 people with epilepsy also have a learning disability. The more severe the learning disability it, the more likely that the person will have epilepsy as well *(Epilepsy Society (2016): Learning disability and epilepsy).*

Orthopaedic surgery may also be necessary for people with cerebral palsy to correct problems with bones and joints. *NHS Choices website 2015*

Finally, there is also evidence suggesting that people with HIV may have a disproportionate need for elective orthopaedic surgery. Particularly:

- Low bone mineral density is prevalent in people with HIV *(McComsey, GA et al (2010) 'Bone Disease in HIV* infection)
- Inflammatory arthropathy and avascular necrosis is common in HIV patients *(Reis MD, Barcohana B, Davidson A et al . Association between human immunodeficiency virus and osteonecrosis of femoral head. J . Arthroplasty 2002; 17: 135-9)*
- Factors that may increase the risk of osteoporosis in people living with HIV include HIV infection itself and some HIV medicines (for example tenofavir disoproxil fumarate) *(Brown T, Qaqish RD Antiretroviral therapy and the prevalence of osteopenia and osteoporosis: a meta-analytic review. AIDS 20 (17): 2165-2174, 2006).*

Changing population trends of those with a disability

Although national datasets are not available for the likely population change of those with disability in the longer term. Local data reports that:

- There are about 5,740 people with learning disabilities in **Southwark,** of whom about 1,230 (21%) have moderate or severe learning disabilities. The number of people in the borough with learning disabilities is projected to increase by 22% to 7,000 by 2030. Looking specifically at adults with moderate or severe learning disabilities, the greatest relative increase is also projected to be seen in the 55 to 64 year age group (a 59% rise over 20 years). *Southwark JSNA (2013): Adults with a learning disability.*

Please note that local data forecasting future trends for other CCGs is not currently available. As engagement continues, stakeholders are being asked if they have access to data pertaining to population trends of people with the disabilities outlined above.

5.3 Gender: Female

Population demographics have not been provided for gender due to the approximate 50/50 split of males/females across all boroughs. Females have been scoped in as having a disproportionate need. The evidence for this is provided below.

Examples of evidence to demonstrate disproportionate need for elective orthopaedic care

Osteoporosis is more common in women than men. Women tend to live longer, with age leading to an increased likelihood to develop osteoporosis (see section 5.1). In addition, at around the age of 50, women experience the menopause, at which point their ovaries almost stop producing the sex hormone oestrogen, which helps to keep bones strong (*National Osteoporosis Society (No date): Risk factors for osteoporosis and fractures).* A woman's risk of having osteoporosis is also heightened if she has an early menopause or a hysterectomy with removal of the ovaries prior to the age of 45 (*Age UK (No date): Osteoporosis: Could you be at risk?).*

Joint pain is common in the condition lupus, especially in the small joints found in hands and feet. The pain normally moves from joint to joint and is often described as 'flitting'. Joint pain and swelling are often the main symptoms for some people, although it is unusual for Lupus to cause joints to become permanently damaged or deformed. About 1 in 20 people with lupus develop more severe joint problems, and less than 1 in 20 have joint hypermobility or a form of arthritis called Jaccoud's arthropathy, which can change the shape of the joints (*Arthritis Research UK (No date): What are the symptoms of Lupus?).* Lupus is more common in women than men, with around seven times as many women as men having the condition. Whilst drugs are often prescribed to Lupus suffers, some also undergo elective orthopaedic surgery.

Up to 50% of women develop Carpal tunnel syndrome (CTS) during pregnancy. CTS in pregnant women often gets better within three months of the baby being born, although it may need surgical treatment if symptoms fail to subside. In some women, symptoms can continue for more than a year. CTS is also common in women around the time of the menopause. (*NHS Choices, 2014, Causes of carpal tunnel syndrome*). Evidence also suggests that more women than men develop CTS, possibly because women naturally have smaller carpal tunnels *(Bupa (No date): Carpal tunnel syndrome).* Occasionally, some medications can also cause the condition. Exemestane and Anastrazole are both medications used for the treatment of breast cancer, thus taken by a disproportionately large number of women. Both drugs are said to potentially cause carpal tunnel syndrome *(Arthritis Research UK (2012): Carpal tunnel syndrome).*

Finally, women are likely to live longer than men and therefore more likely to use elective orthopaedic care (see section 5.1 on age). The average life expectancy at birth for each of the CCGs according to gender and a south east London average is provided below.

Area	Females	Males
Bexley	84.4	80.3
Bromley	84.5	81.0
Greenwich	82.2	78.5
Lambeth	83.0	78.2
Lewisham	82.6	78.2
Southwark	83.1	78.0
South East London	83.3	79.0

5.4 Gender reassignment

Population demographics are not available for the numbers of people undergoing, or who have undergone, gender reassignment. However stakeholders have noted that the number of gender reassignment procedures is increasing. This is support by figures obtained under a Freedom of Information request, which shows that there has been increases in the number of referrals to all of the UK's gender identity clinics (GIC). The London GIC in Charing Cross is the largest adult clinic. The number of referrals has almost quadrupled in 10 years, from 498 in 2006-07 to 1,892 in 2015-16. In 2015-16, NHS England has provided an additional £3m towards funding adult GIC clinics. *'Gender identity clinic services under strain as referral rates soar' Guardian newspaper 10 July 2016*

Examples of evidence to demonstrate disproportionate need for elective orthopaedic care

Trans men (female-to-male) and trans women (male-to-female) may be at risk of developing osteoporosis because of the need to take hormones that change the balance of oestrogen and testosterone in the body. After gender reassignment surgery, the level of hormones may decrease and this may also affect bone density. The degree to which either of these factors affect the risk of breaking a bone, however, remains uncertain. Replacement sex hormones (testosterone for trans men and oestrogen for trans women) are necessary to maintain bone strength and are generally continued long-term. The risk of developing osteoporosis may increase if sex hormone replacement is discontinued, or if levels of replacement are too low (*National Osteoporosis Society (2014): Transsexual people and osteoporosis*).

Research has also found that the male-to-female trans population who have their testicles removed can affect bone density as the body's natural levels on testosterone are too low. However, evidence suggests that taking oestrogen instead compensated for the decrease in testosterone. Some trans men who aren't able to take testosterone use Depo-Provera to stop their periods from occurring, and, there is some concern that using Depo-Provera can negatively affect bone density (*Vancouver Coastal Health, Transcend Transgender Support & Education Society and Canadian Rainbow Health Coalition (2006): Trans people and osteoporosis).*

It must be noted that the research available on this issue is limited, however, due to the evidence presented above, gender reassignment has been scoped in as a protected characteristic that may have a disproportionate need. This will be explored further with clinicians and Lesbian, Gay, Bisexual and Trans (LGBT) community groups.

5.5 Race and ethnicity: White

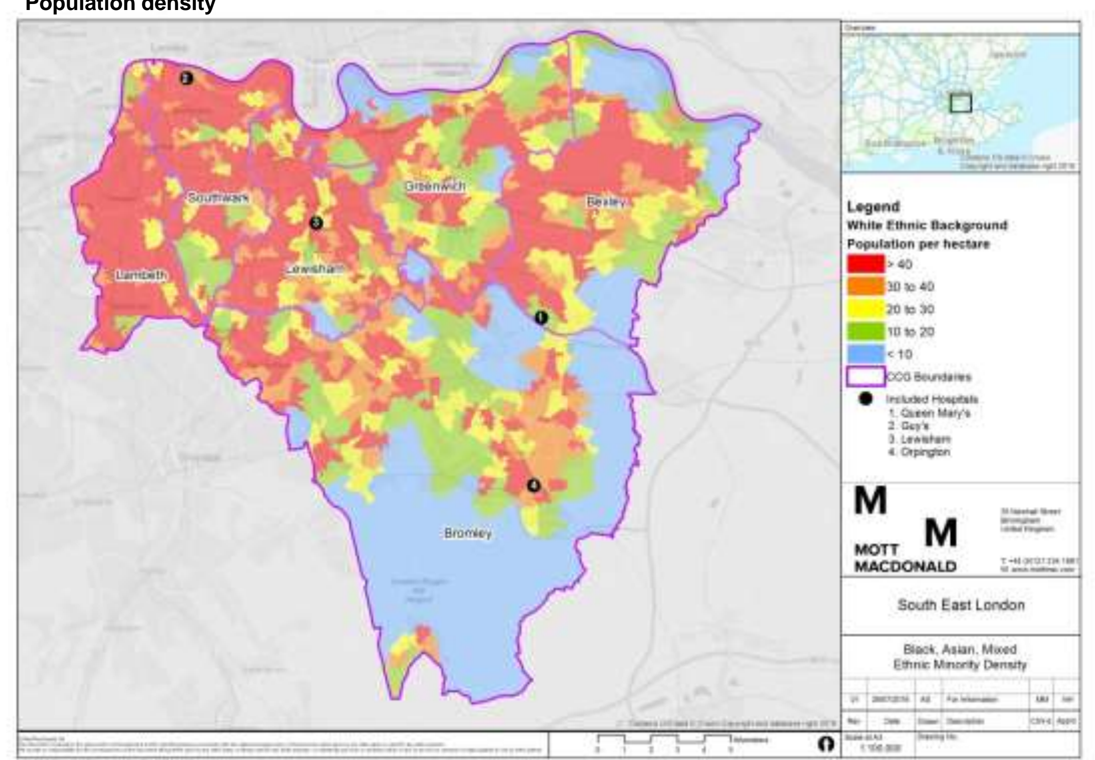
Population with a white ethnic background

Area	White ethnic background	%
Bexley	189,962	82
Bromley	260,870	84
Greenwich	159,002	62
Lambeth	173,025	57
Lewisham	147,686	54
Southwark	156,349	54
South East London	1,086,894	62
Greater London	4,887,435	60

Source: ONS, Mid-year Population estimates, 2014

Bromley and Bexley have the highest volumes and proportions of people from a white ethnic background. Lambeth, Southwark and Lewisham all have high densities, though this is due to their smaller geographies.

Population density



Examples of evidence to demonstrate differential need for elective orthopaedic care

It is important to note that this report is suggesting a differential need amongst ethnic groups, rather than a disproportionate need. This is because there is evidence to suggest that those from different ethnic backgrounds have need for different types of elective orthopaedic care services. The evidence on this page highlights issues pertaining to those from a white ethnic background.

The National Osteoporosis Society states that those from Caucasian background are at higher risk of osteoporosis than Afro-Caribbean people. This is because people from an Afro-Caribbean background tend to have bigger bones. *National Osteoporosis Society (No date): Risk factors for osteoporosis and fractures. See:* https://www.nos.org.uk/healthy-bones-and-risks/are-you-at-risk. In addition, a US study founded that Afro-Caribbean American women's femoral neck bone mineral density (BMD) was 10% to 25% higher when compared to US white women, thereby lessening their risk of developing osteoporosis or hip conditions in their life course *(Dempster, D. et al (2013): Osteoporosis Fourth Edition)*. Data from a UK- cohort of the European Male Aging Study (EMAS) also compared White-British men to a group of Afro-Caribbean British and South-Asian British men. The Afro-Caribbean British group had higher BMD at all sites when compared to South-Asian British and White-British, both before and after adjustment for body size *(Zengin. A. et al (2015): Ethnic differences in bone health).*

5.5 Race and ethnicity: White - Continued

Changing population trends of those from a white ethnic background

Although national datasets are not available for the likely population change. Local data reports that:

- In **Lambeth** the older white population is projected to grow by about 12%. *Lambeth Council State of the Borough 2014*
- By 2020, the white population of **Lewisham** is set to decrease by 2.1%. *Lewisham's Public Health Information Portal*

Please note that white background data includes the following sub-groups 'White: British, White: Irish, White: Gypsy or Irish Traveller and White: Other White' . '

5.5 Race and ethnicity: Black ethnic background

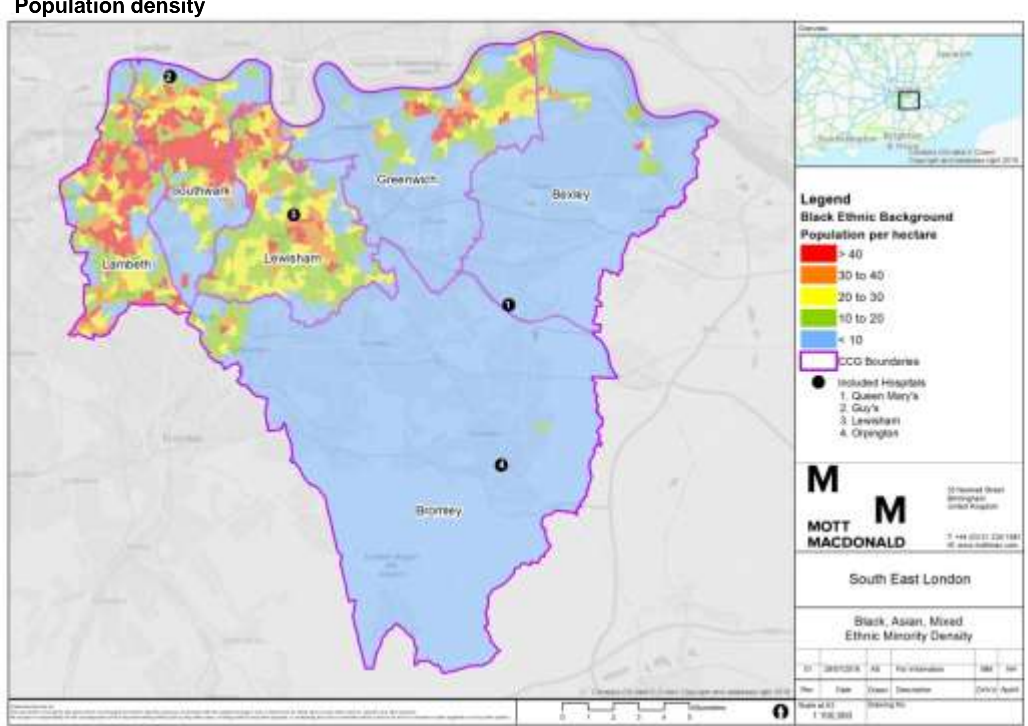
Population with a black ethnic background (BAME)

Area	Black ethnic background	%
Bexley	19,624	23
Bromley	18,686	23
Greenwich	48,655	48
Lambeth	78,542	61
Lewisham	74,942	59
Southwark	77,511	60
South East London	317,960	20
Greater London	1,088,640	13

Source: ONS, Mid-year Population estimates, 2014

The table above shows large proportions and numbers of people from a black ethnic background in the inner London Boroughs of Lambeth, Lewisham and Southwark. The map shows very high densities of people from a black ethnic background in the inner London boroughs. In contrast, Bromley and Bexley have relatively low proportions, populations and density.

Population density



Source: ONS, Mid-year Population estimates, 2014

Examples of evidence to demonstrate differential need for elective orthopaedic care

It is important to note that the report is suggesting a differential need amongst ethnic groups, rather than a disproportionate need. This is because there is evidence to suggest that those from different ethnic backgrounds have need for different types of elective orthopaedic care services. The evidence highlights evidence pertaining to those from BAME backgrounds.

Scientists at the London School of Hygiene and Tropical Medicine discovered that people of non-white ethnicity tend to have more severe disease and have suffered with arthritis for longer by the time they undergo surgery. *(Arthritis Research UK (2012): Socio-demographic factors influence timing of joint replacement surgery).* In addition, reports in the US on differences in knee osteoarthritis between African-Americans and Caucasians report a higher prevalence knee osteoarthritis in African-Americans, as well as more symptomatic knee osteoarthritis in African-Americans than Caucasians. Gait patterns can also differ between ethnic groups in osteoarthritis prevalence. A study has reported that that African-Americans were possibly more prone to lateral compartment knee osteoarthritis than Caucasians *(Chaganti, R. et al. (2011): Risk factors for incident osteoarthritis of the hip and knee).*

Lupus is also more common in some ethnic groups as well, particularly those of African origin (*Arthritis Research UK (No date): Lupus*).

Changing population trends of those from a BAME background

Although national datasets are not available for the likely population change. Local data reports that:

- **Southwark** is predicted to have a 41% increase in 'Black Other' population over the next 10 years. *Southwark Council (2015): Southwark Demographic Factsheet May 2015*
- The Black Caribbean population in **Southwark** is projected to decrease by 1% in the next 10 years. *Southwark Council (2015): Southwark Demographic Factsheet May 2015*
- In **Lambeth** the black Caribbean 60+ population is projected to grow by almost 40%. Similarly, the older black African population, which is currently small, is projected to nearly double. *Lambeth Council State of the Borough 2014*
- The GLA 2013 Round Ethnic Group Projections estimate that, in 2015, the ethnic minority population of **Bromley** is 17.9%, and this is projected to rise to 20% by 2025. The greatest proportional rise is in the Black African group. *Bromley joint strategic needs assessment 2014 - The Population of Bromley: Demography*
- Between 2015 and 2025 it is projected that the largest increases in **Greenwich** will be in: Black African: +10,400 (26.3% increase), Other Asian: +6,800 (37.7% increase) and Chinese: +2,200 (+35.5% increase). By 2041 it is estimated that nearly half of the boroughs residents will be from a BAME background (45%). R*oyal Borough of Greenwich (No date): Ethnic Groups Projections for Royal Greenwich (2001-2041)*
- By 2020, the Black African population of **Lewisham** is set to increase by 16.8% *Lewisham's Public Health Information Portal*

5.6 Deprivation

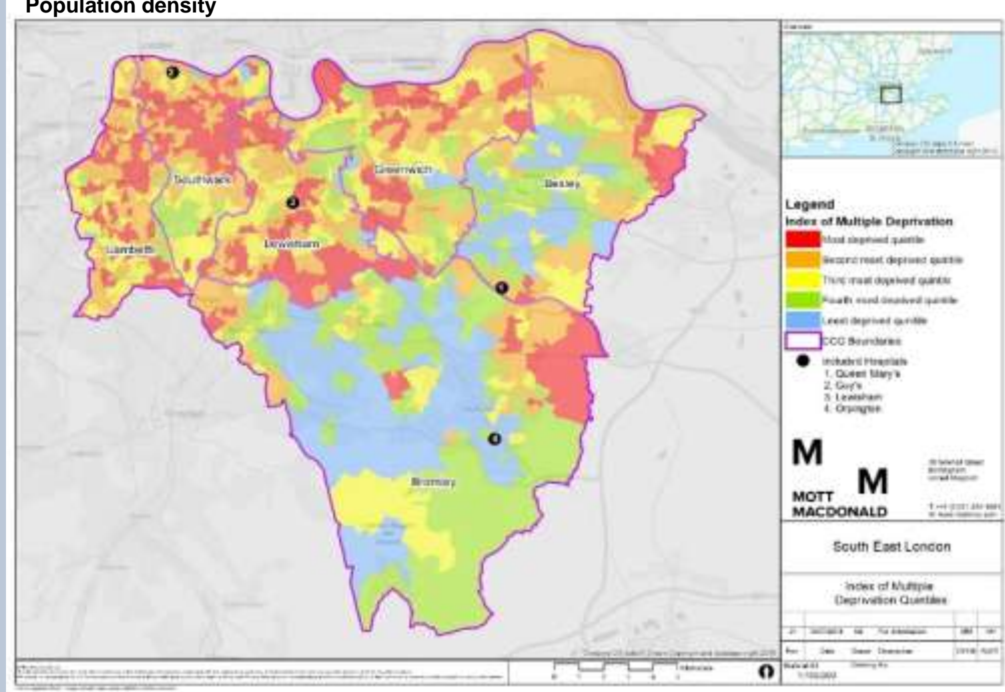
Population classified as deprived[4]

Area	Classified as deprived	%
Bexley	65,900	27%
Bromley	82,300	26%
Greenwich	163,300	61%
Lambeth	232,900	73%
Lewisham	209,00	72%
Southwark	225,700	75%
South East London	979,100	56%
Greater London	4,598,500	54%

Source: IMD, 2015 using Mid-Year Population Estimates, 2014

The data shows that the inner London boroughs are proportionally far more deprived, have higher densities of deprivation and have higher overall numbers of people who are deprived. However, there are also pockets of deprivation in the outer London boroughs too, notably in the north east of Bromley and the north east of Bexley.

Population density



Source: IMD, 2015 using Mid-Year Population Estimates, 2014

Examples of evidence to demonstrate disproportionate need for elective orthopaedic care

Deprivation is associated with greater need for total hip and knee replacement surgery. Moreover, more deprived patients remain in hospital longer, without morbidity, because of a lack of social support available to them in the community. *(Major elective joint replacement surgery: socioeconomic variations in surgical risk, postoperative morbidity and length of stay, Journal of Evaluation in Clinical Practice, 2009)*

Scientists at the London School of Hygiene and Tropical Medicine also discovered that people from lower socioeconomic backgrounds, tend to have more severe disease and have suffered with arthritis for longer by the time they undergo surgery. The researchers looked at data on 117,736 patients, all of whom underwent hip or knee replacement surgery in England in 2009-10 *(Arthritis Research UK (2012): Socio-demographic factors influence timing of joint replacement surgery).*

4. Deprivation is calculated using the indices of multiple deprivation (IMD). Indices of deprivation are based across seven distinct domains (employment deprivation, health deprivation and disability, education, skills and training deprivation, crime, barriers to housing and services and living environment deprivation.) This overall measure of multiple deprivation is calculated for every lower layer super output area (LSOA) neighbourhood in England. Every neighbourhood is then ranked according to its level of deprivation relative to that of other areas. Deprivation is identified when the LSOA is either in the most deprived or second most deprived quintile.

Examples of evidence to demonstrate disproportionate need for elective orthopaedic care

Evidence suggests that malnutrition increases the risk of developing osteomyelitis, as a weakened immune system makes it more likely for infections to spread to the bones *(NHS Choices, 2014, Osteomyelitis – Causes).* Moreover, osteomyelitis is more likely to occur if for some reason an individual's bones are susceptible to infection. Pre existing health conditions, such as diabetes, can cause this. In this instance bones may not receive a steady blood supply, meaning infection-fighting white blood cells cannot reach the site of injury within the bone *(NHS Choices (2014): Osteomyelitis – Causes).* Diabetes prevalence increases with greater levels of deprivation. *Public Health England (2014) Adult obesity and type 2 diabetes.*

In addition, obesity prevalence increases with greater levels of deprivation. *Public Health England (2014) Adult obesity and type 2 diabetes.* Obesity is a strong risk factor for knee osteoarthritis, with obese people 14 times more likely to develop the condition than those of a healthy weight. '*Osteoarthritis and obesity' Arthritis Research Campaign 2013.* Although the main treatments for osteoarthritis include lifestyle measures, in some cases, surgery to repair, strengthen or replace damaged joints is preferred.

Local evidence supports the population demographics shown above. Lambeth is the 14th most deprived Local Authority in England; Greenwich is the 19th most deprived; Southwark is number 41, and Lewisham is the 31st most deprived Local Authority in England. Although Bexley and Bromley (ranking 174 and 203 respectively) score well compared to other south east London Boroughs, they still have significant areas of poor health, exclusion and deprivation. *(Southwark Council (2015): Southwark Demographic Factsheet, Lewisham JSNA: Index of Multiple Deprivation. Joint Strategic Needs Assessment 'Life, Health and Wellbeing in the London Borough of Bexley', Bromley Joint Strategic Needs Assessment 2012, 'Socio-demographic profile of Greenwich' Royal Borough of Greenwich, Documents Lambeth – State of the Borough 2014)*

5.7 Carers

Number of population providing 1-20 hours of care per week and percentage of overall population.[5]

Area	Carers providing 1-20 hours care per week	%
Bexley	14,700	6
Bromley	21,200	7
Greenwich	13,000	5
Lambeth	13,000	4
Lewisham	13,900	5
Southwark	12,400	4
South East London	14,700	5
Greater London	433,400	5

Source: Census, 2011

The percentages of carers in each CCG area are broadly similar to each other and to the greater London average, however Bromley has a significantly higher volume of carers than any other area.

Due to the similar distribution of carers across the six study areas, a density map is not available for carers as it shows no critical mass in any of the six study areas.

Please note that whilst the most up-to-date data on carers is from the 2011 census, figures may have changed since then. In addition, carer figures tend to be under-reported as data requires carers to self-identify. A proportion of those whom the NHS would deem to be carers do not identify themselves in this way. This will be further explored with stakeholders in the next stage of the analysis.

Examples of evidence to demonstrate differential need for elective orthopaedic care

It is important to note here that we are not stating carers have a disproportionate need for elective orthopaedic care, rather they have a differential need due to their caring responsibilities, which is different to non-carers. As older people are more likely to require carers, and they are the greatest users of elective orthopaedic care, carers are likely to be impacted by any service changes.

A report by Carers UK indicated that failing to consider post-hospital support and carers' needs had counterproductive consequences, such as increased readmission *(Carers' UK, 2016: Response to the Public Administration and Constitutional Affair Committee Inquiry into Unsafe Hospital Discharge)*

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5. Information is also available on carers providing over 20 hours of care per week. Please refer to appendix A2. There is a reduction in the number of carers providing over 20 hours a week, though trends remain similar in terms of density and proportion of carers within the six boroughs.

6. Summary of ‘scoped in’ groups

Outlined below is a summary of the groups who have been scoped in as having a disproportionate or differential need for elective orthopaedic care.

Characteristic	Disproportionate need	Differential need
Age: Young people		
Age: Older people	✓	
Disability	✓	
Gender: Female	✓	
Gender: Male		
Gender reassignment	✓	
Marriage and civil partnership		
Pregnancy and maternity		
Race and ethnicity: White		✓
Race and ethnicity: BAME		✓
Religion and belief		
Sexual orientation		
Deprivation	✓	
Carers		✓

It is important to note that the report is not suggesting that other groups will not need these services, rather it is to suggest that there does not presently exist a body of evidence indicating a disproportionate or differential need. This will continue to be updated in subsequent phases of work.

6. Summary of the geographical distribution of 'scoped in' groups

At the CCG level, volume and proportion are used as helpful measures to understand the population of each scoped in group and to understand the relative presence of a particular group.

At a pan south east London level, it is useful to look at density as a measure by which to understand where the greatest concentration of scoped in groups are located. This is important because this helps to indicate where impacts, both positive and negative, are more likely to be realised across the study area without the analysis confined to administrative boundaries.

In the case of this equality analysis and its ability to inform the decision making process, it is crucial to look at future service provision across south east London, rather than at a CCG level.

It is important to note that this summary does not take into account which hospitals are being short listed as they is yet to be decided or travel impacts.

Data on how populations are changing has been excluded from this analysis. This is because for age, the boroughs with the largest volumes of people aged over 65 will remain the same in 2039. Please see appendix A3 for further information.

Scoped in groups	Volume	Proportion	Highlight comments at CCG level	Density	Highlight comments at south east London level
Age (Older people)	Bromley has the highest numbers of those aged 65 or over and aged 75 or over. Bexley also has high volumes.	The greatest proportions of older people are in Bromley (18%) and Bexley (17%), both of which are higher than the greater London average (12%).	Bromley and Bexley are areas with high volumes and proportions of older people.	Density of older people is highest in areas of Lambeth and Southwark.	The inner London boroughs in the north west of the study area have the highest density of older people.
Disability	Bromley has the most people living with a long term illness or disability.	As a proportion of the population, greater proportions of disabled people are in Bexley (16%), Bromley (15%) and Greenwich (15%), all of which are higher than the greater London average (14%)	Bromley, has high volume and proportion of those living with a long term illness or disability.	Lambeth and Southwark have higher densities of those with a long term illness of disability, though pockets of high density also exists in Greenwich.	The inner London boroughs in the north west of the study area have the highest density of those with a long term illness of disability.
Gender: Female					

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6. Summary of the geographical distribution of 'scoped in' groups continued

Scoped in groups	Volume	Proportion	Highlight comments at a CCG level	Density	Highlight comments at south east London level
Race & ethnicity: White	Bromley has the greatest volume of people from a white ethnic background. It is significantly greater than any other area.	Bexley (82%) and Bromley (84%) have the highest proportion of people from a white ethnic background.	Bromley has the highest volume and proportion of people from a white ethnic background. Bexley is also an area with high volume and proportion of people from a white ethnic background.	Lambeth has the highest density of those from a white ethnic background, Bromley the lowest.	Pockets of high density of people from a white ethnic background exist across the study area.
Race and ethnicity: BAME	The greatest volume of BAME communities is in Lambeth, followed by Southwark and then Lewisham.	Lambeth (61%) and Southwark (60%) have the highest proportion of people from a BAME background.	Lambeth, has the highest volume and proportion on those from a BAME background. Southwark and Lewisham are also areas with high volume and proportion	The greatest densities people with a BAME background is in Lambeth.	The inner London boroughs in the north west of the study area have the highest density of people from a BAME ethnic background. Pockets of high density also exists in the north of the study area.
Gender reassignment					
Deprived communities	The volume of people classified as deprived is far greater in Lambeth, Lewisham and Southwark.	Southwark (75%), Lewisham (72%) and Lambeth (73%) also have the highest proportions of deprivation, all of which are significantly higher than the greater London average (54%).	Lambeth, Southwark and Lewisham all have very high volumes and proportions of people classified as deprived.	Lambeth, Lewisham and Southwark have higher densities of deprivation, though pockets also exist in the north east of Bexley and the north east of Bromley.	The north and north west of the study area has the highest density of people living in deprivation.
Carers	Bromley has the largest volume of carers and is much higher than the other areas.	Bromley (7%) has the highest proportion of carers, though all are similar or identical to that of the greater London average of 5%	Bromley has significantly more carers than any other CCG area. It is also has the highest proportion of carers. This is consistent with the fact that Bromley also has the largest volumes of older people.	N/A	N/A

7. Concluding observations

7.1 Equalities analysis

Our analysis to date shows that the following groups need to be further considered as our research progresses; older people, disabled people, females, people undergoing gender reassignment, people from a white ethnic background, people from a BAME background, people in economic and social deprivation and carers.

It is understood that disability is a heterogeneous category and that people with different disabilities have different needs. This report focuses on those with learning disabilities, epilepsy or cerebral palsy as this is where evidence exists to demonstrate disproportionate need. This will be further explored with stakeholders representing disability as engagement continues.

It is important to note that individuals may have more than one of the protected characteristics scoped into this report. However, this does not necessary make their need greater than an individual with one of the protected characteristics scoped in. By way of example, we can not quantify or specify that a woman over the age of 65 has double the level of need than a woman under the age of 65.

7.2 Recommendations for OHSEL consultation

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In the public consultation phase of the work, it is suggested that OHSEL considers asking questions on issues such as the location and access of services, the design of services and monitoring and feedback. This will enable OHSEL to understand to what extent location, the design of services and how feedback is captured is important to patients. This is to be discussed with OHSEL prior to the consultation phase.

The social demographic analysis demonstrates difference in population groups across the CCGs. The north west of OHSEL, including Lambeth, Southwark and Lewisham tend to have higher densities of deprivation and those with a disability. In comparison, the south of the study area tends to have higher densities of the older people and carers. In planning the programme of public consultation, OHSEL may want to undergo consultation activities focused on certain groups in specific areas, according to the trends identified in this paper.

We are happy to discuss these issues in more detail with communications and engagement leads at OHSEL and the constituent CCG areas as necessary.

8. Next steps

The next steps in this equalities analysis are as follows:

- Continue with a programme of engagement with stakeholders. These will take the form of individual one-to-one telephone interviews with strategic and community stakeholders. It has been challenging to engage with stakeholders to date, in order to ensure that we provide stakeholders with the maximum chance to participate, we are extending this engagement phase into stage two of the work.

- In advance of commencing the second phase of work, a meeting will be held with OHSEL to discuss the findings of this report. The engagement strategy going forward into stage two will also be discussed with OHSEL and relevant stakeholders. One-to-one interviews with community groups have failed to engage large numbers of stakeholders to date. Whilst the scope of work originally suggested holding engagement forums in stage two involving community and patient groups, alternative ways to engage communities scoped in will be explored. Specifically, the use of focus groups comprising of participants with one or more of the characteristics identified as having either disproportionate or differential need.

  To date stakeholders have highlighted some potential overarching equality impacts, which we will look to explore in more detail in stage two, namely:
  - **Patient experience and quality of care:** Some vulnerable groups find it more challenging to understand and accommodate change in service provision, either due to challenges in terms of comprehension, anxiety around unfamiliar journeys or venues and/or a lack of independence. This may affect patient experience before and during service receipt.
  - **Travel and access for certain protected characteristic groups:** Centralisation of some services will require longer journey times for some patients. Understanding the extent to which these longer journey times affect the protected characteristics will be critical. This is particularly the case because several equality groups have a higher reliance on public transport than the general population which can compound any accessibility impacts. It is recommended that OHSEL might want to consider this issue quantitatively using travel and access analysis, based on different service options. We can discuss the benefits of this with OHSEL in more detail

- Stage two of the equalities analysis will then begin. Stage two consists of the following activities:
  - Providing expert advice to OHSEL during the public consultation phase.
  - Continuing engagement either through engagement for a or focus groups, to be decided.
  - Undergoing staff engagement through one-to-one interviews.
  - Delivering an equalities training workshop to NHS staff on the data required to fulfil the PSED.

An interim report will then be produced by the end of November 2016.

Appendices

Appendix A Stakeholders engaged 29-30

Appendix B Population density maps 31-36

Appendix C Disability Living Allowance claimants 37

Appendix D Older people population trends 38

A1. Stakeholders contacted during phase one engagement

The following community stakeholder groups have been contacted by Mott MacDonald. This is in addition to stakeholders contacted directly by OHSEL. Stakeholders highlighted green have responded to the opportunity for interview and have been engaged as part of this process. Stakeholders representing disability (Lambeth Mencap), race (Greenwich Race Inclusion Project and Greenwich Migrant Hub) and sexual orientation (Southwark LGBT Network) have been engaged. OHSEL are continuing to extend invitations to engage in the process particularly with groups scoped into this research via their existing contacts and relationships.

Age Exchange	Lambeth Youth Council	Bridge Mental Health	Trans London	Greenwich Race Inclusion Project
Age UK Bromley	Carers Bromley	British Lung Foundation Breatheasy Group, Lambeth	Bexley Maternity Services Liaison Committee (MSLC)	Multifaith forum, Southwark
Basaira Pensioners Forum	Carer's Hub Lambeth	Bromley Mencap	Bromley MSLC	Faiths Together in Lambeth
Bexley Youth Service	Carer's Hub Lewisham	Greenwich Association for Disabled People	Greenwich MSLC	Greenwich Peninsula Chaplaincy
Bromley and Greenwich Age UK	Carers Lewisham	Greenwich Mind	Lambeth MSLC	Brimley Inter Faith Forum
Bromley Childrens and Families Voluntary Forum	Carers Support Bexley	Lambeth Learning Disability Assembly	Lewisham MSLC	Bromley Gay and Bisexual Men's Group
Danson Youth Centre	Greenwich Carers Centre	Lambeth Mencap	Southwark MSLC	Community Empowerment and Support Initiatives, Greenwich
Elders People Support Group	Lambeth Young Carers	Lewisham Disability Coalition	Bexley Multicultural Centre CIC	Haven, Bexley
Greenwich Older Voices	Lewisham Parent Carers Forum	Lewisham Mencap	Ethnic Health Foundation	Lambeth LGBT network
Lambeth and Southwark Integrated Care Citizens' Forum	Southwark Parent Carers Council	Mind in Bexley	Federation of Refugees from Vietnam in Lewisham	Metro
Lambeth Youth COOP	Southwark Young Carers	Mosaic Clubhouse	Indo-Chinese Community Centre,Lewisham	LGBT Community Plan London
Lewisham Youth Aid	Young Carers, Greenwich	Thamesreach Lambeth	Lewisham Ethnic Minority Partnership	Southwark LGBT Network
Oakwood School	Association for Disabled Children, Bexley	Voluntary Organisations Disability Group, Lambeth	Lewisham Irish Community Centre	999 Club
Southwark Young Council	Bexley Deaf Centre	FTM London	Lewisham Turkish Elders Club	Bench outreach project

A1. Stakeholders contacted during phase one engagement continued

Blenheim Nexus Outreach

Bromley and District Osteoporosis Group

Bromley Homeless Shelter

Community Options, Bromley

CRI Lewisham Young People Substance Misuse Service

Deptford Reach

Emmaus Greenwich

Give us a buzz, Greenwich

Greenwich Migrant Hub

Indoamerican Refugee and Migrant Organisation, Lambeth

Lambeth Resolve

SHP-Lambeth Projects

St Mungos

Thames Reach Employment Academy

Thamesreach Greenwich

Thamesreach Lewisham

The Scarlet Centre, Greenwich

In addition to the community stakeholders, strategic stakeholders from all six CCGs have been contacted. These include equality, engagement and clinicians from the six CCGs.

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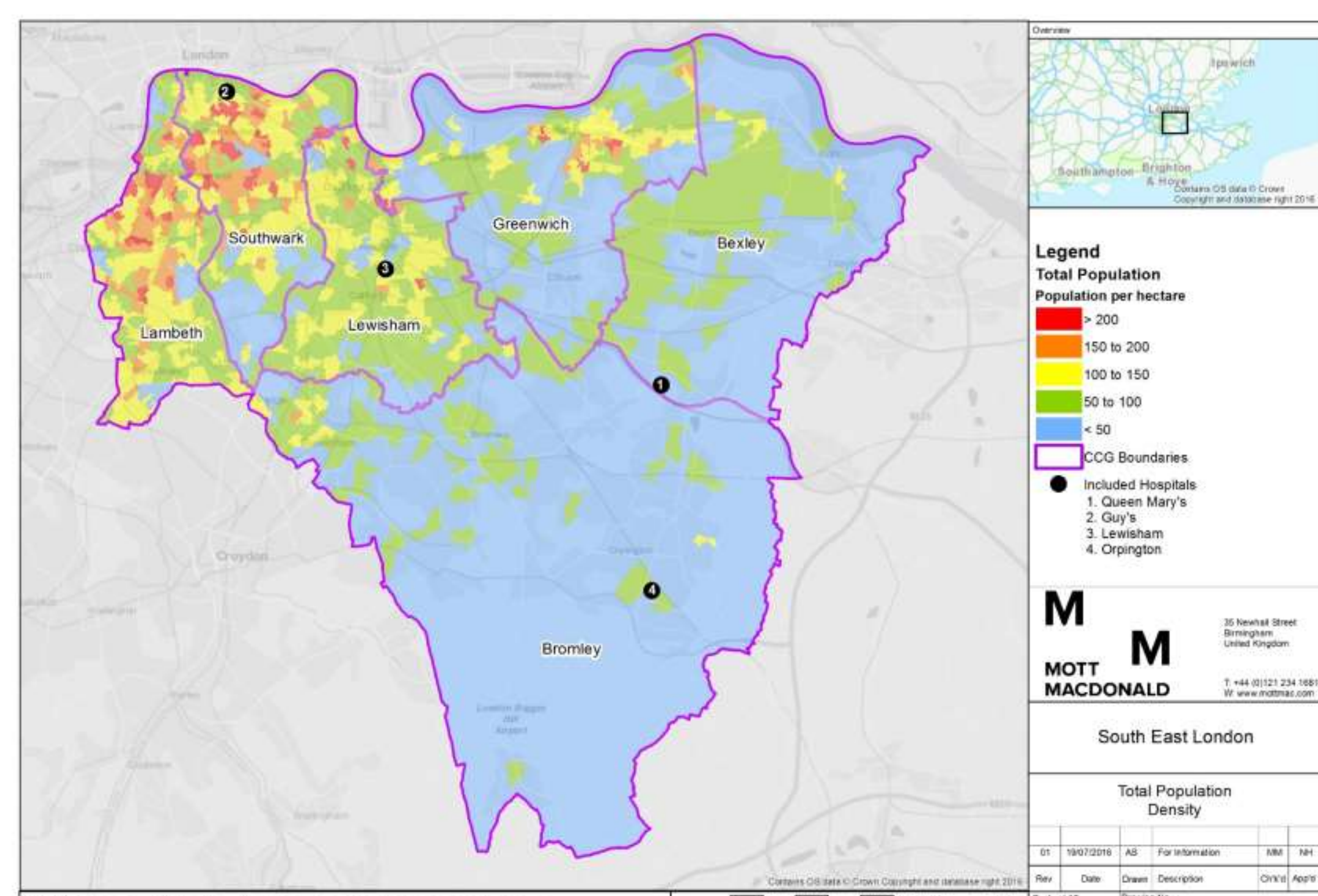
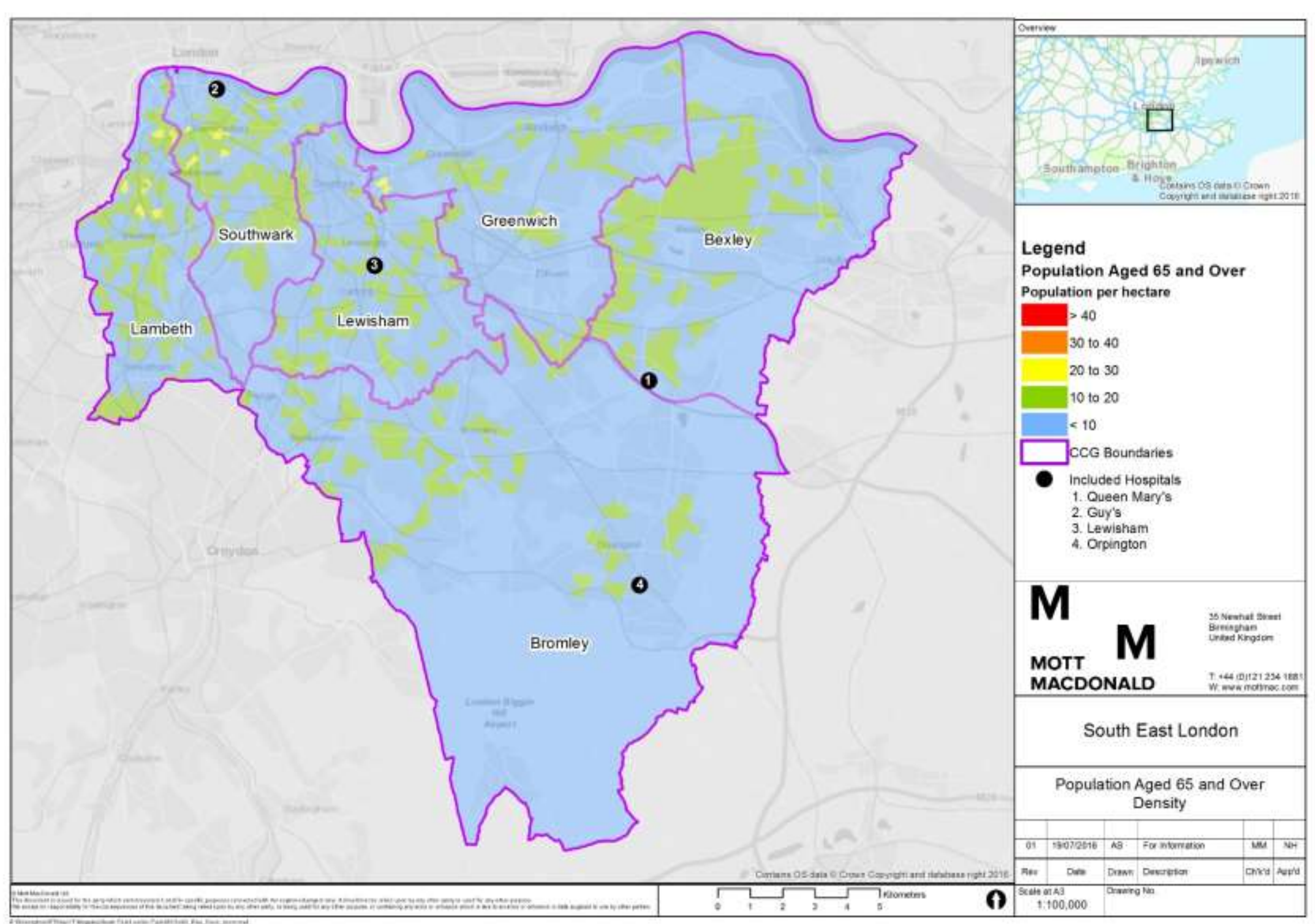
B2.1 Population density OHSEL



B2.2 Population density older people (aged 65 or over)



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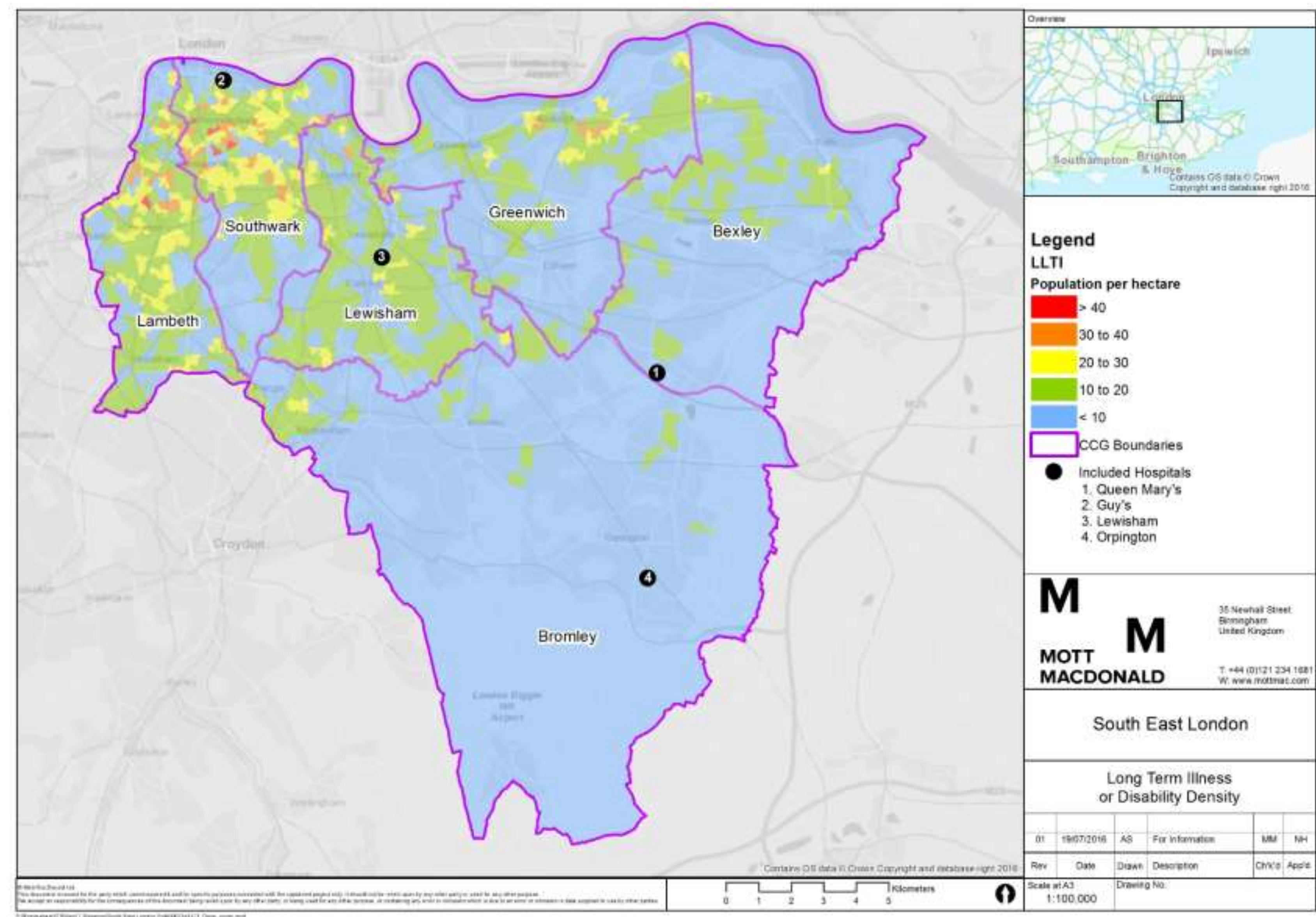
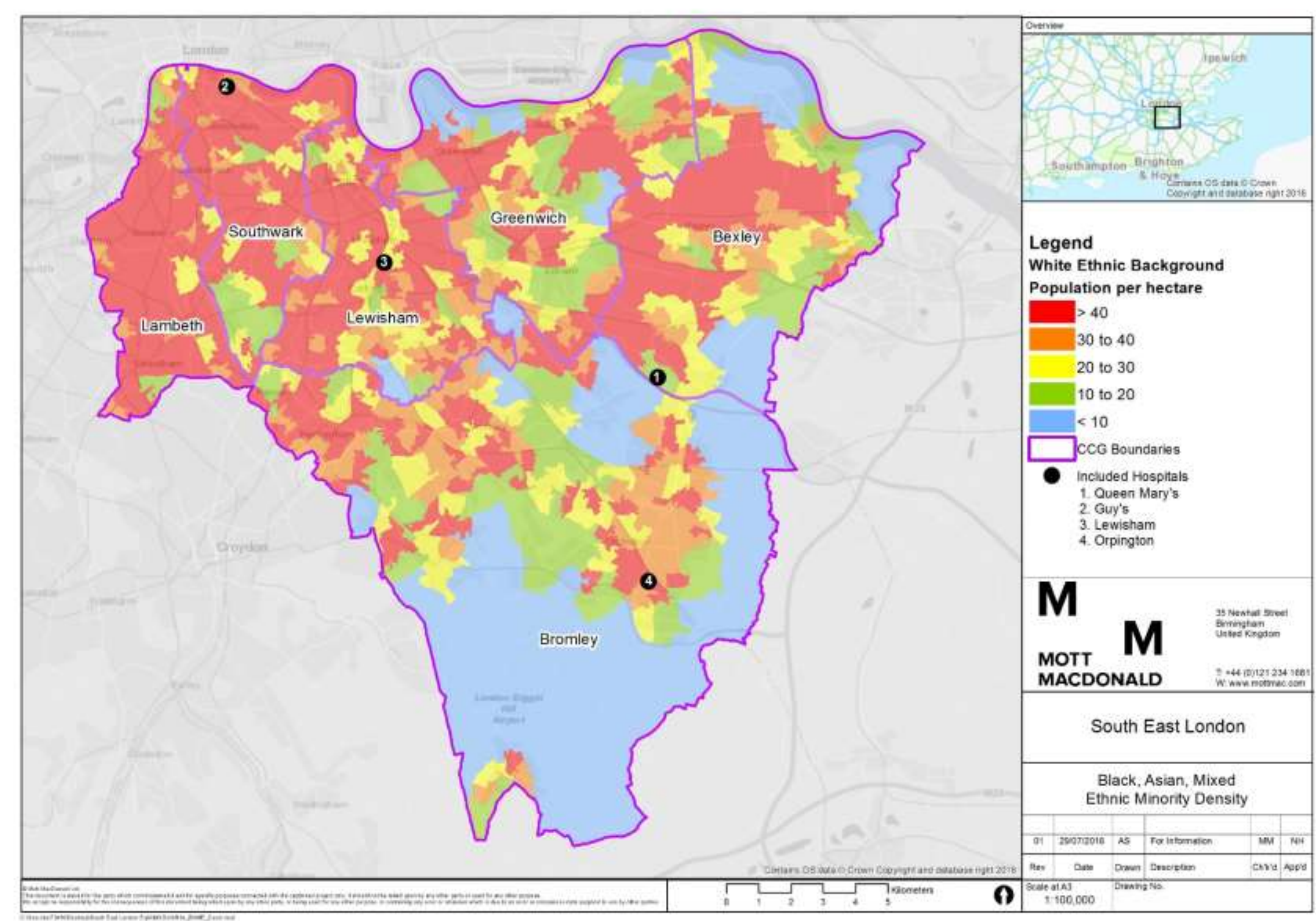
B2.3 Population density disability



B2.4 Population density white ethnic background



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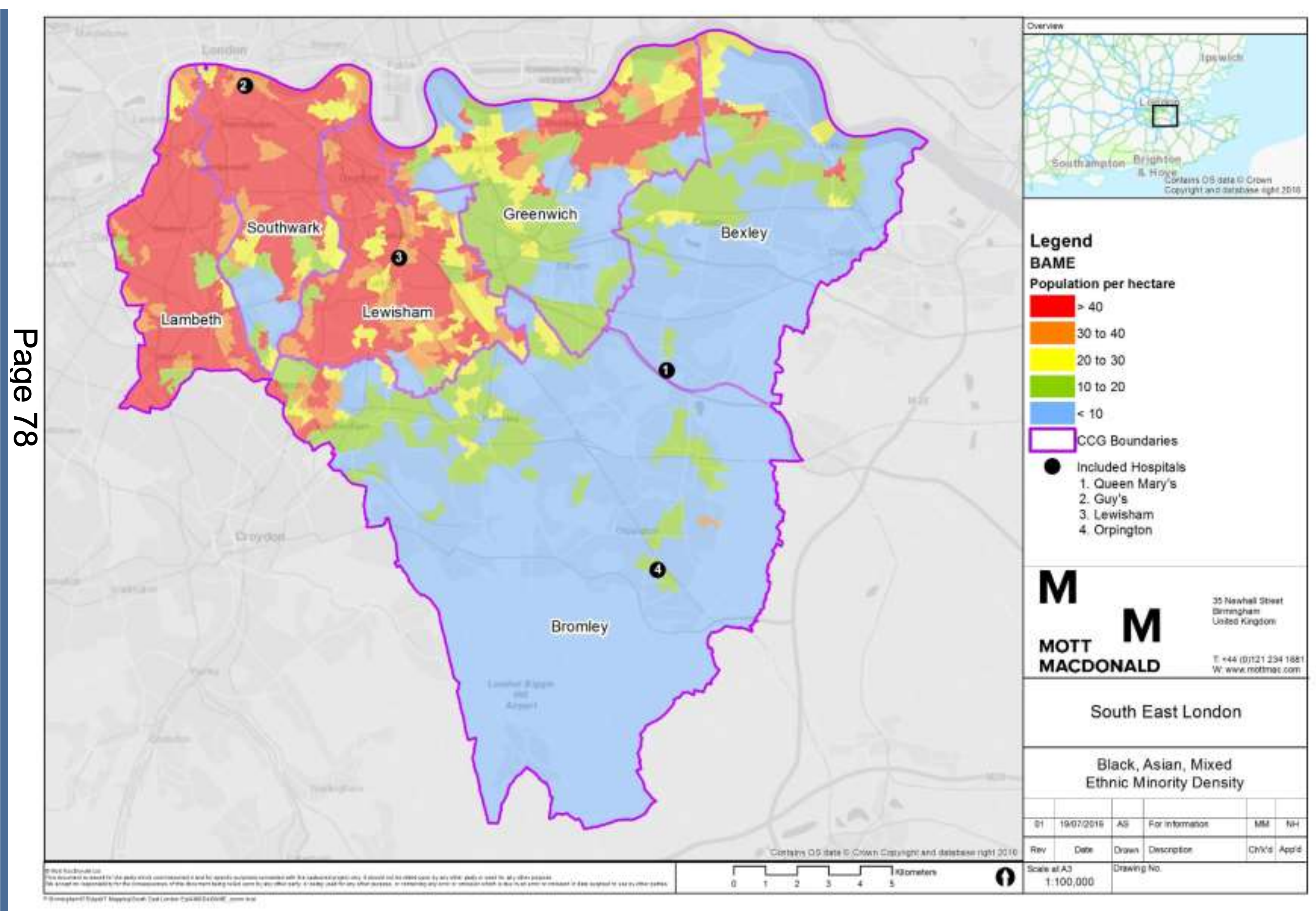
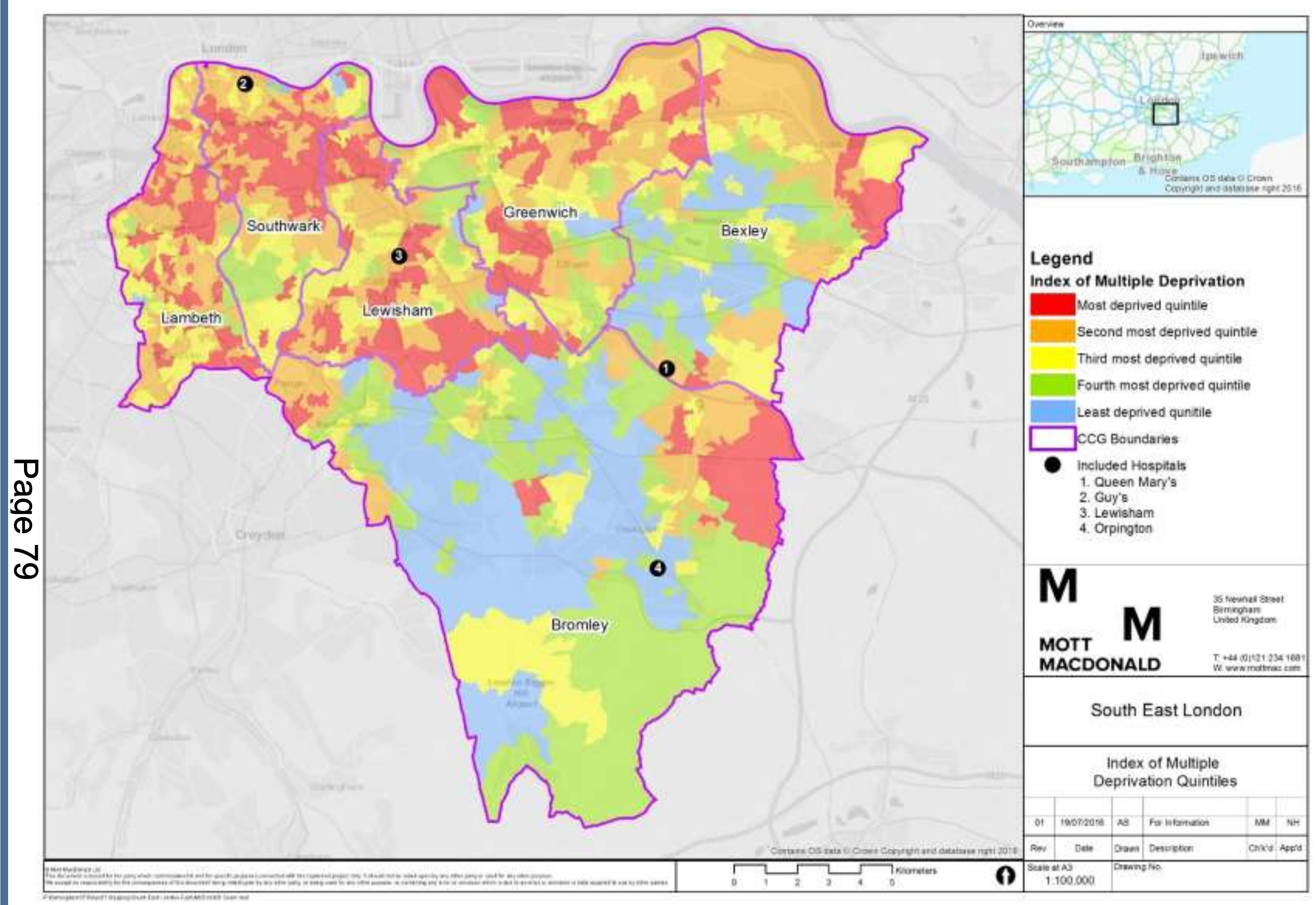
B2.5 BAME



B2.6 Population density deprivation



C1 Disability Living Allowance (DLA) claimants

CCG	Claiming for learning disability	Total claiming DLA	Proportion of DLA claimants that claim for learning disability
Bexley	1,850	9,590	19%
Bromley	2,270	10,730	21%
Greenwich	2,080	12,230	17%
Lambeth	1,940	12,010	16%
Lewisham	2,640	12,600	21%
Southwark	2,050	12,580	16%
South London	12,830	69,740	18%

Source: ONS data, 2016

Please note that this data has been included to provide additional detail. This data should not be seen as the sole indictor for the numbers of people in each CCG area who have learning disabilities as it details those claiming DLA only. In phase two of the works, stakeholders will be engaged on issues of reliably identifying the numbers of people living with learning disabilities in the study area.

A density map has not been produced for these statistics as the numbers of those claiming DLA for learning disabilities is too small to demonstrate any critical mass.

D1 Population trends: Older people volume and percentage change

	Aged 65+ 2014	Aged 65+ 2039	Total Population % Change	Aged 65+ % Change
Bexley	40,000	62,000	28%	55%
Bromley	56,000	88,000	28%	56%
Greenwich	28,000	52,000	32%	86%
Lambeth	25,000	48,000	23%	94%
Lewisham	27,000	52,000	31%	89%
Southwark	24,000	48,000	29%	100%
South London Average	33,000	58,000	28%	75%
Greater London	983,000	1,775,000	29%	81%

Source: ONS Population Projections, 2014