

Appendix 2

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	E07/S/d
Service	Paediatric Critical Care Transport
Commissioner Lead	
Provider Lead	
Period	
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

Paediatric Critical Care Transport refers to the transfer of critically ill children into Paediatric Critical Care (PCC) facilities. The definitions of the full range of Paediatric critical care (PCC) is as follows:

- Level 1 Paediatric Critical Care Units (PCCUs) will be located in all hospitals providing inpatient care to children and will deliver level 1 PCC care. (provided in all district general hospitals where in-patient facilities are available and is not commissioned by NHS England)
- Level 2 PCCUs may be specialist or non-specialist and are provided in tertiary hospitals and a limited number of District General Hospitals (DGH's) and will deliver level 1 & 2 care. These were formerly classified as HDUs. (commissioned by NHS England)
- Level 3 PCCUs (PICUs) are usually located in tertiary centres or specialist hospitals and can provide all 3 levels of PCC.(commissioned by NHS England)

Paediatric Critical Care Transport Services exist to ensure that critically ill children have equitable access to timely, safe and clinically effective PCC provision wherever they present in a geographical area. Since PCC facilities are centralised in a small number of hospitals providing expert specialist care, specialist PCC Transport teams are required to deliver

expert clinical management during transfer to optimise clinical outcomes from the point of contact with the transport team. A PCC Transport Service only provides transport between hospitals and does not respond to 'primary' 999 calls.

1.2.

There are no randomised controlled trials comparing the outcomes following transfer by specialist teams with those provided by referring hospitals. However, published descriptive studies have highlighted the benefits of a dedicated transport team over non specialist teams, where inter hospital transfer of critically ill children by personnel not trained in paediatric intensive care transport has been shown to be associated with unacceptable transport related morbidity and that dedicated transport personnel may be an important determinant of morbidity and mortality.^{*(1,2,3,)}

*1. Ramnarayan P, Thiru K, Parslow RC, Harrison DA, Draper ES, Rowan KM. Effects of a specialist retrieval team on outcomes in children admitted to paediatric intensive care units in England and Wales: a retrospective cohort study. *Lancet* 2010;376(9742):698-704

2. Orr RA, Felmet KA, Han Y, McCloskey KA, Dargotta MA, Bills DM, et al. Paediatric specialized transport teams are associated with improved outcomes. *Paediatrics* 2009;124(1):40-8

3. Edge WE, Kanter RK, Weigle CG, Walsh RF. Reduction of morbidity in inter-hospital transport by specialized paediatric staff. *Crit care Med* 1994;22(7):1186-91

1.3

Between 2009 and 2011, 17,407 transfers into PCC level 3's in UK and Ireland were recorded (PICANET Annual Report 2012). Currently there are 4,500 transfers by specialist paediatric teams each year with an expectation that these numbers will rise as a result of any national reconfiguration of specialist children's services. Other transport services (such as ECMO or neonatal) may overlap or share responsibilities with PCC Transport Services

Publications include:

- *Paediatric Intensive Care, 'A Framework for the Future', report from the National Coordinating Group on Paediatric Intensive Care to the Chief Executive of the NHS Executive*, Department of Health (1997)
- *"Getting the right start: National Service Framework for Children 'Standard for Hospital Services'*, Department of Health (2003)
- *'The acutely or critically sick or injured child in the district general hospital – a team response'*, Department of Health (2006)
- *'Standards for the Care of Critically Ill Children'*, 4th ed. UK Paediatric Intensive Care Society (2010)
- *Joint Statement from the Society of British Neurological Surgeons (SBNS) and the Royal College of Anaesthetists (RCOA) Regarding the Provision of Emergency Paediatric Neurosurgical Services* (2011)

1.4. Current Service Models for PCC Transport and Future Modelling

Traditionally, the term 'retrieval' has been used to refer to the emergency transport of critically ill children by specialist teams into a level 3 PCCU. 'Retrieval' is commissioned throughout England. However, transport of patients requiring admission to a Level 2 PCCU, and transport back to referring units from PCC facilities ('repatriation'), has been commissioned in some areas in England but not in others.

1.5.

A PCC transfer covers the entire pathway for a critically ill or injured child in to a PCC facility. PCC repatriation refers to the transfer back to the District General Hospital (DGH) or PCC facility closest to the child's home. Referral to a PCC Transport Service may originate from a DGH in-patient service, an Emergency Department or a specialist service (including other PCC facilities).

Currently there is only a single HRG currency for PCC Transport. All PCC Transport falls under XB08Z HRG. Future work is needed to allow more sophisticated commissioning of paediatric critical care transport.

At this time, this specification covers only transports into a level 3 PCCU and does not include PCC repatriations or PCC level 2 (HDU) transports.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	✓
Domain 2	Enhancing quality of life for people with long-term conditions	
Domain 3	Helping people to recover from episodes of ill-health or following injury	✓
Domain 4	Ensuring people have a positive experience of care	✓
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	✓

Key Outcomes:

1. To submit data on percentage of retrievals undertaken within agreed scope of care undertaken by the PCC transport team (Domain: 1,3,4,5,)

2. *Transfer team departs from the transport base within 30 minutes of the clinical decision that PCC Transport is indicated. (Domain 1, 3, 4, 5,)
3. The PCC Transport Service arrives at the local referring centre within three hours of the decision to retrieve the child (decision response time) (Domain: 1, 3, 4, 5)
4. Transport services collect timely (within 3 months of patient transport) minimum dataset required by PICANet (Domain: 1,3,5)
5. Governance arrangements in place that allow cross organisational learning within network. Transport teams contribute to and are active participants in the clinical governance arrangements of the NHS pathway of care. (Domain: 1,3,4,5)
6. Governance arrangements in place that allow shared learning with other transport services (Domain 1,3,4,5)
7. Annual report published summarising activity, compliance with quality standards and clinical outcomes, progress from previous year, shared with appropriate stake-holders

*These measures are part of the quality dashboard for PCC transport services.

3. Scope

3.1 Aims and Objectives of Service

Delivery of the service will not depend on in-patient care, will recognise the importance of family circumstances and provide arrangements to undertake or facilitate transfers in all categories as part of its baseline provision.

Where capacity within network does not allow for an appropriate transfer to PCCU a child will be transferred out of network by an appropriate PCC transport team ensuring a safe and timely transfer to another appropriate critical care setting.

A PCC Transport Service must be available at all times and for all units within a designated geographical catchment area providing:

- Clinical advice to referring clinicians
- Safe and effective transfers for critically ill children
- A bed location service for PCC transfers

3.1.2

PCC transfers will be performed by a dedicated PCC transport service, with the ability to:

- Operate 24 hour per day
- Staff all transfers appropriately and in accordance with the clinical condition of the child
- Transfer at least 95% of children where transfer is required within the service specification and any exceptions documented and reviewed at a network level
- Demonstrate performance against specified response time standards
- Allocate transfers according to clinical priority
- Operate in an integrated and supportive way with regional referring units

- Operate in an integrated and supportive way with other Transport Services
- Ensure appropriate governance arrangements, including data collection and audit
- Select an appropriate mode of transport (e.g. air-medical) where this would be clinically beneficial, whilst maintaining appropriate governance and safety standards. This may involve collaboration with other providers

3.2 Service description/care pathway

A specialist PCC Transport team will transfer children requiring intensive care to the most appropriate PCC facility and this process will be quality assured.

The PCC Transport Service will:

- Be contacted in any situation where a transfer may be required
- Be responsible for the organisation of any necessary transfer
- Have clear documented referral processes for all categories of transfer
- Have clear protocols for handover from referring teams to receiving PCC units.

In some cases, due to the time critical nature of the child's clinical condition, children will need to be transferred to a PCC facility by the referring hospital team.

The planning of delivery of PCC Transport should reflect seasonal and other fluctuations in demand to ensure that the standard of care provided to children referred for intensive care is not compromised.

Where such an eventuality arises and with collaborative working across the networks an alternative service will be found to undertake the transfer.

The typical peak of PCC activity between November and January each year can result in an increase in admissions by 20-30% for those months.

3.2.1 Service model:

The PCC Transport Service must be operational 24-hours daily. The ability to respond to demands on the PCC Transport Service should be prioritised based upon clinical need.

Currently, due to historical commissioning arrangements Transport Services are designed in different ways and their scope of service will vary. This will be addressed through the Service Specification Compliance Process.

Urgency:

- Time Critical – normally performed by referring units.

Time critical transfers are required for children who have a life threatening clinical condition where early intervention will have a greater impact on the outcome for these children than transfer by a specialist team e.g. emergency neurosurgery; acute abdomen.

- Unplanned/emergency
Performed by the PCC specialist transport team

- Planned/elective

If commissioned to do so, may be performed by the PCC transfer service

Reason:

- Uplift of care (transfer for care that the referring hospital does not usually provide)
- Resources/capacity
- Repatriation from the level 3 PCC unit (if commissioned to do so)

The decision on the most appropriate team should be based on the needs of the child and the agreed network arrangements.

3.2.2. Levels of care across the patient pathway

Referral to the PCC Transport Service will be based on the child's need for admission to a designated PCC bed.

The PCC Transport Service acts as a mobile intensive care unit to provide care to critically ill children in the network.

To achieve optimum outcomes a PCC Transport Service will work in partnership with the network, PCC facilities and local referring centres to ensure that within the network the following functions are provided:

- Resuscitation and stabilisation by referring staff to agreed guidelines and protocols
- Transfer of stabilised children in an appropriately staffed and equipped mobile intensive care environment to a PCC facility.
- Support for the care of critically ill children including provision of outreach education and training.

3.2.3. Capacity of Transport Service

Commissioners and providers are responsible for transfer capacity and undertake needs assessment and gap analysis on a regular basis to ensure adequate provision to enable delivery of a service at all times.

3.2.4 Staffing

The PCC Transport Service must have adequate numbers of staff with the appropriate skills to provide a safe service for children, including:

- A lead named consultant
- A lead nurse
- 24 hour transport consultant advice and availability to join the transfer team if required
- A doctor or advanced nurse practitioner appropriately trained and experienced to carry out transfers available at all times
- A nurse or other non-medical member of staff trained and experienced to carry out transfers available at all times.
- Team composition will be based on clinical need
- Staff are trained to a required standard for all aspects of equipment use, transport safety and infection control
- Staff receive full appropriate inductions, competency updates and have access to continuing professional development (CPD) programmes.

- Where the Transport Service is co-located with a PCC level 3 the Transport Service staff should not be included in the standard unit rota, and should be supernumerary to this
- Where staff are provided from outside of the network Transport Service, any service level agreement (SLA) or contract will stipulate that staff are trained to meet these standards
- Transfer training updates will be conducted at least annually for PCC Transport Service staff

3.2.5 Referral processes and sources

There should be an agreed network pathway for children referred for PCC with a single point of contact.

For unplanned/emergency transfers the PCC Transport Service provides access to clinical advice, mobilises the transfer team and locates a PCC bed. Activation of the transfer team should not always be dependent on bed availability but on clinical condition.

For a PCC Transport service that is commissioned to undertake planned/elective transfers, decisions about the need for transfer will be agreed jointly by the referring consultant and receiving consultant. The PCC Transport Service will then liaise with the referring centre to undertake the transfer in a timely fashion.

Each service must have an agreed scope of care which would include a collaborative working relationship with the neighbouring Transport Services. Written records of interaction between services must be kept

3.2.6. Equity of access to services

The PCC Transport service must be commissioned to serve the whole geographical population and must provide services equitably across the region that they operate.

Commissioning should take into account the possibility of teams transferring patients outside of their normal remit but within their clinical scope where this is in the best interests of the patient and/or family.

3.2.7. Handover of care

The PCC Transport Service must show evidence of a protocol for concise but detailed handover. The transfer of radiological supporting documentation via PACS (e.g. radiology imaging) is the responsibility of the referring centre.

The responsibility for the care of the patient is a continuum of responsibility over the whole transport event.(from the time that care is formally handed over by the referring team to the time that formal handover is undertaken with the receiving unit).

PCC Transport teams should utilise where possible IT solutions, such as inter-hospital radiology image sharing and telemedicine links, which may improve the transfer process or limit the need for transport.

Where such IT solutions are beneficial to patient care the Transport Service should work together with the PCC network to help ensure that the technology is available in all parts of the network.

3.2.8 Service user / carer information

The PCC Transport Service must have a policy for parental travel arrangements. Where possible, at least one parent / legal carers will be allowed to accompany their child during transfer.

When it is not possible to transfer a parent / legal carer with their child the PCC transport team must ensure that alternative transport arrangements have been made by the referring hospital team.

Parents where possible should always be offered the opportunity to see their child prior to transfer.

Parents and carers will be given written information about the PCC Transport Service and receiving PCC unit, including contact information. Multi-lingual output is advised.

3.2.9 Governance

The process for transfer of critically ill children must be timely, safe and efficient, requiring a high degree of coordination between all service providers. The development of this coordinated approach must be led by the PCC Transport Service, but should be wholly supported by all hospitals in the network admitting and/or referring critically ill children.

The PCC Transport Service will have governance and operational policies (e.g. medication protocols) with clear guidelines for how incidents are reported and resolved.

Serious transport incidents can be complex with several Trusts involved. The area PCC network board/lead will oversee the review process or if in place the Operational Delivery Network, ensuring joined-up cross-boundary responses and learning.

There will be clear mechanisms for quality assurance and incident review, including submission to agreed national bodies. These reports will be available for review by the Area Team Commissioners, network or other agencies and produced on an annual or more frequent basis if required. These are to conform to any agreed local or national format.

Structures must be in place to provide on-going training for those involved with PCC Transport, and to demonstrate relevant competencies for all grades of nursing and medical staff undertaking transfers.

Mechanisms will exist to ensure that all stakeholders involved in the PCC Transport Service have an active input into the delivery of the service. PCC Transport services should establish and maintain a Stakeholder Group which will include clinical personnel from the

Network Units, parents commissioners and where necessary the regional ambulance service.

The Transport Service must work collaboratively with the Network and Level 3 providers to ensure that education and training is delivered to referring centres within the network will cover assessment, resuscitation, stabilisation and maintenance of critically ill and injured children prior to the arrival of the Transport Service.

3.2.10 Reporting requirements

The Transport Service will:

- Monitor the service against agreed standards, including for activity, delays, and exceptions to network pathways.
- Record and monitor activity according to PICANet minimum data set on all referrals and transfers, including referrals that do not result in a transfer.
- Records should include the nature of any medical or nursing advice given
- Participate in annual benchmarking of PICANet minimum transport dataset
- The PCC Transport Service must keep records of all clinical incidents, which should also be included in transfer records and audited.
- Standard NHS England procedures for reporting of incidents should be followed including sharing of incidents with statutory bodies when indicated.
- Regular activity reports and an annual report will be produced and shared with all stakeholders and service commissioners.

3.2.11 Vehicles, equipment, safety and insurance

All modes of transport must comply with Care Quality Commission (CQC) standards and the Health and safety at Work Act 1974 and Electricity at Work Regulations 1989 and European Aero/Medical Institute (EURAMI) or Commission on Accreditation of Medical Transport Systems (CAMTS) standards.

The service will have policies and systems in place covering their scope of care.

3.2.12 Ambulance providers

There will be a contract for the provision of ambulance vehicles for transport.

Vehicles used to transport patients must be constructed to manufacturers' recommendations and meet the EC and UK legislation in terms of roadworthiness and also conform to current Motor Vehicle (Construction and Use) Regulations.

The vehicle provider must operate to the standards laid down by the NHS for ambulance services. Service specification to be negotiated at the time of tender

Insurance: The PCC Transport Service must ensure that there is separate provision of insurance for service personnel against loss of life or injury. The ambulance service must have a public liability insurance policy in place.

The PCC transport am must have robust communication structures in place.

3.2.13 Private contractors

Private contractors carrying out transfers are expected to be registered with the Care Quality Commission (CQC) and be compliant with CQC standards and to perform to the same criteria outlined above for the clinical teams and ambulance providers for commissioned Transport Services. This includes equipment standards, staffing and governance arrangements.

3.2.14 Communication

There will be a single point of contact through which the PCC Transport Service can be contacted and activated at all times for clinical advice and transport planning. This will include teleconferencing, call handling and call recording functionality. Clear, accurate and retrievable records of communications must be kept, in accordance with any agreed standards.

The PCC Transport Service shall have arrangements in place to receive feedback from local referring centres.

3.2.15 Documentation

- Clinical observation and record-keeping during the transfer must be to the same standard as that provided at any other time
- Documentation will include all components of the PICANet transport dataset information

3.3 Population covered

Paediatric Critical Care Transport Services are to be used for any patient that is to be transferred to and from a PCC facility.

Critically ill children are technically defined as those from 0 up to the age of 16 years; this shall include those discharged or transferred from a maternity service or neonatal unit and depending on the patient's needs this exceptionally may extend to a wider age range. Patients for transfer between neonatal units would usually be the responsibility of the Neonatal Transport Service.

The service outlined in this specification is for patients ordinarily resident in England*; or otherwise the commissioning responsibility of the NHS in England (as defined in *Who*

Pays?: Establishing the responsible commissioner and other Department of Health guidance relating to patients entitled to NHS care or exempt from charges).

*Note: for the purposes of commissioning health services, this EXCLUDES patients who, whilst resident in England, are registered with a GP Practice in Wales, but INCLUDES patients resident in Wales who are registered with a GP Practice in England.

3.4 Any acceptance and exclusion criteria and thresholds

Time critical transfers are the responsibility of the referring unit

There should be agreed network transfer protocols for specific patient groups e.g. neonatal/paediatric/ECMO

The protocols will outline specific example scenarios:

- The transfer of neonates between neonatal units will usually be undertaken by the Neonatal Transport Service. (Ref: Toolkit for High Quality Neonatal Services – Principle 4)
- In some regions, the Neonatal and Paediatric Critical Care Transport Service may run as one service.
- Where the two services are separate, when a neonate is being transferred for management at a PCC facility, then the neonate may be transferred by a Paediatric Critical Care Transport Service.
- In the event of a time critical transfer there should be local guidance for the transfer of critically ill children from a referring centre to a level 3 PCCU by a District General Hospital (DGH) team.

3.5 Interdependencies with other services/providers

Critical interdependencies

Critical Interdependencies are PCC facilities, local district general hospitals, transport vehicle providers, statutory ambulance services, other adjacent Transport Services And at times air medical transfer assets

It is acknowledged that all PCC Transport Services will from time to time face acute demands which outstrip their capacity to respond. There should be documented procedures for triage and for requesting the assistance of other teams in these situations. Transport Services should collaborate with their neighbouring PCC transport providers regarding mutual-aid. Agreed regional transfer protocols will be in place to include contingency plans to support the transfer of critically ill children when the PCC Transport Service is not available.

Where a patient is to be transferred across commissioning or network borders the responsibility for the transfer lies first of all with the team covering the region where the child

falls ill.

Transport Services should have written agreement with neighbouring PCC Transport Services about referral and allocation processes unless alternative commissioning arrangements are already in place (e.g. ECMO).

4. Applicable Service Standards

4.1 Applicable national standards e.g. NICE

Core Standards	<i>'Paediatric Intensive Care, 'A Framework for the Future', report from the National Coordinating Group on Paediatric Intensive Care to the Chief Executive of the NHS Executive', DH (1997). http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4005760</i>
	<i>A Bridge to the future nursing standards, education and workforce planning in Paediatric Intensive Care, report of the Chief Nursing Officer's taskforce', DH (1997). http://www.dhcarenetworks.org.uk/_library/Resources/ICN/Policy_documents/Bridge_to_the_Future.pdf</i>
	<i>'Getting the right start: NSF for Children, Standards for Hospital Services' (2003). http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Consultations/Closedconsultations/DH_4085150</i>
	<i>'Standards for the Care of Critically Ill Children' Paediatric Intensive Care Society (2010). http://www.ukpics.org.uk/documents/PICS_standards.pdf</i>
	<i>National Clinical Audit & Outcomes Programme, Paediatric Intensive Care Audit Network (PICANet) participation mandatory as included in the 'Quality Account' outlined in the NHS Operating Framework, 2012/13.</i>

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

As above.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See Schedule 4 Parts A-D)

There is a quality dashboard in place for paediatric critical care – the following measures are directly applicable to paediatric critical care transport services:

PIC13	Domain 1	Number of requests (within agreed scope of care) for retrieval of a patient requiring PIC admission which are refused
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		by the PCC transport team
PIC14	Domain 1	Number of retrievals performed within the agreed mobilisation time

5.2 Applicable CQUIN goals (See Schedule 4 Part E)

At the current time there are no specific CQUINS applicable directly to Paediatric Critical Care Transport.

6. Location of Provider Premises

The Provider's Premises are located at:

To be determined by the Area Team

7. Individual Service User Placement

Not Applicable

14/15 Specification Draft - Stakeholder Testing Stage

Appendix One

Quality standards specific to the service using the following template:

Quality Requirement	Threshold	Method of Measurement	Consequence of breach
Domain 1: Preventing people dying prematurely			
1. 95% of retrievals undertaken within agreed scope of care undertaken by the PCC transport team	95%	Local audit data PICANet submission to validate local audit data	Non compliance with contract General Conditions 8 & 9
2. Transfer team departs from the transport base within 30 minutes of the clinical decision to accept the patient	To be agreed with service provider	Local audit data PICANet submission	Non compliance with contract General Conditions 8 & 9
3. The PCC Transport Service arrives at the local referring centre within three hours of the decision to retrieve the child (decision response time)	To be agreed with service provider	Local audit data PICANet submission	Non compliance with contract General Conditions 8 & 9
4. Transport services collect timely (within 3 months of patient transport) minimum dataset required by PICANet	To be agreed with service provider	Local audit data PICANet submission	Non compliance with contract General Conditions 8 & 9

Quality Requirement	Threshold	Method of Measurement	Consequence of breach
5. Governance arrangements in place that allow cross organisational learning within network	To be agreed with service provider	Local data to demonstrate governance arrangements	Non compliance with contract General Conditions 8 & 9
6. Governance arrangements in place that allow shared learning with other transport services	To be agreed with service provider	Local data to demonstrate governance arrangements	Non compliance with contract General Conditions 8 & 9
Domain 2: Enhancing the quality of life of people with long-term conditions			
Domain 3: Helping people to recover from episodes of ill-health or following injury			
1. 95% of retrievals undertaken within agreed scope of care undertaken by the PCC transport team	95%	Local audit data PICANet submission to validate local audit data	Non compliance with contract General Conditions 8 & 9
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Quality Requirement	Threshold	Method of Measurement	Consequence of breach
Domain 4: Ensuring that people have a positive experience of care			
1. 95% of retrievals undertaken within agreed scope of care undertaken by the PCC transport team	95%	Local audit data PICANet submission to validate local audit data	Non compliance with contract General Conditions 8 & 9
2. Transfer team departs from the transport base within 30 minutes of the clinical decision to accept the patient	To be agreed with service provider	Local audit data PICANet submission	Non compliance with contract General Conditions 8 & 9
3. The PCC Transport Service arrives at the local referring centre within three hours of the decision to retrieve the child (decision response time)	To be agreed with service provider	Local audit data PICANet submission	Non compliance with contract General Conditions 8 & 9
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Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm			
1. 95% of retrievals undertaken within agreed scope of care undertaken by the PCC transport team	95%	Local audit data PICANet submission to validate local audit data	Non compliance with contract General Conditions 8 & 9

Quality Requirement	Threshold	Method of Measurement	Consequence of breach
2. Transfer team departs from the transport base within 30 minutes of the clinical decision to accept the patient	To be agreed with service provider	Local audit data PICANet submission	Non compliance with contract General Conditions 8 & 9
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