TERMS OF REFERENCE

TOGETHER
A HEALTHIER FUTURE

Reporting Group:	Pennine Lancashire A&E Delivery Board

1 March 2018

Item **253/18**

Purpose Information
Action
Monitoring

Title	**A&E Delivery Board Terms of Reference**
Author	Kevin McGee, Chief Executive / Chair

Summary: The PL AEDB Terms of Reference and membership list is to be reviewed by members of the A&E Delivery board on an annual basis.

Recommendations: PL AEDB members are requested to review and provided comment to the PL AEDB Terms of Reference and membership list.

Links

Related strategic aim and corporate objective

- Ensure that patients access safe, timely and clinically effective A&E services, reducing waiting times and delays and improving quality
- Resolve clinical, managerial and organisational issues which impact on the delivery of A&E services and make decisions to both recover A&E performance and ensure continuous improvement, utilising the evidence base and national policy requirements
- Improve interagency collaboration on A&E performance and develop the cultures, relationships and processes for sustainable improvement and accountability.

Version:	1.6
Date of Approval: by A&E Delivery Board	5 January 2017
Approved and signed off by SLF	18 January 2017 tbc
Date of Review	November 2018 or as otherwise determined by relevant structural organisational or policy changes

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Group:	Pennine Lancashire A&E Delivery Board

Responsible Person:	Pennine Lancashire A&E Delivery Board Chair
Version Number:	1.1.2016 (see para 4.11 amended)
Date Approved:	5 January 2017
Approval Group:	Pennine Lancashire Partnership Leaders' Forum and A&E Delivery Board
Purpose	The Pennine Lancashire (Local) A&E Delivery Board (The Board) is established in response to NHSE/ADASS/NHSI Letter 260716 which requires that System Resilience Groups (SRGs) should be transformed into Local A&E Delivery Boards. The letter sets out the scope, geography, leadership, accountability and responsibility arrangements and core responsibilities of Local A&E Delivery Boards which should be effected from 1 September 2016. The Board will focus on the Pennine Lancashire System's shared ownership of A&E delivery and its ability to consistently and sustainably meet the 95% standard; initially this will be about recovery of the A&E 4 hour standard. The Board will also work with the Lancashire & South Cumbria Sustainability, Transformation and Planning Groups (STP) on the longer term delivery of the Urgent and Emergency Care Review. The Board will: • Ensure that patients access safe, timely and clinically effective A&E services, reducing waiting times and delays and improving quality • Ensure that recovery and improvement plans are in place and that agreed priorities are being implemented, in accordance with evidence based practice and national requirements • Resolve clinical, managerial and organisational issues which impact on the delivery of A&E services and make decisions to both recover A&E performance and ensure continuous improvement, utilising the evidence base and national policy requirements • Improve interagency collaboration on A&E performance and develop the cultures, relationships and processes for sustainable improvement and accountability.

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1.0	Authority, Accountability and Governance
1.1	Authority: The Pennine Lancashire A&E Delivery Board will receive its authority from the Pennine Lancashire Partnership Leaders Forum.
1.2	Assurance: The Pennine Lancashire A&E Delivery Board provides assurance to the Pennine Lancashire system, NHS England and NHS Improvement that action is being taken system wide to support the delivery of the key performance measures connected to the Urgent and Emergency care (U&EC) system. The A&E Delivery Board will support delivery, manage risk, report progress and deploy improvement support aligning to the Urgent and Emergency Care Review and the Urgent and Emergency Care Delivery Plan.
1.3	Governance: The Pennine Lancashire A&E Delivery Board will report and update developments and decisions into the Pennine Lancashire Partnership Leaders Forum via the Chief Executive of East Lancashire Hospitals Trust presenting a Chair's Report. The Chair's Report will also be shared with member organisation's governing bodies. A Schematic is appended at **Annex A.**
1.4	Financial accountability: The Pennine Lancashire A&E Delivery Board will have oversight and delegated authority for the resilience budget which is within East Lancashire and Blackburn with Darwen CCGs baselines. The board will be responsible for managing resilience commitments within this financial envelope and making decisions to ensure that it employed to best effect with the intention of supporting system resilience.
1.5	Sub-Groups: In addition to the Pennine Lancashire A&E Delivery Group, The Board may set up Sub Groups as necessary, providing these are directly related to the purpose of The Board. Each group will be mandated in writing with a clear scope and deliverables to be achieved and the decision making powers which are delegated to achieve these. The reporting timescales to The Board will also be clearly established.
2.0	**Chair and Membership**
2.1	The Chair of The Board will be the Chief Executive of East Lancashire Hospitals Trust. The Co-Chair will be the Chief Officer, Lead Clinical Commissioning Group.
2.2	The membership of The Board is set out in national guidance and will comprise: • Senior Executive level staff representing member organisations • Local Authority executives • All Accountable Officers to ensure they are fully and regularly engaged with their Local Authority counterparts The Board will include as a minimum the Acute NHS Provider(s), NHS Commissioner(s), and Local Authorities with Social Care responsibility, Mental Health, Primary and Secondary/Community Care Providers. A list of agreed Board Members is appended at **Annex B**
2.3	The Board will have discretion to co-opt topic experts or otherwise invite their attendance to assist The Board in discharging their responsibilities
3..0	**Decision Making and Reporting Arrangements**

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3.1	The Board will have seniority of representation so that members may hold each other and constituent organisations to account, taking those operational and organisational decisions which are required to achieve the purpose stated above. • At the meeting, for those decisions which are within the scope of the delegated powers given to Accountable/Chief Officers and Senior Executives present. • As efficiently as possible following the meeting for those decisions which are outside the scope of individual officer powers. In this case the Officers will take responsibility for expediting the decision - making process within their own organisation.
3.2	Where it is anticipated that progress between meetings may require a decision to be made outwith the formal meeting of The Board, then there should be a clear record of the discussion to delegate this specific action and decision to the Chair. This and matters related, will normally be recorded formally at the next meeting.
3.3	Decisions taken by The Board which will impact on the Lancashire and South Cumbria Network as a whole will be communicated immediately to the Network for consideration and feedback and before implementation, where possible, to give sufficient time for impacts to be analysed and mitigations to be put in place.
3.4	Decisions taken by The Board which will impact on particular neighbouring partners will be discussed and considered with those partners.
3.5	The Board will work to ensure that the decision-making matrix will be refined collaboratively across the whole Lancashire and South Cumbria Network to ensure appropriate connectivity and impact analysis across the footprint.
3.6	The Board will consider establishing a formal scheme of delegation signed off by each statutory partner organisation which will enable The Board to make the necessary decisions considered outwith individual officer powers and without additional recourse to governing structures.
3.7	The Board will submit: • Performance reports to NHSE and NHSI as requested. • Quarterly Performance Reports to PL Partnership Leaders' Forum. • Reports of proceedings and performance to constituent statutory governing bodies in Pennine Lancashire.
3.8	The Board will receive: • Regular performance and assurance reports from the Pennine Lancashire A&E Delivery Group which will enable it to discharge its role effectively.
4.0	**Core Responsibilities**
4.1	The Board will lead A&E recovery across the system. There are 5 key areas for action 1. Streaming at the front door – to ambulatory and primary care 2. NHS 111 – Increasing the number of calls transferred for clinical advice

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	3. Ambulances – DoD and code review pilots; Health Education England (HEE) increasing workforce 4. Improved flow – 'must do's that each Trust should implement to enhance patient flow **5.** Discharge – mandating 'Discharge to Assess' and 'trusted assessor' type models
4.2	The Board will ensure plans for winter resilience and other key periods where specific planning for the system will be required.
4.3	The Board will ensure effective system wide surge and escalation processes and plans are in place.
4.4	The Board will support whole system planning, including all relevant partner agencies.
4.5	The Board will oversee system performance of all key service areas that impact on A&E delivery including areas such as local ambulance services, 111 and the care system.
4.6	The Board will be able to make recommendations for deployment or re-alignment of system funding to support improvement in delivery of the A&E standard which will accord with a formally agreed scheme of delegation.
4.7	The Board will agree and monitor a key set of system metrics in relation to A&E performance which would inform mitigating actions and future planning.
4.8	The Board will establish and monitor an A&E System Risk Register.
4.9	Working within the STP footprints (& UEC Networks) The Board will deliver the UEC Strategy in Pennine Lancashire with focus being given to • Expanded access to primary care • Creating an out of hospital hub which combines NHS111and Out of Hours Services • Delivery of the 4 key clinical standards for 7 day services in acute care 1. Time to consultant review 2. Access to diagnostics 3. Consultant-directed interventions 4. On-going review
4.10	The Board will support Vanguard and New Care Models (where applicable).
4.11	The Board will be responsible for monitoring and will have a significant role in helping to implement Better Care Fund (BCF) Plans particularly in aligning the discharge elements of A&E improvement and BCF Delayed Transfers of Care (DToC) Plans.
4.12	An outline Work programme is set out in and appended at **Annex C.**
5.0	**Quoracy and Substitution**
5.1	The Board will be quorate when a minimum of five (5) of the constituent statutory organisations are present. When a member nominated by organisations is unable to attend, it will be their organisation's responsibility to nominate a deputy to attend in order to maintain quoracy.
6.0	**Conduct and Interest**
6.1	Members of The Board are expected to declare any interests if the matters being discussed rrelate to, or are likely to affect, an interest which members have recorded in their Declaration of Interest.
6.2	Members of The Board will advise the Chair if the issue being discussed is not one

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	defined as a disclosable interest, but affects them more, either positively or negatively, than other people to which it relates, or if they have a conflict of interest.
6.3	Members of The Board will act as role models to the rest of the system in their behaviours and communications, pursuing effective and constructive professional relationships and building partnerships.
6.4	Members of The Board will put the interests of the patients/ users and carers first and be prepared to challenge and change organisational or individual role restrictions where this is required to secure the greater benefit.
6.5	Members of The Board will work in accordance with their own professional / clinical Codes of Conduct and the Nolan Principles of Public Life: https://www.gov.uk/government/publications/the-7-principles-of-public-life - Selflessness - Integrity - Objectivity - Accountability - Openness - Honesty - Leadership
7.0	**Frequency of Meetings**
7.1	Meetings will be held monthly or as otherwise required. A Schedule of meetings is appended at **Annex D.**
7.2	The Chair may, at any time, convene extraordinary meetings to consider business which requires urgent attention or when required to manage significant risks.
8.0	**Access and Attendance**
8.1	Meetings will normally be closed.
8.2	Topic Experts, other CCG/local authority/provider organisations and representatives from other partner organisations may be invited to attend meetings to speak on specific matters.
8.3	Access to meetings for other professional colleagues will normally be at the discretion and with the permission of the Chair.
9.0	**Agenda and Minutes of Meetings**
9.1	The agenda and supporting papers will be circulated by email in advance of the meeting. Papers may not be tabled without the prior agreement of the Chair.
9.2	Minutes and an Action Tracker will be taken and circulated to members of the group for their review prior to their being submitted for approval at the next meeting.
10.0	**Review**
10.1	The Pennine Lancashire A&E Delivery Board will review its purpose, function, terms of reference and performance at least annually, and additionally at the discretion of the Chair or as otherwise determined by relevant structural organisational or policy changes.

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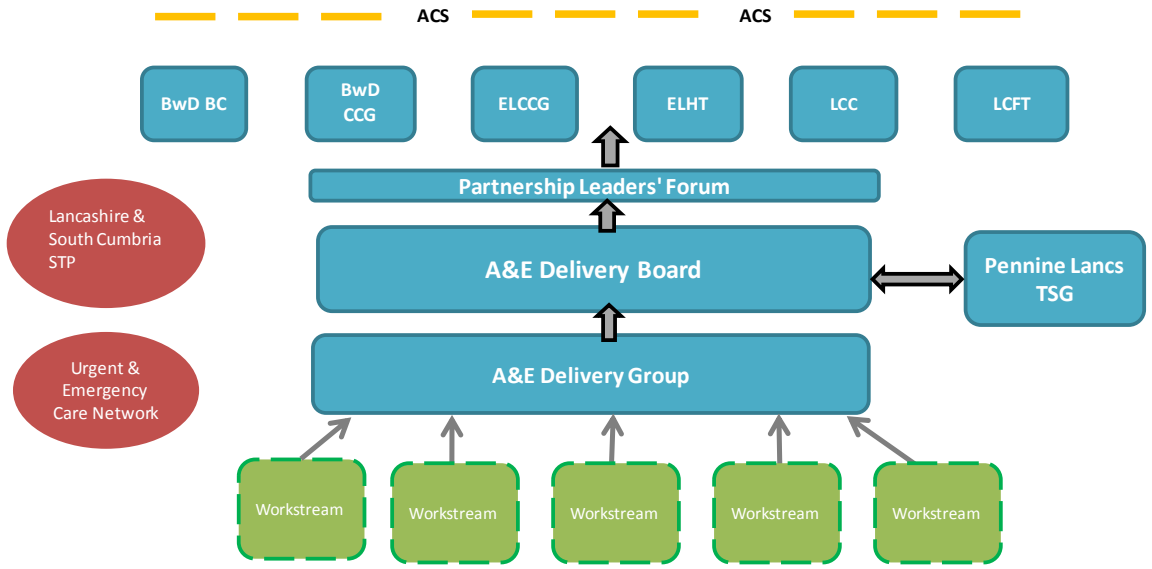
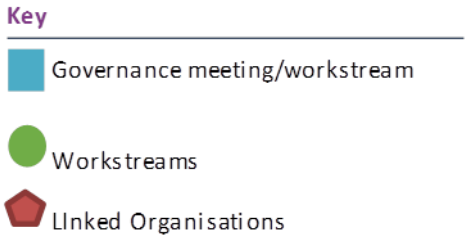
Reporting Group:	Pennine Lancashire A&E Delivery Board

Annex A: Governance Schematic





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Annex B Summary of Membership Confirmed at 1 February 2017			
Name	**Job Title**	**Organisation**	**Board Role**
Kevin McGee	Chief Executive	PL‡	Chair
Mark Youlton	Chief Officer	PL‡	Deputy Chair
Alex Walker	Programme Director for Urgent & Emergency Care	PL‡	System Leadership Key Initiative SRO
Angela Allen	VCFS Director	VCFS	VCFS System Leadership Representation
John Bannister	Director of Operations	ELHT‡	Acute Director Key Initiative SRO
Jonathan Wood	Director of Finance	PL‡	System Financial Assurance
Dr David White	Clinical GP Lead – Urgent Care	PL CCGs	Primary Care Clinical Lead
Mike Smith (NHSE) / Iain Cameron (NHSI)	Head of Assurance and Delivery Delivery and Improvement Lead	NHSE ‡ NHSI ‡	Regional leadership
Sue Lott	Head of Service, Social Care Services	LCC ‡	LA - LCC
Sharon Martin	Director of Performance & Delivery	ELCCG ‡	CCG lead
Louisa Swift	Deputy Head of Operations	LCFT ‡	MH and BwD Community Exec
Peter Mulcahy (Deputy – Ian Walmsley)	Head of Service	NWAS ‡	NWAS lead
Claire Jackson	Interim Director of Commissioning	BwDCCG ‡	CCG lead and Mental Health Commissioner Lead
Michael O'Connor	Business & Performance Manager	ELMS	Non –statutory provider , Out of hours services
Damian Riley	Medical Director	ELHT‡	Acute Clinical Lead
Sharon Rourke	Head of Urgent Care	FCMS	Non –statutory provider, Rossendale Minor Injuries Unit
Sayyed Osman	Head of Safeguarding and Specialist Services, Social Care	BWD LA ‡	LA – BwD Key Initiative SRO

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Annex C: Plan on a Page Work Programme September 2016 – March 2018	
1.	Leading A&E Recovery: To agree a whole system recovery plan which aligns the 5 A&E Improvement Interventions and then to monitor progress against them. A robust work plan (Pennine Lancashire A&E Delivery Board Plan on a Page) has been developed and focuses on the key areas for improvement set out in the NHSE/ADASS/NHSI Letter 260716. **1. Streaming at the front door – to ambulatory and primary care** • This will reduce waits and improve flow through emergency departments by allowing staff in the main department to focus on patients with more complex conditions. **2. NHS 111 – Increasing the number of calls transferred for clinical advice** • This will decrease call transfers to ambulance services and reduce A&E attendances. **3. Ambulances – DoD and code review pilots; Health Education England (HEE) increasing workforce** • This will help the system move towards the best model to enhance patient outcomes by ensuring all those who contact the ambulance service receive an appropriate and timely clinician and transport response. The aim is for a decrease in conveyance and an increase in 'hear and treat' and 'see and treat' to divert patients away from the ED. **4. Improved flow – 'must do's that each Trust should implement to enhance patient flow** • This will reduce inpatient bed occupancy, reduce length of stay, and implementation of the 'SAFER' bundle will facilitate clinicians working collaboratively in the best interests of patients. (SAFER bundle is a systematic process of supporting patient flow whilst in hospital through clearly defined goals in relation to discharge assessments) **5. Discharge – mandating 'Discharge to Assess' and 'trusted assessor' type models** • All systems moving to a 'Discharge to Assess' model will greatly reduce delays in discharging and points to home as the first port of call if clinically appropriate. This will require close working with local authorities on social care to ensure successful implementation for the whole health and care system. To identify funding related to A&E in the system and to recommend deployment or re-alignment of system funding which will support improvement in delivery of the A&E standard To agree and regularly monitor a key set of system metrics in relation to A&E performance which would inform mitigating actions and future planning To agree and monitor a local plan for managing surge and escalation which includes

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	seasonal resilience planning To monitor and maintain effective system risk register.
2.	To oversee the planning and local performance for local ambulance services, and 111 services and to monitor these to inform mitigating actions and future planning
3.	To work with the UEC Network to deliver the wider STP / UECN Plan with specific focus on expanded access to primary care; creating an out of hospital hub for 111 and OOH services; delivering on 4 key Seven day services hospital standards; supporting new care models and linking with BCF/DTOC
4.	To drive key evidence based practice in relation to A&E delivery and system enablers, including the following: • To maintain and improve working relationships between the key health and care partner organisations, embedding the duty of candour and patient centred professional practice • To identify the key roles and responsibilities between these partners including the key handoff and escalation responsibilities • To review and improve the processes between partners that support flow and capacity management, clarifying and consolidating each partner's responsible tasks • To implement evidence based practice and prioritise known accelerators of improvement, agreeing changes to practices which are not evidence based • To regularly review and be aware of patient and carer experience and outcomes in relation to A&E delivery and involve the end users in decisions about their care • To share and agree organisational practices, processes and resourcing plans to a level of detail and transparency required for constructive partnership working • To surface and address issues, obstacles and barriers which are causing delays and sub-optimal care outcomes, with expert mediation or advice where necessary • To agree the principles, standards and protocols that underpin the above and fully integrate these into providers' audit, training and practice development and commissioners' policies and strategies to reaffirm expected ways of working • To share progress and learning with the wider Lancashire and South Cumbria Network and identify areas where collaboration will leverage greater improvement (related to the effectiveness, range and scale of urgent and emergency care services and related workforce / estates as a whole across the system)
5.	To commission and receive reports and analyses of all areas which require scrutiny and improvement, these may include for example: Root Cause analysis of breaches and failures in quality of care.

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Annex D : Schedule of meetings	

Month	Date	Time	Venue
January 2018	4	9.30am – 11.30am	**Boardroom,** **Trust HQ,** **Royal Blackburn Hospital**
February	1		
March	1		
April	5		
May	3		
June	7		
July	5		
August	2		
September	6		
October	4		
November	1		
December	6		
January 2019	3		
February	7		
March	4		

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