Paper E

University Hospitals of Leicester NHS
NHS Trust

To:	**Trust Board**
From:	Catherine Griffiths, CEO, NHS LC& LCR & Suzanne Hinchliffe, COO, UHL
Date:	**7 April 2011**
CQC regulation:	

Title:	**LLR Urgent & Emergency Care System Improvement Programme**

Author/Responsible Director: Catherine Griffiths, Chief Executive Officer, NHS Leicester City & Leicestershire County and Rutland & Suzanne Hinchliffe, Chief Operating Officer, UHL

Purpose of the Report: To update the Board on the development of the Urgent & Emergency Care system improvement programme

The Report is provided to the Board for:

Decision		Discussion	X
Assurance		Endorsement	X

Summary / Key Points:

1. The Leicester, Leicestershire & Rutland Emergency Care Network has been developed to drive delivery of the Urgent Care vision for Leicester, Leicestershire and Rutland and includes continued delivery of the recommendations from the Emergency Care Intensive Support Team received in March 2010. It is chaired by the PCT cluster Chief Executive.
2. The formation of the Network arose as a continuation of the 'summit's' which were effective during December 2010 and January 2011 with Chief Executive Officer attendance across all sectors.
3. An LLR wide governance structure, delivery plan and reporting framework have been put into place to drive this programme to delivery with full support from all agencies across the sub-region, (see attached papers).
4. Through the Emergency Care Network, it is clear to each organisation that is involved in the delivery of the LLR Unscheduled care system that each has its part to play both individually and collaboratively to improve the experience and outcomes for the patients it serves.
5. The Emergency Care Network will oversee performance against each redesign workstream as well as current system performance against the whole system performance dashboard.

Recommendations:

The Board is asked to:

- Note the progress of the Urgent and emergency care work programme
- Support the delivery of the Urgent and emergency care work programme

Strategic Risk Register	**Performance KPIs year to date**

Paper E

Resource Implications (eg Financial, HR) HR – resource requirements for delivery are significant across the health and social care economy.
Assurance Implications
Patient and Public Involvement (PPI) Implications
Equality Impact None
Information exempt from Disclosure
Requirement for further review? Yes – Quarterly review

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **April 7th 2011**

REPORT BY: **Catherine Griffiths, Chief Executive, NHS Leicester City & Leicestershire County & Rutland**

SUBJECT: **Development of the Urgent & Emergency Care system improvement programme**

1.0 Introduction

1.1 The Urgent Care vision for Leicester, Leicestershire and Rutland (LLR) was developed by key stakeholders, and was articulated through the LLR Left-Shift Strategy, previously overseen by the LLR Acute Care Board.

1.2 Following a series of 'health summits' throughout winter 2010/11, the leaders of each organisation agreed to form an Emergency Care Network to oversee the system-wide changes required and to create a clearer governance structure with fewer prioritised workstreams.

2.0 Emergency Care Network: Progress update

2.1 The newly formed Emergency Care Network continues to deliver the underlying principles of the Left Shift Strategy, which include:

- Emergency and urgent care services will be well-publicised, easily accessible and well understood by patients and carers
- The local NHS will work with the public on patient expectations and the use of services. Consistent, high quality care and outcomes will be delivered to patients wherever and whenever they choose to access care
- The right services will be available to patients of all ages with urgent physical, mental or social needs, whether care is provided in a hospital or community setting. Specialist care for the seriously ill will be identified and available as soon as possible.
- Preventative, self-care and community based programmes will reduce the clinical requirement for urgent care
- Clinical teams will streamline and integrate services to reduce duplication and transfer between services

2.2 The purpose of the LLR Emergency Care Network is to ensure delivery of the Urgent Care vision for Leicester, Leicestershire and Rutland (LLR) and includes continued delivery of the recommendations from the Emergency Care Intensive Support Team received in March 2010.

2.3 A revised Programme has been put into place to drive the redesign work required to achieve this, with full support from all agencies across the sub-region. Achievements to date include:

- Formation of an Emergency Care Network, aligning to national best practice, and with a governance structure that allows both clinical and non-clinical change, (governance structure attached as Enclosure 1).

- A comprehensive performance management framework and a joint arena at which to hold each part of the system to account, (sample report attached as Enclosure 2)
- Ownership for planning, implementing and evaluating each ECIST recommendation, along with a monthly reporting framework, (overarching delivery plan attached as Enclosure 3).
- Formation of 2 sub groups, the 'Clinicians Delivering Change Group' and the 'Senior Operational Group' that will deliver measurable, outcome focused improvements to the system, (Summary terms of reference attached as Enclosure 4).
- Communication and engagement with key stakeholders, e.g. GP commissioning colleagues
- Alignment to other work streams across LLR, such as planned care, children's non-elective care and QIPP plans across organisations.

2.4 In addition to the successful formation of the Network, the associated sub groups have started to identify and progress plans to implement solutions to known areas of concern across the system:

- Clinicians Delivering Change Group:
  - Multi-agency agreement on the reconfiguration of the Paediatric model of care, including resource and staffing requirements, with a commitment towards mobilisation of this model.
  - Multi-agency agreement that the Urgent Care Centre and adult minors should be co-located with a central triage point, jointly staffed between Urgent Care Centre and UHL.
  - Specific range of Primary Care initiatives to manage demand earlier in the patient pathway, e.g. development of the red phone system, action plans for each practice following benchmarking of emergency care usage.
  - Identification of actions required for improvements to the Mental health pathway
- Senior Operational Group:
  - Multi–agency collaboration on the use of the reablement funding, with identified priority areas for spend.
  - Tendering process launched for increased intermediate care capacity for city patients.
  - Undertaken detailed analysis of data relating to reportable and non-reportable delayed discharges and transfers of care, which will inform specific areas of focus and action to reduce delays to discharge.
  - Continued implementation of the Elderly Frailty Unit and Frail Older Persons' Advice and Liaison Service

Further progress will be reported to the Board on a quarterly basis.

2.6 Through the Emergency Care Network, it is clear to each organisation that is involved in the delivery of the LLR Unscheduled care system that each has its part to play both individually and collaboratively to improve the experience and outcomes for the patients it serves.

3.0 Recommendations

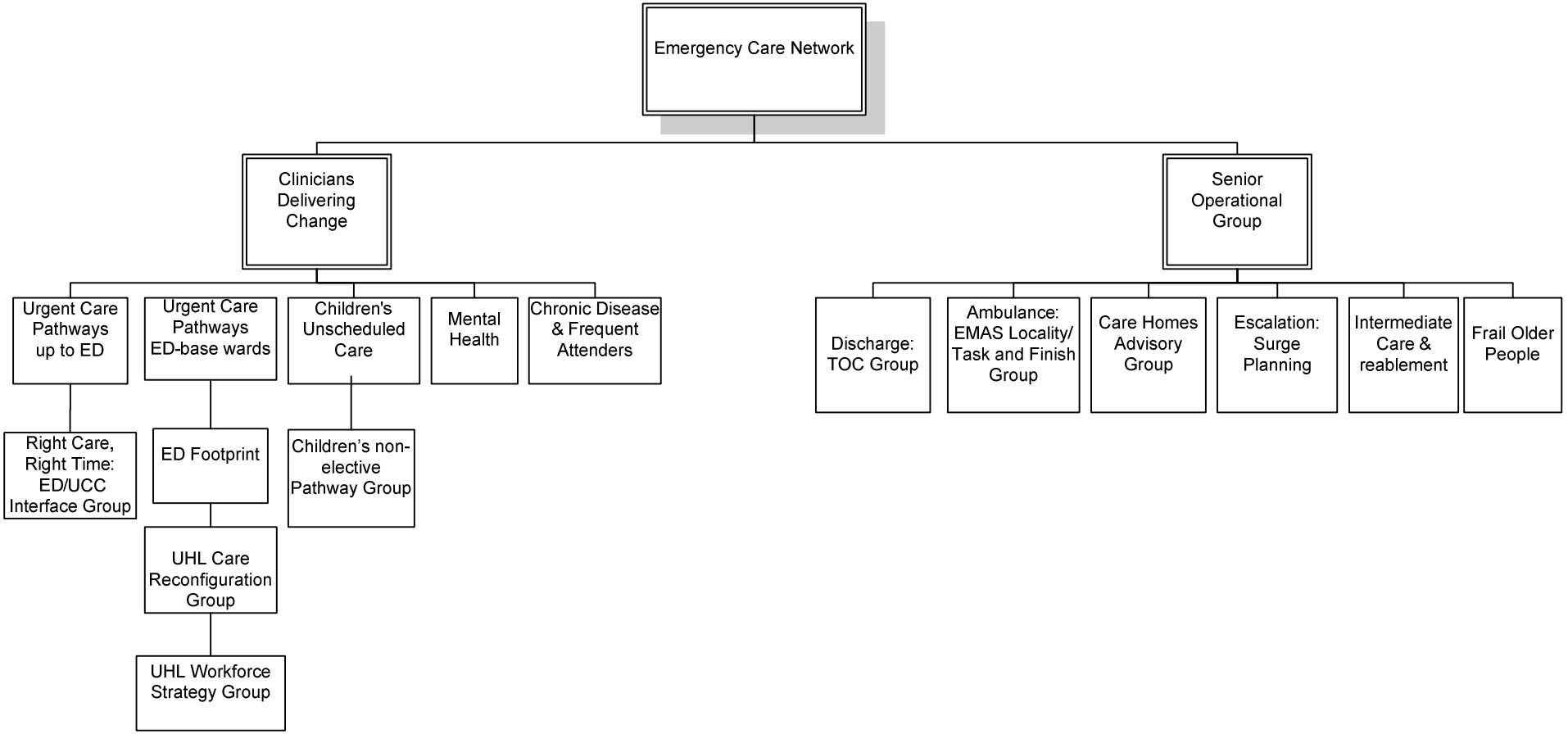
3.1 The Board is asked to:

- Note the progress of the Urgent and emergency care work programme
- Support the delivery of the Urgent and emergency care work programme

NHS
Leicester, Leicestershire and Rutland

Governance Structure

Brief: Produce a schematic outlining groups formed to deliver the work of the LLR Urgent care workstream



Enclosure 1

ENCLOSURE 2 - Characteristics of an effective Urgent Care System

Right Care, Right Time

▪No of community referrals via bed bureau

▪In hours ACS admission rate

▪Admissions to admission areas who are not suitable for an acute setting

• Patients admitted via bed bureau with a 0-1 day LOS

▪Total time spent in A&E Dept

▪Total attendance rate
- % avoidable attendances

▪Divert rate:
- Adult front door divert to UCC
- ED diverted

▪% time between 8am - 12 midnight within a year where a senior shop floor clinician is present within the ED

▪Time btn decision to admit to patient admitted to an appropriate bed less than < 30 mins
•Rebeds by reason

Children's Urgent Care

▪Avoidable attendance rate

▪Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19's

▪Divert rate:
- Front door divert
- ED diverted

▪Paediatric Conversion Rate

Mental Health Access

▪Response time to ED by Crisis Resolution < 4HRS

▪Waiting time from time of MH assessment to bed

▪ Time to prepare a social care package if somebody is not detained under the mental health act following an assessment

Improving Discharge

▪Emergency re-admissions within 30 days by source reason

▪% Discharge rate < noon

▪% Discharge rate for Weekend & bank holiday

▪Bed Occupancy rates < 85%

▪Occupancy bed days for patients who do not require an acute bed

▪% of patients who do not have an Expected Discharge Date (EDD)

▪% started within 48 hours on Reablement following initial referral

EMAS

▪All ambulance trusts to respond to 75% of Category A Calls within 8 minutes

▪All ambulance trusts to respond to 95% of Category A Calls within 19 minutes

▪Ambulance calls closed with telephone advice or managed without transport to A&E

▪Average clinical handover time

▪Reason for delayed clinical handover

▪Cat C conveyance rate

▪Bed bureau referred emergency admissions btn 8pm -8am bought in by ambulance

Chronic Disease

▪Unplanned hospitalisation for chronic ambulatory care sensitive conditions

▪No. of emergency admissions to hospital for people who have a long term condition

▪Patients with more than 3 attendances in 6 months

▪Patients with more than 3 admissions to an acute site in 6 months

Frail Elderly

▪Conversion rate for 85+

▪Total LOS for 85+ (acute plus comm step up/down/
▪inpatient reablement)

▪No. hospital admissions avoided by FOPALs as % of those referred

▪Frail Older People assessed by FOPALS within 24 hrs of admission

▪Readmission rates for 85+

▪% occupancy rates of Geriatric Assessment Clinics

▪% of patients who are fully independent following Reablement

Over arching outcome measures for 2011/12:

(1) 10 % reduction in adult and paediatric attendances to ED and UCC

(2) 5% reduction in adult and paediatric admissions to UHL

(3) 25% reduction in time taken for patient to receive appropriate intervention once in ED

(4) 20% reduction in patients occupying an acute bed when they no longer require acute intervention

(5) 10% reduction in emergency readmissions

GOVERNANCE					
Issue	**Actions**	**Lead**	**Outcome measure**	**Target finish date**	**Progress**
Establish governance framework for the urgent care workstream	▪ Establish ECN/SOG/CDC groups & ToR ▪ Agree priority actions for implementation and baseline associated performance	Catherine Griffiths, NHS LC/R Rachna Vyas, NHS LC/R	Programme governance mobilised	March 2011	Groups formed, priorities agreed with each sub group and Network
Redesign current dashboard with performance measures	▪ Generation of a useable performance framework to highlight areas of concern within the urgent care system	Hina Naik, NHS LC/R	Populated performance framework with target and baseline	April 2011	Indicators agreed, population of the framework in progress
CLINICIANS DELIVERING CHANGE (CDC) – reporting to Aly Rashid, Medical Director, NHS LC & LCR					
Issue	**Actions**	**Lead**	**Outcome measure**	**Target finish date**	**Progress**
ED-UCC Interface	▪ Review current minors deflection to UCC ▪ Create options for further deflection from ED majors to UCC/paeds to UCC/all minors to UCC ▪ Tie in with writing of the TCS UCC specification ▪ Shared clinical governance in place ▪ Embed Deflection Criterion between ED and UCC	Rachna Vyas, NHS LC Kim Wilding, Urgent Care Centre	10 % reduction in ED attendance 5% increase in ambulance conveyance rate to UCC 5% increase in timeliness of transfer from ED to GGH Increase number of minors deflected per day as % of all minors patients	**Pathway in place within 60 days: April 2011**	Deflection criteria reviewed and increased Specifications written, awaiting sign off Clinical governance agreed
EMAS-ED-UCC Interface	▪ Increasing ease of Ambulance access to Urgent Care Centre ▪ Evaluate and roll out North West Leics pilot (EMAS-GP liaison) ▪ Re-launch red phones ▪ Increase usage of SBAR tool to speed up handover to ED staff	Louise De Groot, EMAS Rachna Vyas, NHS LC	NW Leics pilot: Number of patients deflected to community Ease of access measure (to be defined) Evaluation of red phone system to inform re-launch across specialties/primary care	**NWL pilot live in 2 areas in 90 days: June 2011** Red phones: May 2011 SBAR tool: to be defined	NWL pilot launched Dec 10, roll out to Hinckley area by April 2011 Red phone audit underway
ED-UCC Interface (Children's)	▪ Create options for further deflection from paeds to UCC ▪ All paediatric admissions to be routed	Adrian Brooke Peter Rabey &	New model of care mobilised UCC/Paeds S/ Paeds E together	Dec 2011 – Some elements dependant on	Specification for service agreed by CDC group

	through the ED and senior paediatric decision makers to work across ED and SSPAU ▪ Tie in with writing of the TCS UCC specification ▪ Identify and mobilise Quick wins to increase diversions from ED to UCC	Ffion Davies, UHL Mel Thwaites NHS LC/R	10% increase in rate of paediatric diversion to UCC 5% reduction in paediatric emergency admissions (c. 2000 admissions)	footprint reconfiguration Quick wins implemented June 2011 Overall reconfiguration delivered by Dec 2011	Funding for new model sourced
Access to Primary Care	▪ Full implementation of David Carson recommendations ▪ Continued effort to manage demand, including: • Benchmarking of emergency care usage • Re launch of red phones • Service agreements for Nursing homes/care homes • Patient communication • Unregistered patient pilot	Nick Willmott (GP) to lead with representative from each commissioning consortia	10% decrease in avoidable ED attendance rate Sustained reduction in weighted emergency admission rate	Throughout 2011: **5% reduction in avoidable attendance rate in 90 days, June 2011**	All initiatives listed are live
Achieve 1 SPA for LLR/align with introduction of 111	• Integrate city and county SPA/bed bureau • Facilitate bed bureau pathway • Complete and validate eDoS • Roll out to SPA & associate clinicians	Teresa Smith, Community Services	Reduction in avoidable ED attendances Decrease % of 0-1 day admissions via Bed Bureau/GP referral (baseline work ongoing)	Single SPA Dec 2011 Community ACS pathways by July 2011	Scoping paper to Senior Ops grp in April, next steps to be agreed DoS Completed, validation required
Mental Health	▪ Multi agency group will formally review the acute care pathway: • Early intervention, • Admission preventions to an acute bed • Step down care after in patient stays ▪ Identification of actions required for	Mohamed Al-Uzri, Medical Director, LPT, reporting to CDC Colin Read, UHL	Increase in home treatments to nationals standards Response time to ED by CRT > 4 hours Reduction in time from MH assessment to bed	Core group – march 2011 Pathway mapping and action plans – June/July 2011 Comprehensive	A review of the pathway to be submitted to the Care Pathway Pbr meeting in June 2011 and also to the Interface Clinical Group. The

	improvements to the Mental health pathway ▪ Review of acute paediatric pathway	Trevor Friedman, LPT	(Baselining in progress)	acute care pathway in place – March 2012 **Quick wins implemented in 90 days by June 2011**	demand on acute beds will be addresses as part of this review Quick wins identified and presented to CDC in mid-April
Facilitate pathways of care for chronic disease patients	▪ Primary Care o Pathways for ambulatory care sensitive conditions, specific to UTI, cellulitus ▪ UHL – Chronic disease pathways for: o Headache o Chest pain	Nick Willmott (GP) to lead with representative from each commissioning consortia Helen Mather, UHL	5% Reduction in attendance and admission for specific ACS conditions from primary care 5% Reduction in admissions to base wards for specific ACS conditions by UHL 10% Reduction in 'in hours' ACS admissions	Community pathways: July 2011 Headache: July 2011 Chest pain: Aug 2011	Acute Urinary Retention and cellulitus pathway in place & being evaluated.
SENIOR OPERATIONAL GROUP (SOG) – reporting to Catherine Griffiths/Jo Yeaman, NHS LC & LCR					
Issue	**Actions**	**Lead**	**Outcome measure**	**Target finish date**	**Progress**
CHC	• Seek further routes to minimise delays in CHC system • Agree commissioning model for CHC linked to reablement model with social care	Barry Day, Interim Project Lead, NHS LC/R	Reduction in delays to assessment Reduction in placement time from point at which patient referred Overall measure: 10% reduction in Occupancy bed days for patients who do not require an acute bed, (Baselining in progress)	Dec 2011	
Care homes	• Review of current work in progress o Contracting o Quality of care • Confirm priorities relating to: o Discharge o Admission o Underlying quality of care o Roll out of County GP model	Caroline Trevithick, NHS LC/R	Reduction in emergency admissions from Care homes Reduction in conveyances to ED via EMAS (Baselining in progress)	Throughout 2011 – stretch targets & trajectory to be provided once group is re-formed	Handover to new project lead complete Review membership of advisory group Scoping event

	to city homes				planned
Discharge process – Internal UHL	Improvement actions: • Implement and monitor Estimated Date of Discharge (EDD) • Senior clinician review where required • Review TTO process and implement ward based pharmacist model • Review utilisation of discharge lounge, • Timeliness of daily discharges	Suzanne Hinchliffe/ Helen Mather, UHL	Increase rate of discharge by midday to 30% within 90 days 98% patients have an EDD 10% decrease in emergency readmission rate Increase in usage of utilisation lounge Ward linked pharmacist in place	**Discharge before noon: 90 days – June 2011** **Discharge lounge usage up by June 2011** **Readmission rate – declining trajectory to be defined**	
Discharge process – Health & social care community	• Minimise delays in transfers to CHS beds in City & County • Once delays related to e are minimised consider support from CHS for discharge directly within UHL • Bring forward transfer times to CHS beds to avoid re-bedding • Earlier interface with social care • Review discharge software	Jo Yeaman, NHS LC/R		**Discharge before noon: 90 days – June 2011** **Review of software complete within 90 days**	Resource identified to progress project Agreement of Top 5 reasons for delay to be tackled
Optimise delivery of EMAS 999 services	• Alternative pathway for conveyance to UCC/8-8/WiC for Cat c minors calls • EMAS-medical interface, inc Northants model/red phones/care homes pathway	Louise De Groot, EMAS Rachna Vyas, NHS LC/R	5% Increase in conveyance rates to community services	**Protocols in use in 30 days: April 2011**	Criteria for deflection in place, actions to embed these in progress

Optimise delivery of EMAS Patient Transport Service	• Agree contract
	• Specific actions in partnership with UHL/CHS to improve patient flow:
	  • Process in place to ensure eligibility criteria is rigorously adhered too
	  • Process in place to notify EMAS of bariatric patients requiring PTS on admission
	  • Improved communication with social care colleagues
	  • Review access to booking system
		EMPACT
		
		Mark Sheppard, UHL
		
		Michael Byrne, EMAS
			Abort/cancellation <25% per day
			
			Rebeds reduced to nil (declining trajectory to be defined)
			
			UHL/EMAS 90 day target: Reduce to < 5 rebeds a week
				(Throughout 2011)
				
				Interim rebed target: 90 days – June 2011
					Communications between EMAS-UHL in place
					
					Delay in contract is not allowing work to progress at the required speed

LLR Surge and resilience plan	• Resilience plan, including winter and flu, to be agreed across LLR • UHL bed Management policy to be re written in line with the restructuring of Divisions.	Rachna Vyas, NHS LC/R Helen Mather, UHL	Average bed occupancy rates at < 85% for UHL	**Plan ready for use within 30 days: April 2011**	Plan written and agreed across health community. Further work on 'triggers vs. actions' identified

Redesign the Pathway for Frail Older People	• Finalise PID with sign off from all stakeholders
	• Identify project resources
	• Identify current situation and key priority issues
	• Implement solutions
	  ○ Frail Older Person's Advice and Liaison Service (FOPAL) live
	  ○ Geriatrician outreach in community clinics
		Jo Yeaman, NHS LC/R
		
		Simon Conroy, UHL
			Reduction of 20% in admissions to base wards for those referred to the FOPAL's or EFU	Live Dec 2010
				
				Clinic live within 30 days: April 2011
					Frail Older Person's Advice and Liaison Service (FOPAL) and Elderly Frailty Unit implemented in December 2010.
					
					Scheme for geriatric sub-acute clinics approved by commissioners

Develop an integrated vision for health and social care – Intermediate Care and Reablement	• Develop appropriate governance mechanisms • Develop a vision(s) (NB this could be by local authority area) • Develop plan for allocation of reablement monies • Deliver vision and plans	Jo Yeaman, NHS LC/R	Baselining in progress	Vision and strategy agreed by mid-may Strategy implemented by March 2012	Multi–agency collaboration on the use of the reablement funding, with identified priority areas for spend
Deliver increased capacity in intermediate care within the City, linking to above	• Identification of capacity needs and potential solutions • Fully costed options appraisal • Stakeholder engagement • Tendering, procurements and contracting with supplier appointed	Jo Yeaman, NHS LC/R	Increase in city intermediate care provision (inc repatriation of county beds) to 45-57 city based beds	Nov 2011	Tendering process launched for increase in city rehab capacity
UHL Internal Group					
Issue	**Actions**	**Lead**	**Outcome measure**	**Target finish date**	**Progress**
ED footprint	• Develop options for functionally increasing footprint	Suzanne Hinchliffe, UHL Kevin Harris, UHL Helen Mather, UHL	Successful reconfiguration of ground floor footprint; to include increased majors and resus capacity as well as an integrated front door for ED and the Urgent	Footprint sign off: End April 2011 **Business case: Within 30-60 days**	Footprint agreed in principle, subject to Board approval

			Care Centre	Tender process to follow	
UHL workforce, inc ED	• Advertise for 6 additional Consultants (over 2 phases if required) and Advanced Nurse Practitioner roles • Acute Care Physicians/Geriatricians to be integrated from existing Emergency Medical Unit and as part of the Frailty Unit • Multi Disciplinary Team including GPs, plus speciality integration to be part of the rostered workforce • ED Consultants to work 6.5 DCC and extended shifts (10 -1pm) with Consultant Of The Week covering EDU rounds as normalised working • Changing work pattern on AMU with consultants 6 -10 pm to be mainstreamed • Changing work patterns to be incorporated in job planning as consultant recruitment proceeds • Recruit ED consultants with special interest in acute medicine, paediatrics, geriatrics critical care and pre-hospital medicine to increase consultant numbers and increase market and reputational position of the ED • Decrease Band 2s and appoint generic HCA Band 3 and Physician Assistants Band 7, Advanced Practitioners • Mainstream consultant cover between 18.00hr - 22.00hrs on AMU Monday – Friday and additional SpR cover on CDU 18.00hrs – 22.00hrs • Expand physiotherapy and occupational therapy weekend working to full days • Conclude pilot of Primary Care Co-ordinators (PCC) weekend working to support discharge processes	Suzanne Hinchliffe, UHL Kevin Harris, UHL Helen Mather, UHL	Increase in the % time between 8-12 midnight within a year where a senior shop floor clinician is present within ED STAT introduced post appointments Staffing in ED in workshop plans Increase in deflected admissions via PCC (Baselining in progress) (Pending implementation of workforce model and subsequent recruitment)	▪ Recruitment process to be completed within 6 months for 2 rounds of ED Consultants ▪ April 2011: Physicians Assistant ▪ April 2011: Advanced Practitioner ▪ September: 2011: MDT ▪ AMU work patterns: Feb 2011 (dependant on appointment) ▪ July 2011: HCA's ▪ Consultant cover: on appointment ▪ **OT & physio expansion: within 90 days, June 2011** ▪ **Primary Care Co-ordinators (PCC) 7 day working: within 30 days, April 2011**	Geriatricians in post from March 2011 Agreement with LCRCHS/LPT that Primary Care Coordinators are expected to commence 7 day working from April 2011. All other recruitment underway

UHL process (inc ED)	• Implement Emergency Frailty Unit (currently operating in shadow form subject to recruitment outputs) • Transfer EMU and Neurology to LRI as part of implementation of 2-site take • Internal Professional Standards agreed, introduced & monitored • Review and audit internal professional standards for diagnostics and imaging • STAT in place as per ECIST recommendation • Specialist response 'pull' standard in place • Implement rapid assessment and treatment (RAT) or See Treat and Review/Refer (STARR) in the majors area	Suzanne Hinchliffe, UHL Kevin Harris, UHL Helen Mather, UHL	Transfer of EMU and Neurology achieved Internal professional standards introduced (Pending implementation of workforce model and subsequent recruitment) As above	Completed Feb 2011 **IPS Audit due within 90 days in June 2011** **ED process audit due within 60 days May 2011**	Neurology move actioned Dec 2010 Commenced appointments to geriatrician posts Internal professional standards circulated across specialties

Notes:

- Those areas where there are no target figures against the outcome measures, baseline data will inform population of these in the coming months.
- Each workstream will report monthly to either the Senior Operational Group or the Clinicians Delivering Change Group and overall performance management of this plan will sit with the Emergency Care Network.
- This plan is intended to be fluid and will be updated as workstreams progress.

ENCLOSURE 4

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **April 7th 2011**

REPORT BY: **Catherine Griffiths, Chief Executive, NHS Leicester City & Leicestershire County & Rutland**

SUBJECT: **Urgent and Emergency Care work programme: Summary terms of reference**

1.0 LLR Urgent and Emergency Care Vision

1.1 The Urgent Care vision for Leicester, Leicestershire and Rutland (LLR) was developed by key stakeholders, and was articulated through the LLR Left-Shift Strategy and overseen by the Acute Care Board.

- Emergency and urgent care services will be well-publicised, easily accessible and well understood by patients and carers
- The local NHS will work with the public on patient expectations and the use of services. Consistent, high quality care and outcomes will be delivered to patients wherever and whenever they choose to access care
- The right services will be available to patients of all ages with urgent physical, mental or social needs, whether care is provided in a hospital or community setting. Specialist care for the seriously ill will be identified and available as soon as possible.
- Preventative, self-care and community based programmes will reduce the clinical requirement for urgent care
- Clinical teams will streamline and integrate services to reduce duplication and transfer between services

1.2 These will now be delivered through the Emergency Care Network and associate delivery sub-groups below.

2.0 Emergency Care Network

2.1 Scope and Purpose of the Network

- To clarify and communicate the strategic intent for commissioning emergency care;
- To identify what good quality services look like for the whole health community (including the agreement of performance metrics)
- To hold the whole system to account on safe and effective delivery of emergency flows
- To identify key areas for improvement and then deliver and measure the success of an agreed work programme

2.2 Roles and Responsibilities

Network members will be responsible for:

- Representing the views of their organisation and communicating within their own organisation about the work of the Network
- Deploying leadership and influencing skills to ensure that they are able to affect change, agreed by the Network, within their own organisation
- Securing agreement from within their own organisation to implement the agreed Network priorities and work programme

2.3 Reporting and Accountability

The Network will report, and be directly accountable to, the Boards of the various stakeholder agencies.

3.0 Clinicians Delivering Change group

3.1 Scope and Purpose of the group

The CDC will primarily be responsible for the development and delivery of clinical pathways in relation to:

- The principles of Right Care, Right Place, Right Time
- Children's Unscheduled Care
- Emergency access to mental health services
- Provision of ambulatory care - chronic disease and frequent attenders (COPD, Diabetes, CVD, etc)

Members of the CDC group will be selected by Aly Rashid as project lead with representatives from primary and secondary care. The secondary care group will meet first and, once established, will amalgamate with the primary care group and mental health representatives. There will be a NED from each of the PCTs and UHL on the group to keep it focused and for transparency.

3.2 Roles and Responsibilities

The group will:

- Support the development of high quality clinical pathways by facilitating negotiations between clinicians across both primary and secondary care, as well as those of partner organisations
- Facilitate the production of project specific plans, with clear objectives for delivery in 2011 within three months (giving monthly progress reports).

3.3 Reporting and Accountability

The CDC group will report, and be directly accountable to the LLR Emergency Care Network.

4.0 Senior Operational Group

4.1 Scope and Purpose of the group

The primary purpose of this LLR group is to ensure that specific recommendations from ECIST are implemented and performance managed

with the aim of achieving an integrated, high quality & resilient emergency care system.

4.2 Roles and Responsibilities

The Group will be responsible for delivering:

- Improved discharge process
- Improved ambulance turnaround times
- Whole system escalation plans
- Improved pathway for patients from care homes
- Improved pathway for frail elderly patients

Additionally, the group will be responsible for the performance management of the system components.

4.3 Reporting and Accountability

The SOG will report, and be directly accountable to the LLR Emergency Care Network.