NHS
Hillingdon
Clinical Commissioning Group

Hillingdon: Improving A&E Performance

1. Background

Performance in A&E departments across the country in recent months and difficulty in reaching the 95% target for all patients attending A&E to be seen in 4 hours has prompted NHS England to require all Local Area Teams (LATs) to start working on recovery and improvement plans for each local area. Plans are to be drawn up and signed off locally by the Urgent Care Board by 31st May 2013. NHS England advises that plans to improve current standards will be divided into three phases:

1. An urgent recovery programme with significant attention given by local and national commissioners and providers to all factors which can help recover standards (including clear performance management);
2. A medium-term approach to ensure delivery over the next winter period to include care system planning as well as a review of the levers and incentives in the system;
3. In the longer-term, the development of an urgent care strategy in order to deliver safe and sustainable services.

Phase 1 will focus on:

- Delivery of an agreed local plan to bring performance back on track by the end of Q1 2013/14 including a sustainability plan to ensure capacity and demand is aligned across 2013/14 so that the A&E 4 hour target is met in each quarter;
- Completion of the London assurance checklist;
- Preparation for working on the winter plan 2013/14 to be signed off by Area Team by November 2013;
- Evidence that best practice from elsewhere is being implemented that does not stifle local innovation.

2. Introduction

This paper is in response to the guidance outlined above and has been drawn up by the Hillingdon Clinical Commissioning Group (HCCG) together with all key partners. A draft of the plan was shared at the Unscheduled Care Strategy Group on 16th May and has subsequently been

approved by the CCG, THH, CNWL and social care partners at the London Borough of Hillingdon. The final plan will be ratified by the Urgent Care Board at its next meeting on 27th June.

This paper includes details of:

1. An agreed local plan which should be read in conjunction with the London Assurance Checklist;
2. Specific actions to be taken by The Hillingdon Hospital (THH) to achieve the A&E 4 hour standard by end of Q1 and beyond;
3. Other steps to be taken;
4. Top 3 Priorities for Hillingdon;
5. Preparations for Winter Planning;
6. Local Urgent Care Board;
7. Local leadership.

3. The Hillingdon Recovery and Improvement Plan

Delivery of the A&E 4 hour Operational Standard (May 2013) suggests that recovery and improvement plans should be drawn up, using the various stages of the patient's journey through the emergency system as the framework[1]. The following table has been collated in collaboration with partners and represents future plans as well as schemes currently in place as part of ongoing service redesign to improve the patient pathway through urgent care. The completed London Assurance Checklist should be read in conjunction with information in this section.

Legend: Green status = schemes implemented, Amber status = schemes planned or in progress, Red status = no current plans. Where CQUINS are used as the mechanism to achieve the action, this is noted in the status box.

Stage A: Prior to A&E

Aspect of Care	Action	Lead(s)	Delivery Date	Status
Strengthening primary and community care for frail elderly patients	Integrated Care Programme (ICP) case management and risk stratification of >75s through a case management approach working with GPs, health, social services, acute and voluntary care partners.	Zac Arif, HCCG	June 2012	

[1] Key to Status column: Green – already in place, Amber – planned or in the planning phase, Red – no plans in place.

	Rapid Response Team in A&E as well as community and now recruiting a mental health nurse to manage older people with dementia (planned July 2013).	Gill Dickinson, CNWL	May 2012	
	In line with Libera evaluation, increase number of GPs referring directly into Rapid Response Team by involving primary care in the development of the protocols.	Reva Gudi, HCCG	September 2013	
	Assisted Discharge pilot for Falls, funded through Innovation Fund (ICP).	Claire Sheppard, THH Gill Dickinson, CNWL	April 2013	
	A&E support service provided by Age UK.	Sharon Trimby, Age UK	2009	
	Pilot in Emergency Assessment Unit at THH to enable timely supported discharge.	Joe Smyth, THH	April 2013	CQUIN
	Co-ordinate my Care (advanced care planning) launched in Hillingdon.	Esme Young, Hillingdon CCG	March 2012	
	Increased access, capacity and functionality in adult social care reablement team.	Belinda Norris, LBH	October 2012	
	Age UK Home from Hospital Scheme.	Sharon Trimby, Age UK	2009	
	24-hour crisis line to support known mental health service users experiencing crisis.	Cathy Phippard, CNWL	February 2013	
Use of community diversion schemes	Procurement of new model of care in GP-led Urgent Care Centre that will accommodate ~60% of all current A&E activity.	Helen Delaitre, HCCG	October 2013	
	Innovative Falls Project (F Word) provided by Age UK to compliment	Sharon Trimby, Age UK	Planned June/July 2013	

	assisted discharge falls pilot undertaken by acute provider.			
	Case management of diabetes, COPD and heart failure via ICP.	Zac Arif, Hillingdon CCG	June 2012	
	Age UK Community schemes i.e. befriending schemes, exercise classes , clubs and groups.	Sharon Trimby, Age UK	Various	
	Age UK GP Navigator Service to be funded via Innovation Fund (ICP).	Sharon Trimby, Age UK	Planned June/July 2013	
Strengthening GP Out of Hours services	Not commissioned directly by CCG but strong links with GP OOHs care provider who is also provider of 111 service. Recent communication with LMC regarding need to establish local User Group with GPs.	Helen Delaitre, HCCG	Ongoing discussions with LMC	
Use of virtual wards in the community	Not currently part of our community model, however this has been discussed with community providers and will link with the development of the Intermediate Care Strategy.	Joan Veysey, HCCG	No plans yet	
Support to care homes to avoid emergency referrals	ICP project providing dedicated care home liaison nurses helping staff manage patients with dementia and associated psychiatric problems.	Dr Alison Conway, CNWL	Planned June/July 2013	
	Regular training to care homes provided by all specialist nursing teams e.g. tissue viability, RRT, palliative care.	Gill Dickinson, CNWL	Rolling programme	
	District nurses provide nursing care services to patients in all residential homes and support frontline staff training needs.	Gill Dickinson, CNWL	Rolling programme	

	Medicines management scheme reviewing all care home medications including antipsychotic prescribing.	Unoma Okoli, HCCG	January 2013	
	Appropriate Care Pathway (ACP) with LAS so that Rapid Response Team is called where appropriate.	Gill Dickinson, CNWL Chris Miles, LAS	February 2012	
	Hotline for Care Homes and nursing home teams to call the GP OOHs service.	Faye Justice, Harmoni HS Limited	Ongoing	
	Telephone advice offered by A&E consultants to Care Home staff to help avoid admissions.	Noreen Rice, THH	Ongoing	
Reducing ambulance conveyance rates	Strong links with local LAS who attend Urgent Care Board, Capacity Planning Group and A&E Taskforce.	Chris Miles, LAS Helen Delaitre, HCCG	Ongoing	
	Review of local ACPs in place.	Helen Delaitre, HCCG	May 2013	
	LAS and 111 has access to CMC which reduces conveyances.	Esme Young, HCCG	March 2012	
Patient education on appropriate use of emergency services	Outreach project in Hayes and Harlington.	Diana Garanito, HCCG	March 2013	
	Project in schools and communities.	Diana Garanito, HCCG	April 2013	
	Patient and carer booklet being produced.	Diana Garanito, HCCG	Planned June/July 2013	
	“Get Ready for Winter” booklet distributed widely each winter.	Sharon Trimby, Age UK	Planned October 2013	
	Faith-based forum on Long Term Conditions.	Diana Garanito, HCCG	Planned July 2013	
	ESOL modules on health education and awareness.	Diana Garanito, HCCG	Planned July 2013	

	Paediatric care booklet.	Diana Garanito, HCCG	Planned July 2013 subject to funding)	
	Mother and Toddler Group	Diana Garanito, HCCG	Starting June 2013	
	Traveller awareness on minor ailment management and NHS awareness.	Diana Garanito, HCCG	July 2013	
	Behaviour Change Workshop for frequent users of urgent care services.	Diana Garanito, HCCG	June 2013	
	DVDs in various languages on use of NHS services.	Diana Garanito, HCCG	July 2013	
	Courses in 5 Children's Centres on First Aid management of minor conditions at home.	Diana Garanito, HCCG	June 2013	
	Workplace based awareness of use of A&E Services, particularly Heathrow Airport – impact of shift working patterns.	Diana Garanito, HCCG	October 2013	
Roll-out arrangements for NHS 111	Hillingdon 111 launched.	Helen Delaitre, HCCG	March 2012	

Stage B: Patient journey through the Hospital system

Aspect of Care	Action	Lead(s)	Delivery Date	Status
Prompt booking of patients to reduce ambulance turnaround delays	Medically expected patients are transferred directly to the EAU to prevent delays.	Noreen Rice, THH	October 2012	
	95% compliance with 30 minute wait and 100% compliance with 60 minute wait – evidence file has further details.	Noreen Rice, THH	Ongoing	
	Expansion of ambulatory care pathways to create capacity in ED. Implementation is resource	Claire Sheppard, THH	July 2013	

	dependent.			
	HCCG has responded to Ann Radmore's (LAS) invitation to review transformation plans for the service and discuss local health economy plans for urgent care over next 5 years.	Ian Goodman, HCCG	August 2013	
Full see-and-treat in place for minors	Additional ENP/Doctor rostered to minors for late shift 1800 – 0200.	Noreen Rice, THH Claire Sheppard, THH	May 2013	
Prompt initial senior clinical assessment within A&E and rapid referral if admission is needed	Scoping of RAT has been undertaken and identified to run 24/7 as part of 2013/14 CQUIN. Physical layout of A&E hampers delivery, but THH workaround mobile RAT process will be developed.	Noreen Rice, THH Claire Sheppard, THH	Phased implementation expected between June and October 2013	CQUIN
Prompt initiation of blood and radiological tests with rapid delivery of test result	Fully integrated electronic pathology ordering and reporting system now operational.	Kay Sandhu (THH)	In place	
Prompt access to specialist medical opinion	THH has recently agreed ten rules for improving the emergency access pathway which is being monitored weekly by the Clinical Site Practitioners.	Mark Edwards, THH	In place	
Full use of computer-aided patient tracking and system for progress-chasing	Current IT system is limited and unable to provide tracking required. Scope new IT system and develop business case.	Joe Smyth, THH	By September 2013	
	PAS+ to be rolled out to all inpatient areas.	Newton Europe	Roll out planned July - September 2013	
Regular seven-day analysis should be in place for rapid identification and release of bottlenecks	Emergency Services Manager, ADO of Operations and Head of Clinical Site Services review each weeks' performance at Friday Capacity Meetings.	Claire Sheppard, THH Noreen Rice, THH	Ongoing	

	Director of Operations/Deputy meets night shift co-ordinator each day to identify bottlenecks overnight. Reports are shared with all operational management teams and executive directors.	Joe Smyth, THH	Ongoing	
	Process mapping underway – report due June 2013.	Claire Sheppard, THH	June 2013	
	Ten rules for improving emergency care pathways will be expanded to reflect other parts of the system i.e. onward referral and discharge.	Joe Smyth, THH Helen Delaitre, HCCG	October 2013	
Bed base management	Breaches due to bed availability are low (~3%) but roll out of PAS+ will provide real time bed management information and support flows.	Newton Europe	Roll out planned July – September 2013	
Daily consultant ward rounds	Consultant ward rounds as follows: Gynae – 4/7 days Obs – 7/7 days Surgery 7/7 days Medicine EAU twice a day/7 days.	Joe Smyth, THH	Ongoing	
	This is a CQUIN for 2013/14 and therefore gap in provision assessed for each specialty, scope additional resources required to achieve 12 hr consultant review for all specialties.	Joe Smyth, THH	June 2013	CQUIN
	Review of capacity of the health and social care economy to adapt to 7 day working as part of longer term primary care transformation to be undertaken by Intermediate Care Committee.	Reva Gudi (HCCG)	March 2014	
Provision of specific services for patients groups such as those	24/7 Adult psychiatric liaison service provides assessment	Shaun Hare, CNWL	September 2013	

with mental health problems – see checklist for more details.	within 1 hour in A&E and within 24 hours for ward-based patients. This service is currently a pilot until September 2013.			
	ACE Team currently providing multi-disciplinary assessment and rapid turnaround for frail care of the elderly. This pilot will inform the Early Supported Discharge model to be implemented by THH as a CQUIN in 2013/14.	COTE Team, THH	Pilot – delivery of ESD planned for Q3 2013/14	CQUIN
	Access to CAMHS on call and inpatient beds available to A&E via the CAMHS on call pathway.	Javina Seghal, BEHH	Ongoing	
	Provision of additional training to UCC and A&E staff on the identification and assessment of patients with mental health and substance misuse problems.	Shaun Hare	July 2013	

Stage C: Discharge and Out of Hospital Care

Aspect of Care	Action	Lead	Delivery Date	Status
Designation of expected date of discharge (EDD) on admission	Proposed KPI within CQUIN on ESD with THH.	Reva Gudi, HCCG	May 2013	CQUIN
	All emergency admitted patients in EAU to have EDD documented.	Laura Beck, THH	July 2013	
	PAS+ and electronic whiteboards are being implemented which allow local monitoring on wards and centrally by clinical site practitioners for use of EDD.	Laura Beck, THH	Implemented by end July 2013	
Maximisation of morning and weekend discharges	Trust internal ward standards being rolled out which include a target for all wards to aim to discharge by	Laura Beck, THH	Completion by July 2013	

	11am. Standards also include daily board rounds with nursing, OT and physio to encourage action planning for early discharge.			
	Consultant ward round standards are being implemented through the use of standard labels to be documented in patient notes, which will support discharge decisions when the consultant is not available.	Laura Beck, THH	Completion by July 2013	
	Review access to community care services and packages of care during the weekend period.	Joan Veysey, HCCG	September 2013	
Full use of discharge lounges	Discharge lounge poorly used due to location. Alternative location for Discharge Lounge being scoped.	Bridget Shek, THH	Report due end of May 2013	
Minimisation of outliers	There is a focus on early discharge via ACE (Acute Care of the Elderly) and assisted discharge (ICP) projects to facilitate more effective bed management and placement of patients on the correct specialty ward.	Laura Beck, THH	ACE review of pilot due June 2013 ICP Assisted Discharge ongoing	
	Increase the ambulatory care pathways and the size of EAU to minimise need to transfer to specialty wards. ACE Team working with RRT to keep patients on EAU and discharge within 2 days where appropriate.	Laura Beck, THH	Business case re: additional MAU consultant, Band 6 nurse and medical secretary required.	
Delayed transfers of care reduced	Social workers based in THH.	Belinda Norris, LBH	April 2013	
	Review of Section 2's and Section 5's underway.	Kate Kelly-Talbot, LBH Bridget Shek, THH	By September 2013	
	Review joint-working policy.	Kate Kelly-Talbot, LBH	By September 2013	

		Bridget Shek, THH Gill Dickinson, CNWL		
	Newton Europe: operational improvement specialists working with THH and LBH to improve processes.	Newton Europe	By September 2013	
	Improve pathways to alternative care settings including short term social care assessment beds and patients home.	Jane Walsh, HCCG	Ongoing	
Flexing of community service capacity to accept discharges	Fast-track transfer from THH to Northwood and Pinner Community Unit developed.	Gill Dickinson	November 2012	
	Relocate NWPCU to THH site as new layout offers greater flexibility for improved bed occupancy rates.	Gill Dickinson	October 2013	
	Spot purchase of community dementia beds.	Belinda Norris	February 2013	
	Review community bed provision and access criteria.	Jane Walsh, HGGC Hari Pillai, LBH	By September 2013	
Review of continuing care processes	Local review of continuing care includes working with acute trusts to ensure they have effective processes in place linked to hospital discharge, improving the quality and timeliness of continuing care assessments.	Nicola Bradley, HCCG	Ongoing	
Assessment of use of reablement funding by local authorities	Meeting of Project Team every 6 weeks to review use of S256 funding. Monthly reports to Recovery Programme Board.	Joan Veysey, HCCG Moira Wilson, LBH	Ongoing	

4. Achieving the A&E 4 Hour Standard in Hillingdon

THH achieved the A&E 4 hour standard for each quarter in 2012/13 and there are no pre-existing actions agreed with relevant sector regulators i.e. NTDA or Monitor.

The following acute contract KPIs support achievement of the A&E Recovery and Improvement Plan and are monitored with, support from our CSU, through routine contract monitoring meetings which report monthly to the Quality Clinical Risk and Safety Committee and the Governing Body.

LAS arrival to patient handover within 15mins - performance reported using HAS data
LAS arrival to patient handover within 30mins - performance reported using HAS data
HAS data completeness
Number of LAS arrival to handover greater than 30mins
LAS arrival to handover greater than 60mins
Patient experience in A&E

Quarter 1 Performance (April – June 2013)

In order to meet the A&E 4 hour operational standard, THH will have to achieve a daily breach position of 11 or less for each remaining day in Q1.

According to THH, bottlenecks have been identified as occurring in the early and late part of the evening with an increase in batching of patients attending the ED. Although data available to the HCCG until March 2013 does not substantiate this, overall hospital activity including data for April 2013 may show a different picture.

Overall the acuity of patients is on the rise demonstrated by a 5.8% increase in ambulance conveyances in Q3 and Q4 compared with Q1 and Q2 for 2012/13. In addition, care of the elderly attendances have been rising since 2009/10 with an 18% increase in the over 75s. This patient cohort presents with multiple comorbidities, requiring more complex investigations and a high conversion rate to admission. During 2012/13, there has been an increase in care of the elderly admissions of 23% compared to 2010/11.

An analysis of causes of increased activity is currently being carried out at North West London Hospitals Trust by Derek Bell. Hillingdon CCG commissioners will participate in this process in order to share learning on how the analysis is carried out with THH with a view to replicating this process if it is effective.

Allocation of winter funds in Q4 2012/13 allowed THH to address the bottlenecks and improve internal processes by allocating an additional emergency nurse practitioner on a late shift to manage the minors workstream, additional middle grade and phlebotomy input between 1800 and 0200. Other staff were also allocated across the Trust, particularly in EAU to meet demand in Q4.

To ensure performance in Q1 2013/14, THH has continued with an additional ENP, an additional staff nurse to allow the most senior nurse to manage the floor, additional phlebotomy staff and an additional staff grade doctor for the night shift. The additional staff are being deployed at a cost pressure which is not sustainable in the medium to long term. These posts are in place until end Quarter 1. HCCG has indicated to THH that the ENP will need to be maintained until the RAT in A&E comes on stream. THH has also agreed 10 Rules for Improving the Emergency Access Pathway (see appendix).

The expectation is that the Q1 2013/14 All Type 4 hour target will be achieved with additional staff in place to manage periods of peak attendance.

Quarter 2 Performance

To continue to provide assurance of the 4 hour target, THH will need to continue to fund additional staff to manage peaks in attendance and increased acuity of those patients presenting in ED. The RAT model of triage and assessment using CQUIN funding, will be implemented for all majors patients.

THH has also identified that the unrelenting pressure over the winter period has had a detrimental effect on team morale and their ability to continue with the unprecedented demands. The Trust has consulted industry experts who are prepared to support the department to rebuild cohesive relationships and work more effectively as a team. The Trust believes that good team morale is key to improving and maintaining

performance and is committed to securing funding to invest in equipping staff with the necessary skills to manage the stress associated with current activity.

THH has identified a number of actions that other health care partners could take to ensure that the significant pressure on emergency care is mitigated in part by:

1. LAS to have oversight of all ambulances (including private ambulances) to more effectively manage an even flow to each hospital. This has been raised with CSU;
2. Improved collaborative working across North West London to manage capacity. This has been raised with CSU.
3. Review of access to primary care services, following findings of a recent patient survey conducted in A&E (see appendix). HCCG will raise the need to review availability of routine/urgent GP appointments with NHS England Primary Care Contracting Team;
4. Enhancing GP Out of Hours provision (evening and weekends) when pressure on the department is at its greatest. New model of care for UCC will operate 24/7 which should alleviate pressure on ED over the 24 hour period;
5. NHS 111 capacity to be added to the CMS system. This has been raised as a suggestion with CSU and NHS England.
6. Improved provision of rapid response particularly to attend patients' homes at the request of LAS. Recent meeting with Hillingdon LAS to review Appropriate Care Pathway should improve diversion of patients away from ED to RRT.

Quarter 3 and Quarter 4 Performance

By the end of Q3, the UCC is anticipated to be managing 60% of ED activity, compared to 32% currently. Expansion of the ambulatory care pathways (resource dependant) will allow a greater number of patients to bypass the ED. Health economy wide winter planning, coordinated by the CSU and HCCG, will ensure a state of readiness for Winter 2013/14. It is anticipated that this will reduce the number of patients attending A&E. However, it should be noted that it will take time for these schemes to bed down and therefore demand may not reduce as expected. THH is therefore drawing up contingency plans to enhance staffing levels within the ED as part of its winter planning.

Predicted performance for A&E All Types:

Type	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4	Total
Breach	672	676	460	1808	617	562	580	1759	599	576	611	1786	578	527	599	1704	7057
Within	10974	11725	11663	34362	11737	10683	11026	33446	11381	10956	11610	33947	10992	10031	11395	32418	134173
Total	11646	12401	12123	36170	12354	11245	11606	35205	11980	11532	12221	35733	11570	10558	11994	34122	141230
Performance	94.23%	94.55%	96.21%	95.00%	95.01%	95.00%	95.00%	95.00%	95.00%	95.01%	95.00%	95.00%	95.00%	95.01%	95.01%	95.01%	95.00%

The trajectory above reflects national requirements however, THH recognises the need to achieve above this level consistently to assure delivery of the target for the year and internal plans reflect this.

The Urgent Care Board already been using an Urgent Care Dashboard to assess performance however, a new Knowledge and Information tool has been drafted using metrics suggested by the Kings' Fund[2] and the tool is attached in draft in the evidence folder. The CSU will be responsible for populating the dashboard on a monthly basis and submitting to the Urgent Care Board for review. Improvement actions at risk of non-delivery (and mitigating actions) will be highlighted in a risk log to be compiled and regularly reviewed by the Urgent Care Board. The THH Programme Management Office structure is appended which details project management arrangements supporting actions outlined in this plan.

5. Other Steps to be Taken

Although THH and Harmoni (the existing providers of the Urgent Care Centre) currently review all patient feedback, the HCCG and THH will undertake a deep-dive analysis of reasons why patients are attending both the UCC and A&E, their presenting condition and tracking of patients before/after they attend to identify patterns and reasons for service usage. This will be undertaken with the help of MSc students at Brunel University, supported by the Cumberland Initiative. Three students will be attached to THH for a period of six months (starting in June 2013) and the proposed workplan is that one student will review dementia pathways, one will undertake an audit on patients attending A&E and one will look at the use of inappropriate admissions which will include readmissions.

We are also in the process of triangulating HCCG plans in terms of the implications for THH Cost and Improvement Plans (CIPs). Price Waterhouse Coopers have been commissioned to check the alignment of all plans against *Shaping a Healthier Future* and Hillingdon CIPs and QIPPs . Phase 1 (triangulation of data) has been completed and Phase II (review of impact) is underway. Findings of this review are expected to be presented to the HCCG Board to THH Board meeting scheduled for the end of July. In advance of this report, THH has confirmed that CIP plans do not inhibit A&E performance and do support enhanced patient flows by increasing capacity in EAU and expanding the number of ambulatory care pathways. Any bed reductions will only occur if there is a corresponding reduction in length of stay.

HCCG and London Borough of Hillingdon have already established a project group to oversee the utilisation of S256 funding and this group meets regularly. Recent suggestions from the Urgent Care Board that this group will consider are how social workers can be attached to practices (in line with ICP) in order to improve co-ordinated care, multi-agency support to carers to avoid inappropriate hospital admissions and access to assessment and social care packages outside normal working hours.

The HCCG is already in it's second year of the Primary Care Initiative – a supportive programme offered to all Hillingdon GP practices to improve primary care services offered to Hillingdon patients and the Strategy and Transformation Team has already started working with the HCCG to develop a primary care strategy which will ensure that GPs and primary care teams are at the heart of providing high quality,

[2] Urgent and Emergency Care: a review for NHS South of England, Kings' Fund, March 2013

responsive services. One suggestion put forward to the Urgent Care Board is that the HCCG should review GP practice reception staff training and this will be explored as part of the current PCI programme.

In October 2012, the HCCG established a multi-agency group looking at frequent users of all urgent and emergency care services with the aim of identifying frequent users and agreeing multi-agency plans to manage individual patients. For information governance reasons, this group has not continued to meet but the HCCG will reinstate this meeting over the Summer 2013.

THH is close to Heathrow Airport where a number of detention centres are located. Although the Border Agency is responsible for providing primary care to detention centre residents, patients are frequently brought to THH with healthcare needs who have comorbid medical and mental health conditions. The HCCG is responsible for funding urgent care for these patients but due to its unique situation with regard to location of Heathrow airport within the CCG boundary, wishes to enter into a dialogue with the Border Agency and NHS England to review current arrangements.

Beds at THH, Northwood and Pinner Community Unit (NWPCU) and Franklin House were affected by Norovirus over the winter period. CNWL has prepared a report following the one prolonged outbreak at NWPCU which is included as evidence in the folder on section 3 of the checklist. Infection control plans which contribute towards efficient capacity management at THH are also included as evidence in the folder on section 2.

Hillingdon partners have worked together to prepare this Recovery and Improvement Plan for THH but note that over the winter period, all trusts within North West London have been under increasing pressure. With this in mind, the HCCG wishes to explore the possibility of North West London NHIR CLAHRC co-ordinating a sector-wide review of emergency activity with input from public health and LAS commissioners to understand the reasons for this increase in activity and identify why some trusts seem to perform better. Findings from this work will of course prove invaluable in informing plans for Winter 2013/14.

The HCCG adult safeguarding lead will also be working with BEHH over the summer to review the findings and recommendations made in the Francis Report. Three task and finish groups will be established looking at a) data and data management b) user involvement and intelligence and c) culture and leadership and the draft report taken to the Urgent Care and HCCG Governing Body Board in September. A briefing paper, following Francis, that was submitted to the NWL Cluster Board in March 2013, together with BEHH status against recommendations is included in the evidence folder.

6. Top Three Priorities for Hillingdon to Improve Performance

The health and social care economy has worked together to implement considerable improvements and identified all of the above workstreams and initiatives that will improve the flow of patients through the urgent care system in the future. However, using the three key stages of the patient journey, the top three priorities that would reap the most significant benefits for all partners are deemed to be:

- **Prior to A&E:** addressing variable access and uptake of primary care services;
- **Flow within the Hospital:** implementation of the Rapid Assessment and Triage (RAT) model and PAS+ at THH;
- **Discharge and Out of Hospital Care:** maximising potential for weekend discharges.

7. Preparation for Winter Planning

Hillingdon has had an established Capacity Planning Group in place for several years. The group meets monthly throughout the year and leads on collaborative working in preparation for Winter. The group Terms of Reference are appended.

At the meeting on 14th May 2013, the group reviewed and completed the template issued by North West London CSU in support of learning lessons from the previous Winter pressures period (2012/13). As well as reviewing local plans in terms of what went well, any gaps and priorities for 2013/14, the group identified a number of suggestions to be taken forward at CSU level. A copy of the Review of Winter Pressures Management Template is appended.

In addition to the CSU review, the Capacity Planning Group arranged a structured and facilitated Hillingdon-wide Winter Workshop held on 11th June 2013 which informed key priorities for this years' winter planning (the agenda for the workshop and initial findings are attached in the evidence folder). The timing of this workshop fitted with guidance on winter planning expected to be issued mid-July, with winter plans completed and submitted by mid-September. Plans to support delivery of services throughout the winter period, including prompt recovery post-Christmas will be completed in July 2013 and will feed into the assurance process that will be duly signed off by the Urgent Care Board before submission to NHS England.

THH met the 95% A&E 4 hour standard in 2012/13 but as indicated, lessons learned were considered in May and again at the Workshop in June. So that the whole health economy continues to monitor achievement of this standard, we will review our Capacity Planning Dashboard and adapt it so that it can be populated throughout the year. This means that between March and October, only partial information will be available (given Daily Winter Pressure Sit-Rep reporting is only in place between November and February). We will also reinstate the fortnightly operational A&E Taskforce meetings which normally take place during the winter months and have been held for a number of years so that they continue throughout the year. These meetings have in the past been well attended by members from all key organisations

involved in winter pressures and concentrate on operational issues to allow the Hillingdon health and social care economy to maintain performance. We anticipate that the A&E Taskforce meeting will review the Capacity Planning Dashboard on a regular basis. Where barriers to achieving performance arise that cannot be resolved by Taskforce members, these will be raised at the weekly A&E performance meetings we will hold with THH starting in July 2013. Any matters that remain unresolved will be taken to the Urgent Care Board for resolution.

Both THH and HCCG participate in the conference calls arranged for each Monday and Friday by the CSU throughout the Winter period. It is expected that mutual support arrangements to manage winter pressures during 2013/14 from and for neighbouring health economies will be co-ordinated by the CSU. In addition to this, Ceri Jacob, the HCCG Chief Operating Officer meets fortnightly with senior support managers and directors from across BEHH where issues around the delivery of A&E standards are discussed and informal discussions take place regularly between THH A&E Manager and peers across the sector. Information-sharing on plans pan-London are provided through regular attendance at London Improving Urgent Care Programme Board hosted by NHS England.

8. Local Urgent Care Board

Hillingdon has an Unscheduled Care Strategy Group which has been renamed the Hillingdon Urgent Care Board. At the last meeting on 16th May 2013, it was agreed the terms of reference would be redrafted in line with advice provided in *Delivery of the A&E 4 hour Operational Standard (*May 2013) and would be agreed at the next meeting of the Urgent Care Board on 27th June (see appendix for draft terms of reference). The meeting of the Urgent Care Board on 27th June will also provide final sign off to this plan.

9. Local Leadership

Leadership for Urgent Care in Hillingdon lies with the Hillingdon Clinical Commissioning Group. The clinical lead for Urgent Care is a GP who is also a member of the Governing Body and chairs the Urgent Care Board. Local commissioners have a key role in supporting and ensuring the delivery of high quality emergency services and need to ensure:

- They bring the system together and ensure good relationships and prevent fragmentation;
- They provide strategic oversight for the system;
- They have a clear focus on outcomes;
- They tackle the obstacles;
- They ensure that all the appropriate services are in place and they hold each provider to account for playing their part;
- They promote integration and close working between all partners but especially health and social care;

- They ensure providers, including primary care providers are given a strong leadership role in determining the best way to delivery high standards.

These strands are brought together with the HCCG Governing Body holding an oversight and scrutiny role, supported by the use of a capacity planning dashboard and the Knowledge and Information tool that tracks outcomes against actions within the A&E Recovery and Improvement Plan. Hillingdon developed such a tool during the winter of 2012/13 (an example can be found in the evidence folder "diagnostic demand and capacity plans"). Governance for the Urgent Care Board, is provided through the multi-agency Recovery Programme Board and is appended for information.

The THH Board receives a monthly report on A&E performance and related actions. Daily breach reports are circulated to all senior staff from the Chief Executive downwards. The Director of Operational Performance meets with clinical site practitioner staff at 0700hrs each day to review the previous night's performance, identify the bottlenecks and review any requirements for remedial action. The Emergency Care Services Manager and Assistant Director for Operations work closely with the hospital's information team to analyse attendance patterns and deploy staff accordingly. The Medical Director, Director of Operational Performance and Assistant Director of Operations for Emergency Care are all active members of the Urgent Care Board. THH uses a performance framework that includes clear lines of reporting upwards to Monitor but also sideways to the HCCG and where appropriate, the Health and Wellbeing Board.

The Urgent Care Board plans to oversee the development of the Hillingdon Urgent Care Strategy jointly with local partners and will map all existing and planned services and provide the local vision for improving capacity, patient experience and quality across the system, based on evidence of good practice.

Review of performance against nationally agreed A&E standards and targets will be undertaken by the Capacity Planning Group, the Urgent Care Board and the THH Clinical Quality Group.

HD/13.6.13

Appendices:

1. THH 10 Rules for Improving the Emergency Access Pathway;
2. Governance and accountability structure for Urgent Care Board;
3. Capacity Planning Group Terms of Reference.
4. NWL CSU Review of Winter Pressures Management 2012/13;
5. Draft Hillingdon Urgent Care Board Terms of Reference;
6. THH A&E Patient Survey Results;
7. THH PMO Structure.

Appendix 1

10 Rules for Improving the Emergency Access Pathway

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1. A Senior Doctor will be available to make a decision to admit or discharge new patients at, or close to, the time of arrival in the Emergency Department where appropriate, they will use the Rapid assessment and Triage process to make direct referrals to the on-call Medical Registrar or other specialty receiving Doctor.

2. All patients will have a first assessment by an ED Doctor, or Emergency Nurse Practitioner, within 90 minutes of the patient's arrival in ED.

3. Tests requested in ED will be completed and the results available to be reviewed within 60 minutes.

4. If admission is obvious, specialties will not insist on tests that do not contribute to the decision to admit or to the immediate management of the patient. Once a decision to admit is made, patients (if stable) will not be kept in ED for the purpose of further review or assessment.

5. Specialties will have arrangements in place to assess their accepted emergency admitted patients within 90 minutes of the patient's arrival in ED/EAU or within 90 minutes of referral from ED. If a specialty is delayed longer than 90 minutes the senior ED doctor will escalate this delay to the on-call Consultant for that specialty.

6. Junior Doctors in the Emergency Department requiring advice will initially seek that from one of the senior clinicians in the department that is a Consultant or Middle Grade. If it is further deemed that advice from a speciality Doctor is required the Junior Doctor will contact the relevant team.

7. It is expected that a Specialty Doctor will attend when requested to assess a patient in ED. Advice over the telephone or recommendations to transfer the patient to the Observation Ward overnight for further review on the following morning are not a substitute for attendance.

8. If it is subsequently felt that another specialty would provide more appropriate care it is the responsibility of the first specialty, not ED, to make the second referral and arrange safe transfer of care. Patient care and admission will not be delayed by inter-specialty dispute over clinical ownership. If necessary, ED Consultants will allocate clinical ownership to facilitate timely care and admission.

9. Patients will not be transferred from an out-patient area to ED unless the patient requires immediate emergency medical care. If admission is required this will be managed by the Site Nurse Practitioner team.

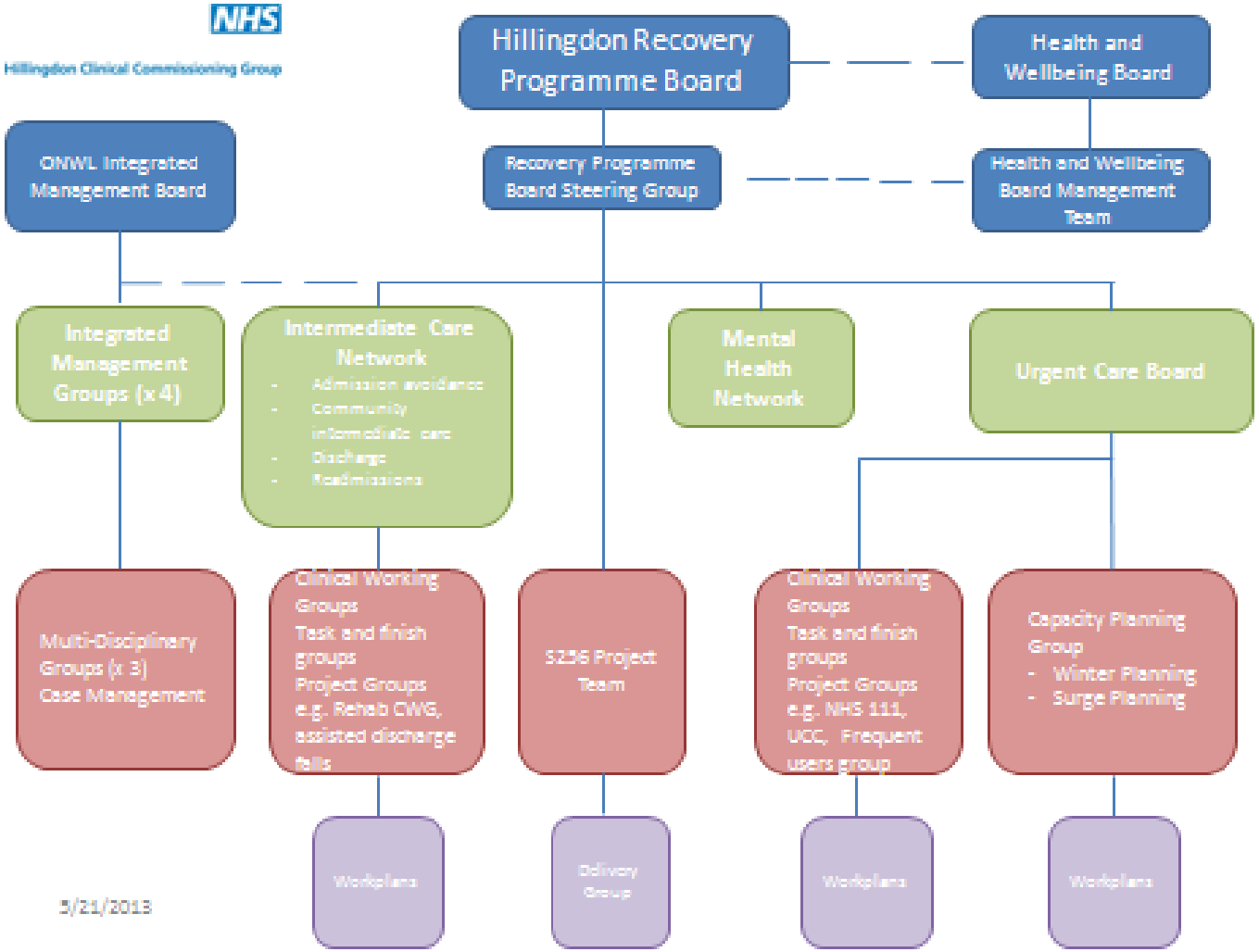
10. All medical staff are expected to follow these rules. If you encounter any difficulties with any of the Specialities, it is your duty to inform the duty Emergency Care Consultant.

12th March 2013 Dr Jas Johal

amended by Dr Abbas Khakoo 8th April 2013

Appendix 2

Governance and Accountability Structure for Hillingdon Urgent Care Board



Appendix 3

Hillingdon Capacity Planning Group Terms of Reference

1. The Hillingdon Capacity Planning Group

1.1 In recent years there has been increasing emphasis on the management of emergency pressures. The NHS and Social Care organisations are now required to plan not just for the winter period, but to engage in capacity planning for the entire year. A focus is, however, maintained on the pressures caused during the winter period, when it is recognised that demand for services is likely to be at its highest level.

1.2 Winter clearly has the potential to impact upon the full spectrum of health and social care services. The smooth handling of the challenges winter brings will be the result of coordinated approaches to planning and management by the NHS and social services, across local health economies. Winter pressures will need to be handled smoothly as part of the NHS' everyday business.

1.3 The NHS and its partners, especially social services, are used to planning for winter and have a proven track-record of successfully responding to additional demands at this time of year. Extra demands on services during winter impact upon all parts of the NHS including primary care, ambulance and acute hospital services, such as A&E, critical care and medical inpatient beds. A coordinated approach is therefore essential to ensure that preparation is robust and that processes are in place that can adapt to the different pressures as and when they arise.

1.4 A crucial element of the response will be local, integrated contingency arrangements to handle unforeseen circumstances.

1.5 Hillingdon has established a Hillingdon Capacity Planning Group to deliver a coordinated approach that ensures preparation is robust and that processes are in place that can adapt to the different pressures as and when they arise.

2. Objectives

2.1 To provide a strategic overview of service capacity in Hillingdon.

2.2 To provide a strategic overview of management of hospital admissions and discharges.

2.3 To ensure effective planning to secure continuity of services, and monitoring arrangements.

2.4 To work closely with partner agencies to ensure effective service and contingency planning.

2.5 To ensure that hospital throughput is maintained throughout the year, but with particular emphasis over the winter period and managing under pressure.

2.6 To produce jointly agreed Winter and other capacity plans as appropriate.

2.7 To inform reports required by the Hillingdon Clinical Commissioning Group and partner agencies.

2.8 To identify trends and develop monitoring mechanisms to inform strategic planning processes.

2.9 To convene and terminate sub groups as deemed appropriate.

2.10 To identify training needs to feed into development plans.

3. Membership

3.1 Membership of the group includes senior managers with operational responsibility from each of the following partner agencies:

- NHS Hillingdon Clinical Commissioning Group
- The Hillingdon Hospital NHS Foundation Trust
- London Borough of Hillingdon
  - Adult Social Care
  - Housing services
  - Public Health
- Central and North West London NHS Foundation Trust
  - Hillingdon Community Health
  - Mental health Services
- London Ambulance Service
- Healthwatch Hillingdon
- Age UK Hillingdon

3.2 Meeting will be chaired by a member from Healthwatch Hillingdon, Hillingdon Public Health, Hillingdon Hospital Team or Hillingdon CCG

3.3 The Hillingdon Capacity Planning Group is in contact with the following organisations in order to provide or seek relevant information and ensure other partners are appropriately involved:

- Independent Sector providers
- Hillingdon Local Medical Committee
- Hillingdon Local Dental Committee
- Hillingdon Local Pharmaceutical Committee
- Hillingdon Local Optometrists Committee
- Metropolitan Police
- Nursing and Residential Homes
- Voluntary Sector agencies
- BEHH Clinical Commissioning Groups Collaboration

4. Reporting

4.1 The Hillingdon Capacity Planning Group reports directly to the Hillingdon Urgent Care Board.
4.2 Individual members are responsible for reporting direct within their organisation.
4.3 Minutes of the meeting will be circulated to Chief Executive Officers of represented organisations or a nominated deputy.

5. Authority

5.1 The Hillingdon Capacity Planning Group has no authority to commit any funds, excepting when arrangements are devolved to the group formally by one or more constituent organisations.

6. Frequency of Meetings

6.1 Meetings will take place monthly however, the chair will review the need for each meeting in the context of current service pressures and decide whether the group should be convened.

7. Quoracy

7.1 The minimum attendance for meetings to be quorate is as follows:

- 1 x The Hillingdon Hospital NHS Foundation Trust
- 1 x Hillingdon Clinical Commissioning Group/ Hillingdon Public Health
- 1 x Hillingdon Social Services/Joint Commissioning Team
- 1 x Central and North West London NHS FT - Hillingdon Community Health
- 1 x Central and North West London NHS Trust – Mental Health Services
- 1 x Age UK/Healthwatch Hillingdon
-

7.2 It is particularly beneficial to have a member of the London Ambulance Service attending, but it is understood that it may not always be possible to field a representative.

These Terms of Reference will be reviewed in April 2014

Name of Organisation:	**Hillingdon Clinical Commissioning Group**

Note: this template was compiled by the Hillingdon Capacity Planning Group on behalf of all stakeholder organisations who provided services over the winter period 2012/13.

Planning and Assurance process:

Prior to the winter, organisations were required to supply evidence against a standard checklist, covering the essential areas of preparedness for winter.

Questions:

- To ensure that the NHS remains prepared for winter pressures, do you have any suggestions about how the assurance process could be improved?
- Is the balance of evidence required about right? Do other areas need to be considered? If so, please supply some suggestions, based on your own experience about what evidence should be required.
- Did the assurance process correctly identify the risks to service delivery for 2012-13?

Response:

The group agreed that there is a need and benefit to working collaboratively. The benefits that were identified include a whole-systems approach to eliminate duplication and promote seamless services and build upon the existing work that the Capacity Planning Group undertakes to ensure good working relationships between all local partners. This is especially meaningful if and when a service needs to use the escalation process.

The Capacity Planning Group has organised a local health and social care economy Winter Workshop that is taking place on 11th June where we will be using this template to identify priority areas for Winter 2013/14.

Effectiveness of plans to manage pressure surges and capacity challenges:

Reflections and learning on achievement of performance over the winter period 2012-13 and lessons learnt.

Please provide a summary of the analysis of pressures and capacity constraints for your organisation e.g. volumes of attendances, staffing shortages?

Questions:

- What worked well?
- What gaps were identified? Were there additional actions undertaken that were not in the original plans that you would want to repeat next winter?
- What key lessons have been identified and what subsequent actions will be taken when planning for next winter?
- Are there any suggestions you would like to make for learning that is applicable across the NWL health and social care system?

Response:

What worked well:

1. Development of Capacity Dashboard – although still in draft, we aim to improve this to include metrics suggested by King's Fund.
2. Rapid Response now working in A&E.
3. Gaps: An assurance process needs to be implemented for Adult Social Care Team to check that social care providers are able to supply seamless packages of care over extended bank holiday periods.
4. Key Lessons: The group will work together to plan for winter fund bids ahead of December 2013 – this will be an agenda item for August 2013 meeting.
5. Suggestion: plans did not go far enough to anticipate extra activity. Need mechanisms in place to monitor capacity across the whole of North West London. Suggestion is that CMS is modified to provide an indication of number of ambulance conveyances in the system by Trust in real time.
6. Suggestion: Include 111 service provider demand/capacity on CMS (this was flagged with NHSE via LAT in January 2013).
7. Consider whether clearer reporting on CMS of DTOCs is possible.
8. Suggestion: Sectorwide understanding of resus capacity – demand is outstripping capacity.
9. Suggestion: NWL Public Health Teams jointly undertake review of 2012/13 winter pressures and provide predictions for activity in Winter 2013/14, including any expected/suspected flu outbreaks.
10. Suggestion: The application of the sector divert policy is not consistently applied, takes too long and is too confusing – it needs to be simplified
11. Suggestion: Directors on-call need to be understand their role in managing pressure surges.

Escalation arrangements and effectiveness: Reflections and learning on escalation arrangements within the organisation and external to the organisation.
Questions: • Did organisational and whole system escalation plans work effectively? What good practice would you highlight? • What gaps were identified? Could action have been taken sooner to mitigate – were triggers/ warning signs effective? • What key lessons have been identified and what subsequent actions will be taken for next winter?
Response: Good local working relationships was key to effective local escalation. Gaps: Sector needs to have a contingency plan when there is a sectorwide surge in demand for services. It is felt that calls in response to surges did not provide proactive guidance to reduce/eliminate surge activity.
NHSCB London Emergency Department Capacity Management Redirect and Closure Policy (ED Policy):
Question: • Are there any areas of the policy or its operational use which need further clarification?
Response: Group generally feel that they are aware of the policy and how it works. More understanding required on LAS divert systems and real time data from a central system that identifies how many ambulances are arriving at Trusts in real time ideally, including private ambulances. Explanation of how LAS Demand Management Plans (DMP) affects the system.
NWL CSU Winter pressure surge Teleconference calls:
Question: • What suggestions do you have for improving the process?
Response: It was felt that the conference calls are using for sharing information, particularly from other Trusts and LAS. Group felt however that clear aims and objectives for teleconferences need to be identified. It was also noted that in times of surge, conference calls are more frequently which is not helpful when managers and frontline staff need to be working to resolve the problems.

Currently, no mandate for community providers to engage, therefore patchy updates. However, need to decide whether useful use of their time to be on conference call. If call extended to community providers, then also need to consider Adult Social Care Input??

Working together:

Effective working together to maintain patient flow across the whole health and social care system.

Questions:

- Did the planning and pressure surge management process for 2012-13 adequately encompass all system partners e.g. community and mental health providers?
- For 2013-14 what additional actions could the following organisations undertake to manage emergency pressures across the whole system?
  - Community service providers.
  - Social services/ Local Authority.
  - Primary care.
  - Acute Trusts.
  - Mental health service providers.
  - Urgent Care Centres.

Response:

Mental Health: noted that Adult Psychiatric Team is able to conduct a quick assessment, but lack of acute beds and crisis response out of hours hampers diversion of mental health patients. Difficulties arranging assessments for detention out of hours.

UCC: unable to flex hours of staff past usual closing time of midnight when A&E department under pressure. Plans to implement 24/7 model of care in Hillingdon UCC in October 2013 will eliminate this problem.

Adult Social Care: fast access to packages of care at weekends would streamline hospital discharges.

Hospital, Rapid Response team and Adult Social Care: working together on acute care of the elderly (ACE) supported discharge pilot and outcomes of the pilot will be transferred into 2013 winter planning.

GP OOHs: CCG does not commission GP OOHs – as all Hillingdon practices opt in to provide this. CCG has raised concerns with Londonwide LMC that GPs need to be monitoring the delivery of this service more pro-actively to ensure that fast response times are maintained when urgent care services under pressure.

Work towards more integrated care pathways, given we all need to consolidate our resources.

In progress: joint working on discharge process, particularly the improvement of Section 2 and Section 5s.

NHSCB Winter Access Funding Initiatives 2012-13:
Questions: • What were the key learning points? • What outcomes were achieved, including impact on performance improvement? • Which initiatives will be included in organisation plans for next winter?
Response: Notification of funding was too late (end December 2012) and not enough time given for responding. Trust received approval of 2nd tranche winter funding in the second week of March, leaving no time to utilise funding by end March. Capacity Planning Group enquired at NHS NWL workshop in September 2012 whether Winter Funding would be forthcoming and were informed that there would be no additional money available. Early notification would have enabled the group to prepare more comprehensive plans.
Additional Information: Please use this space to provide any additional commentary or feedback on any aspect of winter pressures planning that you have not covered above:
No additional comments .

Appendix 5

Draft Terms of Reference for Hillingdon Urgent Care Board

1.0 Background

The Hillingdon health and social care economy has identified the need to develop and implement a programme of work that delivers fully integrated unscheduled care services across the borough. This will ensure that accident and emergency, urgent and unscheduled care is delivered in the most appropriate settings, delivers the best possible health outcomes to patients and represents best value for money.

At the same time, due to the rising tide of patients accessing unscheduled care services, there has been increasing emphasis on the management of emergency pressures. The NHS and Social Care organisations are now required to plan not just for the winter period, but to engage in capacity planning for the entire year.

2.0 Constitution

The multi-disciplinary group to oversee this work borough-wide will be named the 'Hillingdon Urgent Care Board' and will be a strategic group that reports on progress to local stakeholders and agrees and delivers service plans and proposals to constituent stakeholder Boards for approval. The group will ensure that actions taken are in accordance with the overall strategic objectives of all stakeholder organisations.

3.0 Aims and Remit of the Board

To provide assurance to local stakeholders that:

- Any redesign is as good if not better for the patient than existing models of care, and therefore is in the patient and public interest
- The overall cost of the service is less than currently spent on emergency and unscheduled care, and represents good value for money
- Decisions are founded on evidence and an objective analysis of the risks and benefits
- Delivery of QIPP priorities and efficiency plans are enabled by the work programme
- Any developments benefit all stakeholders and produce system-wide improvements.

The Board will do this by:

- Agreeing and sharing priorities and goals which will be incorporated in a whole system vision for urgent care
- Working across boundaries to improve patient experience and clinical outcomes

- Supporting strong inter-agency collaboration
- Whole system monitoring to help improve quality and accountability
- Developing a culture that is comfortable with change and continuous improvement
- Reviewing the findings of investigations and root cause analyses from individual organisations so that all partners can help achieve system changes
- Resolving any operational issues that arise and ensure appropriate risk management strategies are in place
- Reviewing and using best practice from elsewhere, if appropriate.

The Hillingdon Urgent Care Board will oversee a rolling programme of projects and workstreams that meet the needs of the local population. These currently include:

- Winter and capacity planning
- Redesign of UCC/A&E
- Admission Avoidance – intermediate care and improved pathways of care for people with long term conditions, care of the elderly and end of life care
- Improved discharge practices
- Improved liaison between primary, secondary, community and social care services to ensure patient experience is enhanced
- Improved liaison with local Nursing Homes
- Improved interface between IT systems
- Communication and engagement with all stakeholders.

At the same time, the Urgent Care Board will oversee the effectiveness of:

- Primary care services including out of hours and admission avoidance schemes
- Community services including the Hayes Walk In Centre, Mount Vernon Minor Injury Unit and how these integrate with A&E
- A&E Operational and Clinical Standards
- The London Ambulance Service
- The NHS 111 Service
- Services supporting key categories of patient who attend or are admitted frequently and high dependency individuals such as vulnerable adults and children.
- Services provided that support timely/early discharge.

The Hillingdon Urgent Care Board will oversee the approval of:

- Project Briefs

- Work Programmes and Timescales
- Individual Workstreams and their corresponding timescales and outputs
- Local recovery and improvement plans, where deemed necessary
- Funding associated to delivery of the above.

4.0 Interface

There is an interface between this Group and the following:

- The Hillingdon Hospital NHS Foundation Trust Executive Team
- Hillingdon Clinical Commissioning Group Governing Body
- Central North West London NHS Foundation Trust (Hillingdon Community Health)
- Central North West London NHS Foundation Trust (Mental Health Services)
- London Borough of Hillingdon
- London Ambulance Service
- Harmoni HS Limited
- Hillingdon Health and Wellbeing Board
- HealthWatch Hillingdon
- Local Independent Sector providers of urgent and unscheduled care services
- Local Voluntary Sector providers of urgent and unscheduled care services
- Capacity planning and urgent care networks at local, regional and national level.

5.0 Membership

Membership of the Hillingdon Urgent Care Board will incorporate strategic and operational leads from across the local emergency care system including consultants, GPs and patient representatives and represent a broad range of disciplines. A list of the representatives follows:

Name	Title	Organisation
Mitch Garsin (Chairman)	GP Lead for Urgent Care	Hillingdon Clinical Commissioning Group
Moira Wilson	Deputy Director, Adult Social Care, Health and Housing	London Borough of Hillingdon
Maria O'Brien	Managing Director	Hillingdon Community Health, CNWL
Reva Gudi	GP Lead for Intermediate Care	Hillingdon Clinical Commissioning Group

Kuldhir Johal (Deputy Chair)	GP Lead for 111/Unscheduled Care	Hillingdon Clinical Commissioning Group
Ceri Jacob	Chief Operating Officer	Hillingdon Clinical Commissioning Group
Trevor Begg	Lay Member Lead on PPE	Hillingdon Clinical Commissioning Group
Shirjeel Tahir	Urgent Care Medical Director	Harmoni
Richard Grocott-Mason	Medical Director	The Hillingdon Hospital NHS Foundation Trust
Jas Johal	Consultant, Emergency Medicine	The Hillingdon Hospital NHS Foundation Trust
Joe Smyth	Director of Operational Performance	The Hillingdon Hospital NHS Foundation Trust
Joan Veysey	Deputy Chief Operating Officer	Hillingdon Clinical Commissioning Group
Helen Delaitre	Senior Commissioning Manager	Hillingdon Clinical Commissioning Group
Chris Miles	Hillingdon Station Manager	London Ambulance Service
Faye Justice	Regional Operations Director	Harmoni HS Limited
Shaun Hare	Deputy Director, Psychological Medicine Services	Central and North West London NHS Foundation Trust
Claire Sheppard	ADO, Medicine and Urgent Care	The Hillingdon Hospital NHS Foundation Trust
Graham Hawkes	Chief Executive Officer	HealthWatch Hillingdon
Bernard Quinn	Directory of Delivery and Performance	BEHH Federation of CCGs
David Gibbins	Account Director	Commissioning Support Unit

Representatives from other organisations will be invited to attend where subject matter is relevant.

Where the meeting involves decision-making:

- a minimum of the Chairman (or his deputy)

- one clinical and one managerial representative from Hillingdon Hospital NHS Foundation Trust
- one clinical and one managerial represenative from Hillingdon Clinical Commissioning Group
- one representative from Hillingdon Health Limited/Harmoni; and
- one representative from either Hillingdon Community Health, London Borough of Hillingdon, Central North West London Mental Health Services or the London Ambulance Service respectively

must be present for the meeting to be quorate.

The Chairman of the Hillingdon Urgent Care Board will be elected by members of the Board and a Deputy Chairman will also be elected, who is a member of the Urgent Care Board.

6.0 Accountability

The Hillingdon Urgent Care Board is accountable to the Hillingdon Recovery Programme Board. Representatives from each stakeholder organisation should follow their own organisations' governance framework to ensure relevant information is disseminated appropriately. Ultimate decision-making responsibility for the commissioning of urgent care services, within the remit of the overall project brief, lies with the Hillingdon Clinical Commissioning Group. However, the HCCG will wish to ensure that all representative stakeholder Boards are engaged with this process.

7.0 Frequency of Meetings and Dissemination of Information

Meetings are held bi-monthly, or more frequently should the Chair deem it necessary.

All communications relating to meetings will be issued and papers/reports circulated in advance of meetings.

Agenda items should be submitted no less than 8 days in advance of the meeting to the Senior Commissioning Manager who will subsequently ratify the agenda with the Chairman.

These Terms of Reference will be reviewed annually.

8.0 Reporting

The Hillingdon Urgent Care Board will report to the various committees and boards on progress as directed. Information updates will also be provided to the Hillingdon Health and Wellbeing Board.

9.0 Conflict of Interests

If a member has a pecuniary, personal or family interest, whether actual or potential, direct or indirect, in any proposed contract or other matter which is under consideration by the Urgent Care Board, the member should disclose the interest as soon as they become aware of it. Arrangements will be made for the exclusion of a member declaring any interest from any discussion in the matter in respect of which an interest has been disclosed.

Date for Review: May 2014

Appendix 6

Public Awareness of the Different Healthcare Provider Options: a survey of patients attending Hillingdon Hospital Accident and Emergency Department

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A short questionnaire was conducted in Accident and Emergency to review:

1. Whether patients had contacted another healthcare provider before attending A+E, if so which provider and what the outcome was
2. Whether patients are aware of how to contact their GP / the Out of Hours GP / the 111 service

A total of 288 patients were surveyed. The results are summarised below.

Total Number of Patients Surveyed:

Date	Number of patients surveyed	Number of patients surveyed 'in hours' (Mon-Fri 9am-5pm)	Number of patients surveyed 'out of hours' (Sat-Sun or Mon-Fri 5pm-9am)
14.4.13 (Sunday)	16	0	**16**
22.4.13 (Monday)	77	38	**39**
23.4.13 (Tuesday)	54	20	**34**
24.4.13 (Wednesday)	40	25	**15**
26.4.13 (Friday)	65	37	**28**
27.4.13 (Saturday)	7	0	**7**
30.4.13 (Tuesday)	19	15	**4**
Unknown (date or time not recorded)	10	10	**0**
Total	**288**	**145 (50.3%)**	**143 (49.7%)**

Note: Patients with no date/time recorded were counted as attending 'in hours' (Mon-Fri 9am-5pm)

Patients surveyed 'in hours' (Monday- Friday 9am-5pm):

Total number of patients surveyed	145
Number who had contacted another healthcare provider	70
Number who had not contacted another healthcare provider	75

Outcome if another healthcare provider had been contacted prior to attending A+E:

Healthcare provider contacted	Outcomes					Other comments
	Unable to contact them	Unhappy with assessment/ advice	Had to wait too long for an outcome	Advised to attend A+E	Other outcomes	
GP 55 patients	4	3	3	36	8 patients attended as no GP appointment was available	1 patient had no outcome documented
111 8 patients	1	1	0	6		The patient who was 'unhappy with advice' was advised to attend A+E as no appt with their GP was available
Other	2 advised to attend by medical staff at work 1 advised to attend by private hospital 1 advised to attend by site nurse 1 advised to attend by walk in centre 1 advised to attend by Mount Vernon Hospital Minor Injuries Dept 1 advised to attend by sports therapist Other comments: 3 patients were not registered with a GP					

Patients surveyed 'out of hours' (Sat-Sun or Mon-Fri 5pm-9am):

Total number of patients surveyed	143
Number who had contacted another healthcare provider	71
Number who had not contacted another healthcare provider	72

Outcome if another healthcare provider had been contacted prior to attending A+E:

Healthcare provider contacted	Outcomes					Other comments
	Unable to contact them	Unhappy with assessment/ advice	Had to wait too long for an outcome	Advised to attend A+E	Other outcomes	
GP **52 patients**	1	4	8	29	8 patients attended as no GP appointment was available 1 patient was advised to go to A+E by their GP as the GP did not have enough time to do their dressing	1 patient had no outcome documented
111 **9 patients**		1 patient was advised to contact Harmoni by 111, Harmoni then advised them to attend A+E		7		1 patient had no outcome documented
Other	1 advised to attend by employer 1 attended as walk-in centre was closed 3 advised to attend by pharmacist Other comments: 2 patients were not registered with a GP				1 looked on NHS direct website then attended A+E 1 advised to attend by optician 3 advised to attend by Mount Vernon Hospital Minor Injuries Dept	

Relevant Comments from patients:

- GP advised attending Hillingdon A+E as it is quicker than Wrexham Park A+E
- Patient says mother contacted GP, who advised them to go to A+E to get something stronger than piriton
- Not clear from survey but ?advised to go to A+E because wait for GP appointment was too long
- Patient did not contact GP 'as it is a waste of time'
- Patient 'can never get an appointment with their GP'
- Patient called 111 – was advised to contact Harmoni, who advised them to attend A+E
- Patient attended A+E because they do not like other services
- Patient called GP but could not wait until Monday for an appointment
- Patient contacted GP – no appointments were available, so was advised to go to A+E

Number of patients aware of how to contact different healthcare providers:

Healthcare Provider	Was patient surveyed aware of how to contact healthcare provider?			Total
	Yes	No	Not answered	
GP	268 (93.1%)	20 (6.9%)	0	288
OOH GP	167 (58.0%)	121 (42.0%)	0	288
111	223 (77.4%)	64 (22.2%)	1	288

Appendix 7
PMO at THHFT