Date: 5 July 2000

Venue: Committee Room 2, National Assembly for Wales

Title: Task Force on Emergency Pressures including Delayed Discharges (The Emergency Pressures Task Force)

Purpose

1. This paper reports on the work of the Emergency Pressures Task Force, and provides a brief account of its key recommendations. A fuller report will be available in September. In the meantime the Health and Social Services Committee is invited to consider the conclusions.

Preparing for This Winter

2. The recommendations of the Task Force are broken down into those that can, and should be implemented for the coming winter and those that require immediate attention and work as part of a longer term approach.

3. The recommendations of the Task Force have been included in interim guidance that will be issued to the NHS and its partners in mid July. This supports the £40 million, £35 million recurrently, allocated to the NHS last month to specifically tackle waiting lists and emergency pressures over the coming year and beyond.

Background

Graph 1 - Emergency Admission Trends (All Wales Data, all specialities, acute General Hospital Sites) (Source – Data collected by the Capacity Planning Sub Group)

4. The health and social care system faces rising demand for emergency treatment each year (Graph 1 below). There are peaks and troughs throughout the year, however the pressures are greatest during the winter, largely due to seasonal factors such as the weather and the increased incidence of ‘flu and respiratory illness. The NHS and its partners must also cope with the disruptive effect of the extended Christmas and New Year holiday period which often sees the start of the most difficult period of the winter.

5. These pressures affect the whole health and social care system, and they are most obvious in the secondary care sector - where GPs and patients find it difficult to access beds; patients are sometimes forced to travel for a critical care bed; and, there are unacceptable trolley waits in Accident and Emergency for an acute bed to become available.

6. Changes in demographic patterns mean that patients are older; with increased admissions in the 75+ category causing problems with bed availability. Lengths of stay for elderly patients are also increasing, suggesting greater case-mix complexity and more complex discharge packages.

7. Last year the healthcare system in Wales faced severe challenges. In the month before Christmas and in the two months that followed all sectors of the system were under extreme pressure. Flu levels peaking at 190 cases per 100,000 of population in January 2000 were more than twice that of the previous year and nearly 100 times the typical monthly average. Flu and flu related illness tended to affect people for longer than usual and hit the young as well as the old. When healthcare workers, social care workers and carers were also struck down, the capacity of the system was reduced and at the same time demands on the system rose.

8. Data provided by the Capacity Planning Sub Group suggests an 18% increase in all emergency admissions in the years since 1995/96, representing an extra 46,000 patients, with a 26% increase in emergency medical admissions, an increase of over 25,000 patients.

9. As the health and social care system becomes more efficient and operates closer to full capacity, coping effectively with the emergency pressures has become increasingly difficult. There is no longer a margin of substantial spare capacity in hospitals which can be easily deployed to meet the winter peak in demand. Careful planning of services is vital to address the pressures.

10. Meeting the needs of emergency patients diverts attention and resources from elective inpatients and to a lesser extent daycases. As a result, waiting lists often rise when emergency pressures are at their most extreme during the winter. Elective inpatient admissions have reduced by 19% over the last 5 years. This partly arises from a planned transfer of cases from inpatient to day case work, but, more recently, an increasing problem with bed availability for elective work due to increased emergencies.

The Emergency Pressures Task Force

11. The remit of the Emergency Pressures Task Force set up in January 2000 was to:

- review the causes and responses of the NHS and partner organisations to the pressures experienced over the winter period and to identify examples of good practice for early promulgation;

- In the light of the risk/implications of continuing to rely on existing arrangements, to recommend both short and medium term responses by the respective partners, to provide a framework for medium term investment and planning, and to promote a whole systems approach in line with Health Improvement Programmes and Social Care Plans;

- to produce an initial report by summer 2000 and recommendations for future evaluation and review, taking into account the likely availability of resources.

12. In order to develop a whole system approach the Task Force set up 6 sub groups, 5 of which investigated various parts of the system, while the sixth worked on developing early interim guidance for the NHS and its partners for Winter 2000-01.

13. The conclusions and recommendations of the Task Force can be broken down into three related areas:

- **Public Health Initiatives aimed at preventing illness**
- **joint working in the community to reduce the risk of inappropriate hospital admissions and to properly manage patients discharged from hospital; and**
- **Improvements in secondary care, including capacity, workforce planning and the facilitation of timely discharge from the acute hospital setting**

14. These areas cannot be viewed in isolation and links must be made across sectors and organisations to ensure that actions have the maximum impact.

Public Health Initiatives Aimed at Preventing Illness

Background

15. Illness caused by flu and other viruses create extra demand on services whilst at the same time often limiting the ability of services and carers to deliver care. Influenza prevention, targeted at those aged 65+, the section of the population most likely to have severe or complicated illness, can offset this. The evidence for protection via immunisation is good for people aged 65+ and in the case of those with heart and chest disease, whatever their age (about 50% of those immunised). The main effort should be directed at those groups where evidence of benefit is clear. Other groups could be phased in as the system recommended became more efficient and effective.

16. Other methods of reaching those needing vaccination should be explored, including a more rigorous approach to immunisation and monitoring in venues such as nursing/residential homes for the elderly. Outpatient Departments provide an excellent opportunity to remind people of the need for immunisation as 36% of in-patients and 23% of out-patients are aged over 75.

17. A pro-active immunisation programme together with timely surveillance of influenza, judicious use of medication and a **"Keep Well and Warm"** campaign should anticipate some of the problems in Wales. At the same time it will promote the improvement of the infrastructure of Primary Care and raise the profile of elderly and vulnerable people, especially those who do not have contact with health services. This points to the need for a whole systems approach that includes, at least as information givers, home helps, luncheon club organisers carers and a wide range of voluntary organisations.

Recommendations for Action Winter 2000/01

i) Raising Public Awareness of Self Help Initiatives

Co-ordination across the Assembly should aim to maximise awareness of a "Keep Well and Warm" campaign, drawing together all of the programmes and campaigns sponsored or run by the Assembly. The campaign running from September 2000 to January 2001 would provide information and support to people over 65, to enable them to keep well this winter, and will raise awareness among the target audience through a series of themed messages supported by community action during the campaign period. The campaign would be sensitive to specific audiences, with health professionals receiving information through seminars and articles in professional journals and news weeklies, as well as via a letter from the Chief Medical Officer and other guidance.

ii) Maximising Immunisation Within the Target Group

To encourage an increase in the uptake of immunisation, health authorities should co-ordinate efforts in specific geographical locations. A priority must be developing a standard system for measuring vaccine uptake levels if the success of the new policy is to be monitored and if coverage targets are to be met. Guidance should be issued to strengthen the requirement for a register or other proactive methods of monitoring. Efforts should be concentrated on the 65+ age group and other vulnerable people.

iii) Immunisation of Health and Social Care Workers

There is little formal evidence of the benefits obtained by immunising health and social care workers, although there is sense in offering protection to this group. However, the priority is to immunise the group with the greatest need and the highest potential fatalities.

Recommendations for Action Now with Longer Term Outcomes

i) Changes to Methods of Remuneration and Reimbursement

If the pay agreement achieved by Department of Health for this year is implemented in Wales, its benefits in increasing the uptake of flu immunisation should be monitored. In the longer term there may be benefits to be gained, in terms of system

control, by changing the current process of influenza immunisation to the successful system used for childhood immunisation under which GP's are given target payments. This, however, can only occur if, for example, the support mechanisms are in place and the GPs are willing.

ii) Review of Vaccine Supply and Storage

Vaccine supplies have already been ordered by GP's so there is little that can be done this year. However, preparations should begin to move the system of order and purchase to the childhood immunisation programmes model. Steps to move from GP purchase to a Trust storage facility, and in the longer term to central purchase and supply should be considered. It would be advantageous if more than one manufacturer was involved as the unique nature of influenza vaccine and the need for annual immunisation in a short time frame makes the programme vulnerable to supply failure.

Joint Working to Provide the Appropriate Primary Care and Community Care Settings

Background

18. The majority of all illness are seen initially in Primary Care. With the introduction of Local Health Groups (LHG's) in 1999, local planning and management arrangements can be developed across health service provision and in co-operation with local authorities. Clear focuses on priorities for local action are being developed by LHG's across Wales, in particular to ensure that financial resources are most wisely invested to generate local change.

19. Since the Community Care reforms introduced in 1993, Social Services Departments have had a responsibility for securing the most effective balance of service provisions in the community. This acknowledged the even bigger contribution of informal care within specifically identified resources. However, Social Services Departments have been forced increasingly to focus their resources more tightly on those most at risk. This makes it more difficult to fund preventive work to help limit an increasing spiral of expenditure and demand for residential forms of care.

20. A particular priority is the management of chronic disease. A systematic, integrated approach is needed straddling the traditional care sectors (primary, secondary, tertiary, community, social) but with a renewed emphasis on rehabilitation and community based support. A small number of chronic illnesses account for a large proportion of the increase in winter hospital admissions. Improving the management of these conditions could reduce winter bed occupancy.

21. Joint working has been a critical component of this progress, but more is achievable with long term commitment from all partners. A key need is to manage expectations of the local community. This will, arguably, be the most influential factor in supporting changed practice and procedures. Local professionals must co-operate to influence local expectations to achieve changes agreed by all as the most positive ways of using limited local resources.

<u>Recommendations for Action Winter 2000/01</u>

i) Joint Working is Essential

In the context of managing emergency pressures, partners should plan for both short term management improvements and how they propose to develop service models to: firstly, eliminate any 'boundary' problems in transfers between services, and secondly build the kinds of joint projects and practices which provide effective bridges between hospital and community based services. As a first step all the boundaries between services (whether geographical, professional or organisational) need to be analysed, reviewed and where necessary thoroughly overhauled to ensure the <u>overall</u> effectiveness of the service to the patient/client and the best possible use of each agency's resources.

It is essential to provide, through joint working, information to local communities on how to make use of local services and what they can expect from them. This should include the provision of information to vulnerable groups and the wider

community, designed to help people prepare for the winter. It should also include how, and in what situation people should contact the various out of hours/emergency advice or support services.

ii) Using Multi-Disciplinary Rapid Response Teams

LHGs and Social Services Departments should ensure that adequately resourced multi-disciplinary rapid response teams are available in the community to assess patients quickly and to support them in their own homes wherever possible. Such services have been proven to assist in reducing admissions to hospital and, when they have a rehabilitative element, to facilitate effective discharges.

iii) Defining Delayed Discharge

'Delayed discharge' creates particular problems in parts of Wales. More needs to be done to understand the causes and find ways to overcome them. The plans for monitoring delayed discharges being implemented by the Scottish Executive and the work undertaken in the Iechyd Morgannwg Health Authority area should be used to help develop a widely accepted definition and explore how a monitoring system could be introduced in Wales. Discharge arrangements must derive from multi-disciplinary agreement as to how care should be managed and progressed with regard to individual patients.

iv) Extending Working Periods and Improving Out of Hours Services

Consideration should be given to how <u>all</u> agencies can co-operate to extend the working day/week to facilitate access to services, especially during crisis periods to make the best possible use of available resources and minimise delays in transfers between services.

Primary Health Care Teams and Local Health Groups (LHGs) should ensure that "Out of Hours" (OOH) services operate to the same protocols and procedures used during the working day and that patients are not admitted to hospital because their problem arises outside surgery hours. LHGs should also ensure, in association with NHS Trusts, that adequate community nursing services are available on a 24 hour basis to support carers and enable patients to remain at home wherever possible.

v) Use of Intermediate Care Should be Maximised

PHCTs/LHGs should ensure that maximum use is made of "intermediate" care arrangements and facilities. This should include the active use of "Primary Care Support Centres" or Community Hospitals and the organisation of effective local networks including appropriate arrangements for secondary care support for both diagnosis and treatment. LHGs should review all of the local arrangements and facilities for health and social care provision to ensure better integration of services. Community hospitals should be used as alternatives where appropriate to admission to general hospitals and not simply as "step down" facilities following discharge from a general hospital.

vi) Chronic Disease Should be Actively Managed

Action should focus on chronic obstructive pulmonary disease, asthma, diabetes, ischaemic heart disease, and heart failure. Intensive ***specialist rehabilitation*** *for patients with chronic disease can reduce health service usage. Evidence from a Welsh randomised controlled trial shows that multidisciplinary pulmonary rehabilitation improves quality of life, functional status and halves the number of days patients with chronic lung disease spend in hospital in the year following rehabilitation. Similar programmes should be considered as a matter of urgency with priority given to patients with a history of hospital admission.*

Many patients with chronic diseases are admitted to hospital requiring relatively unsophisticated medical management but needing hospital services because adequate support is not available at home to meet the patient's needs. Trusts in

conjunction with LHGs should be encouraged to put in place support teams. These teams would evaluate and, if appropriate, discharge patients back to the community with enhanced levels of support determined by the team.

Trusts should have formal mechanisms in place to ensure that appropriate cases have rapid access to day hospital and rapid access specialist clinics e.g. for chest pain, or transient ischaemic attacks.

Investment should be used to improve the availability of aids and equipment, with processes to ensure early referral, efficient access and fitting of such items by individual trusts and social service departments, and to ensure that an appropriate discharge environment is in place. This would decrease discharge delays while patients are waiting for basic equipment such as a special mattress, hoist or commode and reduce risks of readmission.

Hospital based social workers can improve links between wards and social services, collaborative discharge planning and aftercare, and decrease delays in discharge attributed to slow or late social service assessment.

Consultant availability should be improved by advertising a time slot and their telephone number when they are available to GPs to discuss and provide advice on cases within their specialism and provide a list of nurse specialists availability. The aim is to provide access to senior hospital/specialist advice without admission of patient, e.g. telephone, telemedicine advice.

Recommendations for Action Now with Longer Term Outcomes

i) Integrated Care Pathways Should be Developed

PHCTs/LHGs should ensure that, where well managed vertical integration is particularly appropriate (eg when a patient's treatment regime is expected to follow a relatively linear course), integrated care pathways are developed in association with trusts and other stakeholders to ensure that the stages of the care and treatment process are clearly defined and organised as effectively as possible. This should include involvement of the patient in the various stages of the treatment and care process.

This should also build on the lessons learnt from the monitoring of delayed discharges. Discharge processes should be seen as an integral part of 'care pathways' being developed to help improve patient care management. Such arrangements should be inter-disciplinary. They should recognise that discharges must be anticipated and planned from the time of admission and that local protocols between co-operating agencies must explicitly state the communication and agreed arrangements which will facilitate these processes.

ii) The Voluntary and Independent Sectors Should be Used Whenever Appropriate

Health authorities and local authorities should together review local arrangements for commissioning care within the voluntary and independent sector to ensure that the services provided are fully integrated with those provided by statutory agencies and that there is appropriate provision both to help avoid unnecessary admission to hospital and to support people after discharge from hospital but require continuing care.

The independent sector is a major provider of nursing and care services within Wales and can represent a cost-effective alternative and offer a means of providing a more effective engagement between health and social care providing a more flexible and responsive service. Development needs to be considered on a very local basis. The independent sector should no longer be treated as an option to be used, only when other options have been exhausted, but as an important contributor to be used whenever it can offer a cost effective and appropriate alternative to meeting particular health care needs.

iii) Using Technology

Use should be made of alarm call centres that are developing new equipment to help monitor people in the home as well as acting as centres for advice and information. The use of electronic communication and integrated IT systems should be explored to help with information transfer and data collection.

iv) Longer Term Chronic Disease Management Should be Developed

Rapid response and support teams should be subjected to randomised controlled trials. These should be expanded to enable response with expert advice, support, education and rehabilitation for patients with chronic conditions suitably identified by primary care teams.

Respite care should be developed to increase the range and capacity available for carers, in hospital if the patient requires the input of a multidisciplinary team or investigation, in nursing/residential home if this is more appropriate, or in the patient's own home if possible.

Flexibility within pharmacy services should be encouraged through, for example, employing pharmacists on a sessional basis to improve medicine management in primary care. There is also scope to improve prescribing and dispensing arrangements pre-discharge to ensure that medication is available in time.

The shared care record as used in cases of diabetes and for children should be extended to other chronic disease to facilitate communication between primary and secondary care. The sharing of information will be further facilitated as IT develops.

Joint educational sessions (primary, secondary care) should be developed to agree shared care protocols and to improve integrated care.

Rehabilitation Services should be re-established both in terms of bed availability and rehabilitation staff (medical/non-medical) time.

v) Vulnerable People Should be Identified Within Primary Care

Primary Health Care Teams should develop systems that readily identify vulnerable patients, which can help establish effective programmes that aim to prevent as well as treat. Systems should be regularly audited.

Improvements in Secondary Care

Background

22. Over the last 5 years emergency admissions have increased by 18% across all specialties. Although there has been a levelling off in some areas over the last year, many hospitals continue to be under an increasing year on year pressure. There has been a 26% increase in emergency medical admissions over the last 5 years. There are increased admissions in the 75+ category and lengths of stay for elderly patients are also increasing, suggesting greater case-mix complexity and possibly demanding more complex discharge packages.

23. Daily emergency admissions in Wales are unpredictable making planning of emergency and elective capacity difficult. Monday is usually the busiest day and the weekends generally quiet. This raises issues about providing services on a 7-day basis and profiling elective work on a more even basis. Delayed discharges cause local operational problems, with significant numbers of beds unavailable.

24. There are varying levels of available medical, surgical and intermediate beds per 1000 population across health authority areas There are also variations across Health Authority areas in terms of nursing home and residential home beds.

25. Risks of bed shortages are minimal if the mean bed occupancy remains below about 85%. Above a mean occupancy of 90% an admitting hospital will regularly be unable to meet demand. Moreover, studies suggest, hospitals that have to refuse further admissions faces a long recovery period. By way of example a hospital with at 85% mean occupancy, that runs out of beds for four days in a year, may be disrupted for up to 8 weeks. Analysis indicated that hospitals in Wales are operating close to the maximum capacity for medical beds throughout the year and that the peaks experienced in winter cause significant on-going disruption.

26. Calculations suggest that, assuming an 85% bed occupancy target and current lengths of stay, there is an implied deficiency of the order of 400 medical beds in Wales in order to deal with pressures experienced during the year. However, if length of stay could be reduced or a higher level of occupancy is assumed, the shortfall is less. Additional medical bed capacity requirements can be addressed through:

- Resourcing additional medical bed capacity in hospitals that are under constant pressures;
- Reassigning surgical beds, accepting this would reduce elective capacity;
- Creating flexible bed capacity to meet peaks in demand experienced during the year;
- Reducing lengths of stay, e.g. by action on delayed discharges
- Implementing a whole systems approach to avoiding admission.

Analysis also indicates there is a significant shortfall in critical care capacity in Wales.

27. A sub-group looking at workforce issues agreed that innovative ways of working were likely to have the biggest impact. Various options for more flexible working from the time a patient is admitted to the time of discharge including diagnosis and treatment, both for elective and emergency patients, were identified.

Recommendations for Action Now for Winter 2000/01

The sub groups made recommendations in the following areas:

i) Increase Medical Bed Capacity

Increases in medical bed capacity to manage emergency admission pressures and to ensure elective activity. The number of beds required and the balance between acute and community hospitals to be determined locally, following a dialogue between Health Authorities, Local Health Groups and Trusts.

ii) Increase Critical Care Capacity

Increase in critical care capacity in Wales by 30 ITU beds, with appropriate staffing. Trusts and Health Authorities to commence urgent discussions about the best way to achieve this and consider location, resources and staffing issues in order to provide appropriate numbers of critical care beds in Wales.

iii) Commence Return to Work Initiatives

It is recommended that funding provided in 1999-2000 for return to practice courses for nurses be provided again in 2000-2001 to combat shortages . It is also recommended that an exercise be carried out to investigate the use of bank and agency staff in NHS Wales.

iv) Implementing Innovative Ways of Working

Consideration should be given to piloting initiatives around 7-day working and more innovative working practices that would have an immediate impact on emergency pressures. It is recognised that this would not be a resource neutral exercise and would have staff implications. Funding would need to be provided centrally for these pilots. The following initiatives should be considered for 6 month pilots review:

- *GPs working in A+E in 3 pilot Trusts, possibly reducing diagnostic resting and referrals*
- *Physiotherapists and Occupational Therapists working in A+E in 3 pilot Trusts (or other staff that would speed up A +E processes)*
- *7 day working in Occupational Therapy, Physiotherapy, Pharmacy, Radiology and Pathology in 3 pilot Trusts, to speed testing, assessment and treatment*
- *Physiotherapists based in GP practices providing rehabilitation based in the community - pilot in 5 LHGs.*

To enable accurate monitoring of the success of the pilots and other Welsh initiatives it is suggested that information be collected from the trusts to monitor exactly what work is being taken forward across Wales and its impact.

The relevant sub-group were concerned that the 7 day working pilot would not be successful unless a "whole systems" approach (including primary care, transport and social services) was taken. It is therefore recommended that a "whole systems" approach be piloted in 1 or 2 Trusts. Pilots should concentrate on those Trusts where the worst pressures have been identified.

v) Introduce other flexible working approaches

All trusts and health authorities should consider piloting the above pilots locally and new flexible methods of working around:

***the admissions process** – for example*

- *training of paramedics to assess whether patients in emergency situations could be treated in primary care.*
- *introduction of 7-day working in admission units*
- *extending the role of practitioners (eg. nurses authorising tests after the appropriate education and training) and expanding the role of radiographers and radiologists*
- *timely review of patients by senior doctor/consultant*
- *rapid access to Psychiatrist or Community Psychiatric Nurse in the case of self-harm*
- *development of nurse-led minor injury units in community hospitals.*

***more selective diagnostic testing** – through e.g. giving decisions to senior doctors/nurses rather than junior doctors.*

***flexible use of staff** – use of all staff on a 7-day basis including patient records staff; use of support workers, releasing clinical staff to deal with treatment e.g. nursing support workers for cleaning and other domestic services; nurses in prescribing (dependent on changes in legislation).*

***speedier discharge** – reviewing who can authorise discharge from hospital; extending discharge to 7 days per week; joint work involving social services and the private sector to ensure patients needing rehabilitation can be looked after 7 days a week in the community; using Community Hospitals more for rehabilitation; making transport available at weekends for patients being discharged – using ambulance or can hospital car volunteer schemes.*

vi) Research is needed into the "Whole System" Approach

The reasons for increasing referrals need to be clearer so that a balance can be struck across the whole system, including demand management, acute care, rehabilitation, return to home and on-going support. Issues include the drivers for

increases in demand, the implications of an ageing population and the scope for improving the use of medical beds. Health communities need to consider the various dynamics at play to ensure the most appropriate balance of services to meet their population's needs. The Acute Services Review may help inform this debate in ensuring that the long-term plans are robust.

vii) Better Planning is Essential

Action is required to plan for the the variations in daily emergency admissions, recognising the impact of shortfalls in out-of-hours infrastructure and lower levels of admissions over the weekend. This would lead to a more stable planning environment to balance emergency and elective workload. This will require

- *a critical review of the role for community hospitals and intermediate care, adopting flexible criteria and providing a continuum of care for patients, creating the right balance of acute and intermediate beds within each health community*
- *clarification of the reasons for variations in bed numbers across health authority areas*
- *improved data collection in critical areas, including delayed discharges, case-mix complexity and medical outliers*

Recommendations for Action Now with Longer Term Outcomes

i) Create additional bed capacity

In the medium-term, the number and location of acute medical beds and critical care beds needs to be considered within the context of the Acute Services Review. Increasing medical bed capacity will benefit elective workload. Reducing medical outliers has a dual effect of accommodating medical patients in an appropriate ward environment and freeing elective capacity to deliver waiting list targets

A more detailed critical care review is required using an expert group to identify the longer-term requirements for critical care. However, it is not simply a matter of funding, as trained doctors and nurses need to be recruited..

ii) Run Further Pilots

Further pilots in other areas identified above should be considered once the outcomes of the initial pilots have been evaluated.

iii) Develop Workforce Planning

Work already underway on developing more robust workforce planning systems in Wales should continue, including a review of the current workforce planning system through setting up a Workforce Development Group, to consider:

- *the purchase of a new workforce planning computer package, enabling trusts to produce more sophisticated plans.*
- *the purchase of a new Human Resource and payroll system for Wales*
- *the purchase of a nurse workload measurement system for the NHS in Wales.*

iv) Support Additional Training

Training numbers for centrally funded nursing and PAMs courses and the education and training of doctors should be increased in 2000 to combat staffing shortages. The Education and Training Group should consider student attrition and the causes and different approaches to training for non-medical and dental staff groups.

The sub-group on workforce issues noted that these changes would not have an immediate effect. Planning would improve

but the impact would not begin to be felt for 3-4 years at the earliest. Increases in training numbers and improvements in the current workforce planning processes, which identify trusts staffing requirements, will have an impact on emergency pressures in the long term ie. enabling trusts to predict their staffing needs more accurately, and in turn ensuring that these needs are met by supplying enough newly qualified staff to meet these needs.

Appendix 1

Emergency Pressures Task Force

Membership

Ms Jane Hutt, Assembly Secretary Health and Social Services Committee (Chair)

Dr Eddie Coyle , Director of Public Health, Gwent Health Authority

Mr Simon Jones, Chair, Bro Taf Health Authority

Mr David Hands, Chief Executive, North Wales Health Authority

Mr Denis Jessopp, Chair, Gwent Healthcare NHS Trust

Mr Paul Williams, Chief Executive, Bro Morgannwg NHS Trust

Dr Chris Jones, GP and Chair Rhondda Cynon Taf LHG

Dr David Prichard, Medical Director, North Wales NHS Trust

Ms Val Parker, Head of Information, Conwy and Denbighshire NHS Trust

Ms Liz Hewett, Secretary to the Welsh Board Royal College of Nursing

Ms Eirlys Warrington, Chair, Welsh Board Royal of College Nursing

Dr Alison Ross, Liaison Committee of Royal Colleges

Mr David Galligan, Regional Head of Health, Unison

Ms Lorene Read, Executive Nurse Gwent Healthcare NHS Trust

Mr Hugh Gardner, Chair, Assoc. of Directors of Social Services and Director of Social Services City and County of Swansea Council

Dr Bill Harris, GP and BMA representative, Taff Vale Surgery

Dr Terry Morris, Consultant & BMA representative, North Glam NHS Trust

Mr Mike Hedges, Leader of City and County of Swansea Council

Mrs Jane Jeffs, Chief Officer, Welsh Community Health Councils

Mr John Wreford, Director of Social Services Merthyr

Mr Chris Jones, Chief Executive, NHS Direct Wales

Mr Don Page, Chief Executive, Welsh Ambulance Services NHS Trust

Mr Tom Begg, Director of Social Services, Newport County Borough Council

Ms Sue Kent, NHS Chief Executive (Retired)

Assembly Officials:

Mr Peter Gregory, Director NHS Wales

Dr Ruth Hall, Chief Medical Officer

Dr David Salter, Health Professionals Group

Ms Rosemary Kennedy, Chief Nursing Officer

Mr Graham Williams, Chief Inspector, Social Services Inspectorate Wales

Mr Colin Williams, Performance Management Division

Mr Stephen Redmond, NHS Human Resources

Ms Helen Thomas, Director Social Policy Group

Ms Gaynor Legall, Public Health Division

Dr Chris Riley, Performance Management Division

Dr Jane Wilkinson, Health Professionals Group

Ms Sue Cromack, Human Resources Division

Mr Roger Perks, Performance Management Division