Appendix 1

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Accident and Emergency Provision at Wexham Park Hospital

Findings of Health Scrutiny Panel Task and Finish Group

July – December 2013

Contents

Foreword

It gives me great pleasure to introduce the findings of the Health Scrutiny Panel Task and Finish Group looking at the Accident and Emergency provision at Wexham Park Hospital.

It is hoped that this report will bring many of the issues facing the Department to light, and the opportunities for supporting work to reduce the pressure on services through improvements at Wexham Park Hospital, access to GPs and public understanding of what urgent care services are available in the borough.

The Task and Finish Group worked extremely hard to draw out the different elements of this complex picture, and I would like to thank Councillors Chohan, Davis, S Dhaliwal, Mittal and Strutton for their contributions to this work. In addition, I would like to thank, on behalf of the whole Task and Finish Group, Grant MacDonald from Heatherwood and Wexham Park Hospitals NHS Foundation Trust and David Williams from the Clinical Commissioning Group for providing invaluable information to our discussions; and Sarah Forsyth and Amanda Renn for their support in drawing our discussions and conclusions together.

Colin Pill
Chair, Accident and Emergency Task and Finish Group

Recommendations

Demand and Capacity

a) That the Health Scrutiny Panel assess the impact of the redesign of the A&E department's layout on the capacity of the Department to manage high levels of demand over the winter period following the end of the financial year 2013/14.

b) That the Health Scrutiny Panel undertake a line of questioning in March 2014, when discussing improvements in the quality of care provision at the Trust, on the effectiveness of the discharge processes at the hospital and how the hospital staff and social care staff co-ordinate ongoing care needs.

Staffing

c) That the Health Scrutiny Panel monitor the effectiveness of the Trust's plans for recruiting qualified, skilled, experienced staff and retaining them; and how the Trust is being established as employee of choice in a highly competitive market?

d) That Heatherwood and Wexham Park Trust consider using HCAs, Porters and other support staff in A&E to improve the overall patient experience through the provision of 'hotel'-type strands of work, such as providing drinks to patients or ensuring patients are comfortable and properly clothed etc.

Patient Flow

e) That the Health Scrutiny Panel assesses the impact of the Rat-ing triage system after six months.

f) That the introduction of an electronic patient records system, currently within the medium term plans of the Trust, is brought forward.

g) That plans for improving diagnostic and pharmaceutical support in order to speed up the flow of patients through the hospital system are considered by the Health Scrutiny Panel, particularly in relation to weekend service provision, in the 2014/15 municipal year.

Avoiding Unnecessary Attendances

h) That the Health Scrutiny Panel review the Urgent Care Action Plan at 6 monthly intervals in order to assess the impact of changes are having on service delivery and levels of attendances at Wexham Park Hospital Accident and Emergency.

i) That the CCG review the accessibility of surgery numbers in Slough and work with individual surgeries where the 084 numbers are still in operation to phase these out, and confirm to the Health Scrutiny Panel a timetable for completing.

j) That a public survey is undertaken one year after the launch of the Talk Before you Walk campaign to begin to assess the penetration of the campaign and the understanding of the messages being given. This can then be used by the Health Scrutiny Panel to inform and evaluate how behaviour may be changing over time to assess the effectiveness of the campaign.

k) That the CCG consider a pilot scheme, along the lines of that undertaken in Walsall, to introduce a payment to surgeries who will provide an additional 3 hour evening session,

weekly, offering a range of clinical appointments (GP, nurse practitioner, practice nurse) for that period. The advertising of this pilot scheme should be targeted specifically at full time workers. The pilot would enable an assessment of need for this particular patient-group, and once the need has been judged and decision could be taken as to whether the additional service hours should be permanently introduced across the borough, with surgeries deciding individually whether to opt out of providing the service.

1 Background

1.1 Accident and Emergency departments are specialised units within acute hospitals, providing access to treatment for life threatening emergency injuries and illnesses 24 hours a day. Across the UK there are over 20 million attendances at A&E departments each year, where an A&E doctor or nurse assess a patients condition and decide on further action, whether this be treatment within the department or admission to the hospital.

1.2 Over the past year the condition of A&E departments across the UK has come under intense scrutiny. It has been reported in the press that the pressures on A&E departments has been growing, culminating in a level of crisis during the winter of 2012/13. A review by The King's Fund in autumn 2012 found that the number of people facing long waits when attending A&E departments had risen by 21% over the previous year. The national target for A&E departments is to see 95% of patients within four hours, and whilst this target was met across the UK as a whole, individual hospitals, Wexham Park among them, have struggled.

1.3 There are different types of A&E departments, and the data collated by the Department of Health breaks attendance and admissions down according to type. The three types are:

- Type 1 – A consultant-led 24-hour service with full resuscitation facilities and designated accommodation for the reception of A&E patients. Known as Major A&E.

- Type 2 – A consultant-led single specialty A&E services (e.g. ophthalmology, dental) with designated accommodation for the reception of patient.

- Type 3 – Other types of A&E/Minor Injury Units/Walk-In Centres, primarily designed for the receiving of A&E patients. A Type 3 department may be doctor-led or nurse-led; and it may be co-located with a major Type 1 or 2 A&E or sited in the community. A defining characteristic of a Type 3 department is that it treats, at least, minor injuries and illnesses and can be routinely accessed without appointment.

1.4 Wexham Park Hospital has a Type 1 facility (Heatherwood Hospital currently operates a Type 3 facility). Due to the unplanned nature of patient attendance, the A&E department must provide initial treatment for a broad spectrum of illnesses and injuries, some of which may be life-threatening and require immediate attention. The department operates 24 hours a day, and staff levels are adjusted regularly in an attempt to mirror patient volume/need. On average, Heatherwood and Wexham Park Hospitals NHS Foundation Trust deals with more than 100,000 A&E attendances every year.

1.5 On 17 July 2013, the Care Quality Commission (CQC) published its findings from an inspection of Wexham Park Hospital in May 2013. This report set out a series of issues relating to A&E which the Hospital was required to address:

- That people's privacy, dignity and independence was not always respected.
  - The design of the A&E department was cited as a particular challenge in this regard, with those arriving by ambulance entering the building via the resuscitation area, during which time they were able to observe patients already being treated.
  - Patients were queuing on ambulance trolleys in corridors as there was no place to them when they arrived.
  - Doubling up of bays meant staff were unable to keep conversations confidential and patients' dignity was not respected.
- That patients did not always have their care needs adequately assessed, planned, and delivered.
  - In relation to A&E the particular focus was the pressure that staff were under due to the high level of attendances and lack of in-patient beds available. This meant that the

quality of care could be inconsistent, and there were delays in assessment and treatment, long patient waiting times and queues of patients on ambulance trolleys waiting to be triaged. This lead to a concern that patient safety could be compromised.
    - The A&E department was noted, however, for having a real sense of teamwork.
- That standards of cleanliness and infection control were not satisfactory in some areas.
    - In A&E concerns raised during a July 2012 infection control standards audit had not been addressed, including: intravenous (IV) fluids stored in an open corridor which was unsupervised and unlocked; vials of emergency drugs left on countertops when they should have been stored in locked cupboards; lack of a cleaning schedule or checklist for cleaning trolleys; and equipment being visibly unclean.
    - In addition, CQC raised concerns about inappropriate storage of dirty linen and a lack of storage space in general, and 45% compliance with hand hygiene standards (from a further audit in April 2013).
- That there were not enough qualified, skilled and experienced staff to meet people's needs.
    - Whilst this was a concern trust-wide, CQC felt there were sufficient numbers of consultants and doctors in A&E, however, there was a concern (raised during a Joint Clinical Quality Review Group) that A&E staff were working additional hours, and throughout the inspection concerns were raised about the pressure on staff in the department.
- That the Trust had failed to ensure the quality of patient care in managing the high demand in A&E and knock on effect on in-patient beds.
    - This meant that the Trust had struggled to meet the four-hour A&E waiting time and ambulance handover targets.
    - CQC noted that the Trust had brought in an external A&E improvement group to look at ways to improve patient flow through the department.
- That accurate and appropriate patient records were not maintained.
    - A specific concern relating to A&E in this regard was that records were not bound together to prevent sections being lost.

The findings of the CQC inspection, in many ways mirrored the concerns of the A&E Task and Finish Group, and therefore, the Group agreed to set out the Review through four key areas:

- Demand and Capacity
- Resources/Staffing
- Patient Flow
- Unnecessary attendances at A&E

- Patient views – whilst recognising the importance of patient views, with Healthwatch newly established the timing of this Review did not allow for a joint piece of work to gather patient views. Such a piece of work should be looked at as part of any follow up pieces of work that come from this Review.

1.6 In order to inform these areas, the Group met with the following witnesses:

- Grant MacDonald (Deputy Chief Executive, Heatherwood and Wexham Park Hospitals NHS Foundation Trust)
- David Williams (Director of Strategy and Development, East Berkshire Clinical Commissioning Groups)

2 Demand and Capacity

2.1 The nature of the demand for unscheduled care means it cannot be regulated. By nature it is unpredictable and volatile. Wexham Park A&E deals with approximately 280 patients per day (104,000 per year); but these attendances are not consistently spread out through the day, and the levels of required activity vary in each case making capacity planning extremely challenging.

2.2 The general rising trend in Wexham Park A&E attendances saw a rise of approximately 3% in 2012, with the current year looking at a further increase of approximately 6% if the trend continues. This leads to the challenge of capacity planning, which must be dealt with through two general elements:

- Capacity within the A&E department
- Capacity of admitting departments (as this is often the key to the waiting time for admittance)

2.3 Wexham Park has attempted to address first the issue of capacity within the A&E department. CQC highlighted the difficulties presented by the layout of the department, so there has been a reorganisation which, it is hoped, will increase capacity whilst also dealing with the issue of patient dignity and privacy. There has been a new modular unit brought in to house the waiting area, which has freed up the previous waiting area for clinical space, with the reconfigured layout ensuring that those arriving by ambulance no longer need to be brought in through the resuscitation area. With the creation of 40% more private bays in adult A&E[1], there should no longer be the need to stack patients because of a physical lack of capacity.

2.4 The reorganisation of the layout of A&E should also be used to provide an appropriate collation area for those patients returning to the department on completion of tests. Previously, these patients have been left without knowing where to go and waiting for a member of the nursing staff to notice them and direct them appropriately. A collation area would lessen this stressful situation for the patient, as well as improving the process for the nursing staff who will know where these patients are.

2.5 As we have said previously, capacity within the hospital's admitting departments is often the key to the target of 4 hours being met. Following the difficulties experienced last winter, Wexham Park Hospital has undertaken a bed capacity review, using the midnight bed status over the past 6 months, and the past 38 months (this has enabled an understanding of the impact of the closure of A&E at Wycombe Hospital to be developed), and using a queuing theory model to understand where escalation is needed.

2.6 With the admission rate for the next 6 months predicted to require an extra 8 beds, and a target to reduce those staying longer (28+ days group which has grown) by 16 beds, and using an estimated 85-92% occupancy rate, the calculations estimate the requirement of an additional 2 beds on top of the baseline planning number.

2.7 This all means that an additional 57 beds were required. With Ward 17 providing 28 beds, this still leaves a shortage of approximately 26 beds. Wards 10 and 11 are scheduled to be refurbished and opened in March/April 2014 with approximately 55 beds, as a new surgical block. In the meantime, the Trust has identified a range of options to meet the planning shortfall.

2.8 What is clear from this exercise is the need for the whole system to work together. With improvements in primary and social care to limit those needing to go into hospital in the first place, and then providing suitable care in homes to allow those admitted to leave hospital at the earliest possible time.

[1] There has also been a 40% increase in private bays in the children's A&E but this is not within the scope of this Review.

Recommendations

a) That the Health Scrutiny Panel assess the impact of the redesign of the A&E department's layout on the capacity of the Department to manage high levels of demand over the winter period following the end of the financial year 2013/14.

b) That the Health Scrutiny Panel undertake a line of questioning in March 2014, when discussing improvements in the quality of care provision at the Trust, on the effectiveness of the discharge processes at the hospital and how the hospital staff and social care staff co-ordinate ongoing care needs.

3 Staffing

3.1 The Review was provided with a breakdown of staffing levels in A&E at all times. The table below sets this out:

SHIFTS	Early		mid		Late		Twilight		Night		
	Trained	HCA	Trained	HCA	Trained	HCA	Trained	HCA	Trained	HCA	
Shift Leader	1 x 7				1 x 7				1 x 7		
Triage	1 x 5/6				1 x 5/6				1 x 5/6		
Resuscitation	1 x 6				1 x 6				1 x 6		
	1 x 5		1 x 5		1 x 5				1 x 5		
Majors A	1 x 7	1			1 x 7	1			1 x 6	1	
	1 x 5		1 x 5		2 x 5				2 x 5		
Majors B	1 x 6				1 x 6						
	1 x 5				1 x 5		*1 x 5		2 x 5		*18.00 - 02.00
Majors C											
Paediatrics	1 x 6				1 x 6						
	1 x 5				1 x 5				2 x 5		
EDDU	2 x 5				2 x 5				2 x 5		
UCC	1 x ANP				1 x ANP		1 x ANP				
	1 x 5				1 x 5		*1 x 5				*16.00 - 00.00
Total	**14**	**1**	**2**		**15**	**1**	**3**	**1**	**13**	**1**	
Total	14		2		15		3		13		
2012/13 (pre Wycombe)	13				15				11		
Peak periods											
Stacking	2 x 5						2 x 5				
	08.00-16.00						15.00-23.00				

3.2 Wexham Park A&E operates on a staffing rota split into shifts. In addition to the standard early, late and night shifts there are mid and twilight shifts. This system means that on an average day there are 14 trained nurses on an early shift with support from one health care assistant (HCA), these will be supplemented with two trained nurses on the mid shift (starting between 10 and 12). The late shift consists of 15 trained nurses and one HCA, supplemented by three nurses and one HCA on the twilight shift.

3.3 In terms of doctors, Wexham Park A&E operates with at least one consultant on the early shift and one on the late shift. There are also, currently, five doctors on the early shift (consisting of two middle grade (registrars) and three juniors, known as Senior House Officers (SHOs). On the mid shift, there is a supplementary doctor, usually an SHO. The late shift in split in two for the doctors, between them comprising of six doctors (three registrars and three SHOs). The twilight shift adds an additional registrar and SHO, and on the night shift there is one registrar and four SHOs. The Trust confirmed that the staffing levels remain the same during weekends and bank holidays.

3.4 During identified peak periods a further two trained nurses (known as stack or queue nurses) work shifts of 8 a.m. – 4 p.m. and 3 p.m. – 11 p.m. with the hours being extended or varied as appropriate. In addition to the nursing team, there is an additional registrar on the rota and additional SHOs between 10 a.m. – 6 p.m.

3.5 It is noted that there has been an increase in the number of permanent consultants in the department and that the recruitment for the middle grade (registrars) has been successful.

3.6 A concern, which it is recognised is not necessarily controllable, is that whilst there has been an overall increase in nursing levels (across the Trust) that turnover has also been high, meaning that there are still a number of vacancies, although this does not necessarily impact directly on staffing levels in A&E. The continuous nursing recruitment through open advert, campaigns (both local, national and international) and the use of recruitment firms should all be noted for how the Trust is attempting to deal with this issue. There are however still concerns about international recruitment and the need to ensure that language and cultural barriers do not interfere with the effective provision of service, particularly in the high pressure environment of A&E.

3.7 There is recognition that when compared against the national acuity tool, Wexham Park staffing levels are above the national average, and this Review Group expects this to continue with the necessary levels of staff on shift to meet the increased physical capacity of the A&E department. However, the Trust does need to improve the optimisation of staff in individual shifts. An example of this could be the use of HCAs in A&E. The allocation of one HCA per shift is due to the limited work for them in this environment, however, there is the potential to use this role to provide more 'hotel'-type strands of work, such as providing drinks to patients or ensuring patients are comfortable and properly clothed etc., which will improve the overall patient experience, and take pressure off of the nursing staff when such requests are made by patients. It is felt that more focus on the traditional elements of care, in addition to high quality clinical treatment, will help Wexham Park A&E becoming a leader of A&E provision, maximising the patient experience.

Recommendations

c) That the Health Scrutiny Panel monitor the effectiveness of the Trust's plans for recruiting qualified, skilled, experienced staff and retaining them; and how the Trust is being established as employee of choice in a highly competitive market?

d) That Heatherwood and Wexham Park Trust consider using HCAs, Porters and other support staff in A&E to improve the overall patient experience through the provision of 'hotel'-type strands of work, such as providing drinks to patients or ensuring patients are comfortable and properly clothed etc.

4 Patient Flow

4.1 The flow of a patient through the service is key to patient experience and a measure of staffing effectiveness.

4.2 The first stage for A&E is the effectiveness of the triage system. An effective triage process will ensure that patients are directed quickly to appropriate areas for treatment, such as urgent care, minors or majors. Wexham Park A&E is currently trialling the use of 'Rat-ing', this Rapid Assessment and Treatment (RAT) process typically involves the early assessment of 'majors' patients in the Emergency Department, by a team led by a senior doctor, with the initiation of investigations and/or treatment. This approach consciously removes 'triage' and initial junior medical assessment from the care pathway, and the first doctor a patient sees is one who is fully

qualified to make a competent initial assessment, define a care plan and make a decision as to whether a patient requires admission or referral to an in-taking specialist team. Nurses and junior doctors allocated to the RAT team then implement the initial stages of the care plan. At the time of writing we do not have any feedback from this trial.

4.3 A lack of electronic patient records at Wexham Park could also be seen as an issue, particularly following the findings of the CQC inspection. Wexham Park is looking at ways of improving this, and it is noted that the introduction of electronic records is part of the Trust's 'medium term plans', the timescale for which is unclear. This is a key element for improving service provision. Records should follow patients automatically through the system which means that patients would not need to repeat information, and provides additional assurance that accurate treatment for the individual's circumstances would be administered. The Trust does have a bed management tracking system in place on the wards, but this does not apply to A&E (where a bespoke system would be required). It is also noted that the Trust does have good working processes for the transfer of patient records to GPs, however, this does not address the issue of record keeping within the hospital or the effectiveness of the transfer of patient records from A&E to admitting wards. An effective patient records system is required at Wexham Park. Staff in A&E need the support of up to date technology, to streamline records management, and reduce the problems over safeguarding information; creating efficiency savings through realtime completion, and a more effective system for records to follow the patient through each stage of the system.

Recommendations

e) That the Health Scrutiny Panel assesses the impact of the Rat-ing triage system after six months.

f) That the introduction of an electronic patient records system, currently within the medium term plans of the Trust, is brought forward.

g) That plans for improving diagnostic and pharmaceutical support in order to speed up the flow of patients through the hospital system are considered by the Health Scrutiny Panel, particularly in relation to weekend service provision, in the 2014/15 municipal year.

5 Avoiding Unnecessary Attendances

5.1 The increases in pressure on Wexham Park Hospital's A&E department are consistent with the general pattern across the UK. However, for Slough's residents it is important that the system, as a whole, works together to target this problem and bring about a more sustainable future for the service. In this regard, the Slough Clinical Commissioning Group (CCG) is vital to ensuring that only those who truly need to use A&E attend, by making primary care options more effective, accessible and better understood by the local population.

5.2 The Slough CCG commissioned a report (Verve Report) by Verve Communications Limited with the central purpose of understanding the public's awareness, perceptions and motivations for accessing A&E services and how the CCG could enable, support and encourage patients to make the right choices about where they access urgent and unplanned care.[2]

5.3 The CCG recognised the key patient patterns that emerged from the Verve Report findings, specifically:

[2] Urgent and unplanned care in east Berkshire (Verve Communications Limited, June 2013)

- that A&E is a strong brand and a popular choice for urgent care, with patients often not contacting their GPs at all in such circumstances for diagnosis and/or treatment;
- that 999 is also a strong brand;
- that GP services are perceived as a routine service, and not for urgent or emergency cases; and
- that there is an issue around GP access in Slough.

5.4 In order to tackle pressures on A&E specifically over the winter period, Slough had been awarded a £6.6m grant from the Department of Health (DoH) to support the service. With HWPT having already undertaken steps to increase the physical capacity of the department, there are three specific areas the Urgent Care Action Plan (developed by the CCG, HWPT and Social Services) aims to target with this money:

1) GPs and access to urgent care alternatives
2) boosting staffing in A&E alongside the increases in ward capacity; and
3) the introduction of measures to speed up the discharge process to move patients safely back into the community at the earliest opportunity.

5.5 In addition, the CCG are putting in place:

- 5% additional appointments daily at each surgery across the borough using innovation funding;
- linking NHS 111 with the GP appointment systems so that patients do not have to make a further call to organise an appointment;
- launching the 'Talk Before You Walk' campaign to better sign post residents to the most appropriate service for their needs;
- increasing the coverage of flu jabs across the NHS and social care sector to protect frontline staff;
- provide funding for two additional ambulances specifically to deal with GP call outs over the winter period; and
- investing in additional community matrons who would be able to effectively treat patients in their own homes.

5.6 Whilst recognising the recognition of the pressure on A&E across the primary, secondary and social care sectors, and the scale of work that is taking place to try and mitigate these problems, this Task and Finish Group does have concerns as to whether the Urgent Care Action Plan (UCAP) of the CCG will provide a robust enough response over the winter period. The Group is also concerned about the sustainability of improvements in the system's ability cope with these pressures as the additional DoH funding has only been confirmed for the current year, with the likelihood of a further year's funding being made available, but nothing beyond this.

5.7 A particular area of concern around the UCAP is how effective it would be at dealing with the problem of GP accessibility in Slough, which is a central factor in people going straight to A&E for urgent care diagnosis and treatment.

5.8 Even before they ask for a GP appointment, there is, at least, one GP surgery in Slough using an 084 number which charges at a higher call rate than a local number. This Task and Finish Group understands that NHS England recently wrote to the Local Area Team asking them remind all practices in their areas of their contractual obligations regarding the possible impact on health inequalities and access to health care, and the need to take all possible steps to phase out the use of such numbers. This Task and Finish Group supports this position and would ask that the CCG specifically take up this matter with the one surgery in Slough affected.

5.9 In addition, the Task and Finish Group understand from anecdotal evidence that the NHS 111 system thresholds may default patients to the emergency category. The CCG confirmed that the thresholds used by NHS 111 in Slough are based on national pathways.

5.10 Whilst it is good news that the CCG has agreed to fund an additional 5% of appointments at each surgery in the borough, there are some concerns as to how these additional appointments will be made available, how they will be distributed across the working day, and what the longer term options are as the funding is only guaranteed for one year (with an assumption of a secondary year over the 2014/15 winter period) and therefore will not address the broader GP accessibility problems in Slough.

5.11 The CCG has confirmed that these appointments will not be actively communicated to patients beyond a generic statement that additional capacity is being provided. The reason for this is that these extra appointments are to be ring fenced for NHS 111 and A&E to offer to patients. Whilst linking up NHS 111 with the GP appointments system is a positive step, the accessibility issues around GP appointments will not be mitigated if additional appointments are not widely available to the public contacting their surgery, and therefore the additional 5% appointments would not assist with a number of the issues this Review has highlighted. As yet, the issue around timely and convenient access to GP appointments for full-time workers has not been dealt with and therefore this large patient group may feel the only viable option available to them is to attend their local A&E department. None of the plans made available to this Group have indicated how this will be addressed, and therefore this appears to be a weakness in the current plans.

5.12 There has been a recent pilot in Walsall, where the local CCG introduced a scheme that paid individual surgeries to stay open later at night, specifically for those who work during normal business hours. The Walsall CCG scheme paid surgeries £570 for a weekly three hour session, providing a variety of clinical services (GP, nurse practitioner, practice nurse) in order to divert patients from A&E to their local GP. The Walsall pilot was then rolled out across the borough, although some GP practices opting out. Such a pilot in Slough would enable the CCG to effectively assess the demand for such a service provision.

5.13 The Talk Before You Walk campaign should raise awareness of other options for urgent care rather than using A&E as a first port of call. It is making use of a wide range of approaches through more traditional leafleting, newspaper and radio messaging, as well as social media. The Slough-specific programmes of work include mass mail-outs to households registered with a Slough GP, television information screens in surgeries and information packages on children's health distributed through children's centres.

5.14 Whilst this approach is a good start, particularly the element around children's centres, the mail-out should be to all households in the borough rather than just those already registered with a GP. A particular problem around attendances at A&E is by those not registered with a GP and therefore a mail-out to all households would also look to engage those not currently registered with a GP and could be used to provide information on the benefits of doing so. It will also be important to ensure that all those within the health care service, primary, secondary and community must be delivering the same message.

5.15 The Task and Finish Group would like to see how the campaign is really going to influence patients' every day actions, and successfully ingrain the messages into normal practice over the longer term, and assessment of this can only be done in hindsight.

Recommendations

h) That the Health Scrutiny Panel review the Urgent Care Action Plan at 6 monthly intervals in order to assess the impact of changes are having on service delivery and levels of attendances at Wexham Park Hospital Accident and Emergency.

i) That the CCG review the accessibility of surgery numbers in Slough and work with individual surgeries where the 084 numbers are still in operation to phase these out, and confirm to the Health Scrutiny Panel a timetable for completing.

j) That a public survey is undertaken one year after the launch of the Talk Before you Walk campaign to begin to assess the penetration of the campaign and the understanding of the messages being given. This can then be used by the Health Scrutiny Panel to inform and evaluate how behaviour may be changing over time to assess the effectiveness of the campaign.

k) That the CCG consider a pilot scheme, along the lines of that undertaken in Walsall, to introduce a payment to surgeries who will provide an additional 3 hour evening session, weekly, offering a range of clinical appointments (GP, nurse practitioner, practice nurse) for that period. The advertising of this pilot scheme should be targeted specifically at full time workers. The pilot would enable an assessment of need for this particular patient-group, and once the need has been judged and decision could be taken as to whether the additional service hours should be permanently introduced across the borough, with surgeries deciding individually whether to opt out of providing the service.

6 System Link Up

6.1 The Task and Finish Group welcomes the good collaborative approach to the issues around A&E involving HWPT, the Slough CCG and adult social care, culminating in the UCAP; this includes regular joint meetings to discuss pressures on A&E, daily GP/A&E consultant audits of unnecessary attendances at A&E, and monthly performance reviews. With GPs writing to their registered patients who use A&E unnecessarily, there is also an opportunity to include messages around appropriate alternative services for their specific circumstances.

7 Conclusion

7.1 This Review recognises that a lot of work has been done to improve Wexham Park A&E's level of preparation for the winter period, but also that much of the effectiveness of this preparation will only be known under testing.

7.2 There is also a recognition of the need for the system to work as whole, and we are particularly keen to see quick progress made by the CCG on their work to cut the number of attendances at A&E through better access to, and understanding of the services available in, primary care. However, to be successful the three elements of this system (primary, social and secondary care) must work together, with no 'passing the buck' to the other areas. It would be good to see this partnership clearly, transparently working effectively to reassure the public of the good processes that are being put in place for the whole of the pathway. It is hoped that the recommendations made by this Review can inform and support those strains of work already underway to improve the service provision that Slough residents receive when access urgent and emergency care in the borough.

Appendix A – The Committee agreed the following Terms of Reference for this Review:

Review Title	Accident and Emergency Provision at Wexham Park Hospital
Membership	Health Scrutiny Panel Task and Finish Group – Councillors Chohan, Davis, S Dhaliwal, Mittal and Strutton, and Colin Pill (Healthwatch Slough)
Chairing	Colin Pill
Lead Executive Member	Councillor Walsh – Commissioner for Health and Wellbeing
Strategic Director	Jane Wood – Strategic Director for Wellbeing
Officers	Sarah Forsyth – Scrutiny Officer Amanda Renn – Corporate Policy Officer
Objectives	To review the provision of accident and emergency Services at Wexham Park Hospital.
Key Lines of Enquiry	1) How busy is the A&E department at Wexham Park and what impact is this having on waiting times? 2) Does the A&E department have the necessary resources (including staffing levels and make-up) and what investment is scheduled for A&E to meet changing needs? 3) What other programmes of work are being done to assist with attendance levels? 4) What is the patient experience of A&E at Wexham Park?
Operation	The Task and Finish Group to produce a report following evidence gathering, detailing its findings and any recommendations.
Schedule of Meeting(s)	Task and Finish Group meetings
Duration of Review	July – November 2013