Response to *Urgent Care Centres: Proposed Shortlisting Approach (Ver. 6)*

The paper on Urgent Care Centres being presented to the Programme Board on 4 February 2015 should not be approved. It is at best work in progress but includes a number of assumptions and propositions that are not evidence-based and that, if implemented, could result in a clinical risk to patients.

In responding to this paper, I have included as appendices three documents that may not have been provided to the Board:

- Appendix 1: Email to the Evaluation Panel, 27/01/2015.
- Appendix 2: Revised version of the UCC paper to the Evaluation Panel, v5, 22/01/2015.
- Appendix 3: My comments on UCC Paper v5.

I will refer to these appendices in my comments on the final draft, version 6.

My conclusion, detailed at the end of this response, is that there can be an alternative proposal with UCCs in urban and rural locations having differing levels of service provision more suited to their potential footfall. Prototyping using this principle could provide an outcome that provides a "best fit" design to meet the needs of the whole of our population, urban and rural.

Work in Progress

The paper has been through multiple drafts over the last two weeks. If this were just a matter of refining language, including better definitions, or removing ambiguities, this would be understandable and acceptable.

However, the changes are sometimes more fundamental and raise a concern as to how well the model has been thought out.

In the version of the paper being presented to the Board, version 6, it states in discussing prototyping UCCS that:

> *These requirements demand an emphasis on designing, and then prototyping a low to medium acuity model.*[1]

This is in marked contrast to the previous draft which stated:

[1] V6, p10

These requirements demand an emphasis on designing and then prototyping a medicalised, medium to high acuity model of urgent care centres…[2]

The implications of the difference between these two versions are enormous in terms of resourcing, access and clinical risk. I do not believe it is advisable for the Board to approve a document when the thinking behind it is so clearly still in flux.

Consistency of UCC offer

Much is made in the document of a requirement for a consistent UCC offering. In my response to the previous draft, I highlighted that The Keogh review into Urgent and Emergency care had no such requirement.[3] This national review proposes to:

> *Support the co-location of community-based urgent care services in coordinated Urgent Care Centres. These will be locally specified to meet local need, but should consistently use the "Urgent Care Centre" name, to replace the multitude of confusing terms that are available at present. Urgent Care Centres may provide access to walk-in minor illness and minor injury services, and will be part of the wider community primary care service including out-of–hours GP services...*

The key is the local specification, which, if it does not have to be the same in both Hereford and Shropshire (both covered by the same West Midlands Ambulance Service), does not have to be the same for all potential sites in the Future Fit area.

The Board recognised this when it agreed in the parameters for the Evaluation Panel:

> *The Board approved a Long List of eight options comprising:*
>
> *…*
>
> *c) A range of between four and seven Urgent Care Centres which should ideally be co-located with Local Planned Care facilities and Community Units, and should be scaled to serve local need.*[4]

The email from the Programme accompanying version 6 of the UCC paper seeks to provide some evidence that the requirement for a single offering across all UCCs is best practice.[5]

Two sources are provided. First, a discussion document from the Primary Care Foundation published in October 2012.[6] The Programme quotes from the document that there may be risks and confusion if Urgent Care Centres provide differing services. The programme does not quote the conclusions of the report, *Chapter 6 Lessons: key points for clinical*

[2] V5, p4
[3] Comments, p1
[4] Evaluation Panel Shortlisting Pack, p5
[5] Email, p1
[6] PCF, *Urgent Care Centres, what works best?*

commissioners, which assume that there may well be different service offerings at different UCCs and propose methods of dealing with the issue. For example:

> *Describing urgent care services accurately. The Directory of Services – the DoS – underpins NHS 111. It lists the local services and the skills they have on hand as well as their opening hours and contact details. Call handlers receive an incoming call from a member of the public and ask questions guided by an IT-based clinical assessment system. This identifies the clinical skills that are required to treat the caller, enabling the NHS 111 call handlers to search the DoS for the local services with the necessary clinical skills available. Patients are then directed to the best-placed local service to meet their needs.*

> *Commissioners should ensure that this data is utilised both to update information for patients and reflected in NHS Choices and similar local sources of information. Whilst there are many alternative ways in which it could be presented we recommend that, at least for NHS Choices, a consistent structure is used that makes plain what conditions can be treated and whether there are limitations on prescribing, for example because the service is staffed only by nurses.*

The emphasis is on making it clear which services are available at the UCC at what time, not an assumption of a single standard offering across all UCCs.

The second source is the report of the West Midlands Clinical Senate Future Fit review published 19 January 2015. The Programme email suggests the report amounts to an endorsement of a single consistent offering for every UCC. This is not clear from the statement the Programme quotes:

> *The success of UCCs will be dependent upon ensuring a consistent and equitable service provision for all service users regardless of where they live (or whether the UCC is collocated with the EC).*[7]

The use of the word equitable is in relation to patients regardless of where they live. Equitability in this situation has to balance access (ease and time) with the service provision. It does not seem to me that the review has explored this issue fully. Indeed they could not. The review comments that this will be necessary to do later:

> *As part of the stage 2 review, there will be a need to further understand the travel and clinical activity modelling, which the panel was informed would be available by January 2015.*[8]

Overall the conclusions of the review can be seen as no more than tentative:

> *The stage 1 review was necessarily limited by the early phase of the FFP, and a range of untested, underpinning hypotheses. Some of the assumptions upon which the proposal was based are novel and the causal relationships asserted are not established through published studies or experience of successful*

[7] Clinical Senate Review, p15
[8] Clinical Senate Review, p15

reconfigurations and service/pathway modernisations. Finally, all of the conclusions are limited to the evidence presented, and are not exhaustive.[9]

I do not believe, based on the statements contained in the review, it can be used to sustain the argument that all UCCs are required to have identical service provision.[10]

Overall the review is a good deal less supportive of the proposals than the email from the Programme might indicate. It is a cautious document.

On workforce issues, the Clinical Senate warns that changes to working patterns 'may result in further destabilisation of the workforce', and that 'it was not possible to express an opinion over the reasonableness of the workforce plans within FFP at this stage'.[11]

On projected activity reductions, the Clinical Senate report notes:

> *The panel were of the view that the proposed reductions in activity through preventative strategies within FFP are ambitious, as reductions of this magnitude have not previously been achieved within the NHS, and it was yet to be evidenced whether this will result in a reduction in clinical need, activity and bed occupancy.*[12]

The FFP is urged to 'keep remodelling' its assumptions.

Very similarly, on proposed reductions to hospital length of stay, the Clinical Senate Review comments:

> *The application of this model across all acute activity for Shropshire and Telford however was felt to represent a significant, albeit logical, step which has not previously been delivered successfully at such scale elsewhere in the NHS. The panel's opinion was that the modelling will benefit significantly from further sensitivity analysis around this factor in advance of the stage 2 assurance review, as well as further exploration of the clinical evidence from elsewhere to support this contention.*[13]

On risk, we are told:

> *The panel had concerns, however, regarding the level of potential clinical and financial risk; and was clear that a significant level of detail would now need to be*

[9] Clinical Senate Review, p6

[10] I am also concerned, although I do not believe that this is reflected in Clinical Senate's report, that the review should be considered by the panel as "a highly political subject". In the signed minutes of the Clinical Senate dated 9 July 2014 discussing setting up the panel, a representative of the Programme is quoted as saying "… whoever will be chair of the review needs to be aware it is a highly political subject due to the fact there are currently two hospital sites which will ultimately reduce to one – there will be immediate scrutiny on the review process."

[11] Clinical Senate Review, p16

[12] Clinical Senate Review, p16

[13] Clinical Senate Review, p17

worked up in order to prove the model could be clinically and financially sustainable.[14]

The panel was of the view that there are several modelling assumptions which either assert novel causal relationships or else are significantly in excess of previously achieved outcomes. Work, therefore, needs to start as early as possible to model the impact of these assumptions…[15]

This is not a resounding endorsement of the Future Fit proposals.

Access

If identical services across all UCCs are not required by national policy, and if there is not a strong evidence base for doing so, should we attempt to prototype this model anyway?

I think the answer is no and there is a strong basis for believing this is more in line with the Keogh review. In the introduction to his report, Professor Keogh says:

We will need different approaches in metropolitan, rural or remote areas.

In the body of the report, he goes on to say of community-based urgent care services:

These will be locally specified to meet local need, but should consistently use the "Urgent Care Centre" name, to replace the multitude of confusing terms that are available at present. Urgent Care Centres may provide access to walk-in minor illness and minor injury services, and will be part of the wider community primary care service including out-of–hours GP services.

So Keogh suggests "different approaches" in urban and rural areas, and the only consistency he requires is in the naming of the UCCs - note the use of the word "may" in describing service provision which itself implies differentiated provision based on local need.

The Future Fit area, Shropshire, Telford and Wrekin, and northern Powys is predominately rural with two urban centres. The 2011 Census categorises the majority of the population of our catchment area as living in rural locations (this is even with some of the market towns such as Ludlow being categorised as urban). The implication of this is that rurality cannot be simply an afterthought for Future Fit. While we cannot forget the needs of the two urban centres, Shrewsbury and Telford, Future Fit cannot proceed by ignoring the urgent care needs of the majority of our population.

Frequently our rural areas have a high proportion of elderly people who are more likely to need urgent care. Similarly, there are large pockets of rural deprivation, with associated health needs, that are often less visible than those in urban settings.

[14] Clinical Senate Review, p18
[15] Clinical Senate Review, p18

Access to healthcare is a fundamentally important issue. Ensuring that the most common healthcare needs are brought closer to home is vital. This cannot be done if the Urgent Care Centres are only located in the major urban areas.

A survey conducted by Ludlow's Station Drive Surgery Patient Group showed that 32% of patients would be dependent on public transport or getting a lift to attend an appointment at RSH, rising to over 39% for appointments at PRH. Also striking is the finding that there is an increased reluctance/ability to use one's own car as a patient transport with increasing age. For under 55s, 83.3% would use their own car; 55-65s, 71.7%; 65-75s, 64.9%; over 75s, dropping to 46.7%. This demonstrates very starkly the problem of access with an ageing population.

The paper rightly recognises that the services provided by a UCC must provide an activity level that is sustainable. The catchment patient numbers for the potential UCC locations are different between the rural and urban locations. All of the rural locations have a catchment population at or below 30,000. It has been suggested at Evaluation Panel meetings by a representative of the Programme, that the service offerings for a UCC would be modelled using a population of 50,000. This in itself gives rise to the question of sustainability of rural UCCs.

It is recognised in the paper that it is not simple to increase a catchment population through restricting the number of locations in rural areas. Patients from Bridgnorth would rather travel to Telford or Wolverhampton than Ludlow for treatment if there were no UCC locally.

The projections in the paper show a tremendous disparity in patient activity between the various potential locations. Although, because the Bishops Castle number did not include most of the potential Powys patients, the projected patient activity there is artificially low. The total activity at the 4 other "market town" UCC locations is projected to be between 1.95 and 2.49 per hour. With this level of total activity, it is certain that some services which would be sustainable with the much higher footfall of the urban UCCs would not be sustainable in the rural locations.

There are two choices, with this disparity, if we are to have UCCs outside the two urban centres. Firstly, a common offering across all UCCs which would be lower than would be sustainable at the urban locations. I do not believe that would be in the best interests of the urban population. Secondly, a differentiated offering that recognised that some of the potentially underutilised services would not be offered at all locations. This would enable some assessment and treatment closer to home for rural patients but not require an unsustainable level of service everywhere.

The question of viability

The proposals for UCCs are ambitious. The UCC paper opens with the suggestions in the Clinical Model. UCCs will be open 16 hours a day, and will be able to 'signpost' for the

remaining 8 hours.[16] They will offer ultrasound and x-ray facilities, simple bloods, an observation unit, and a pharmacy.[17] The observation unit is extended in the latest versions of the UCC proposals to include short inpatient stays.[18] At least one clinician 'will require expertise to perform comprehensive geriatric assessments' and we are told 'Therapy services will also be required…'.[19] The need for paediatric expertise is slightly fudged, but we are advised 'rapid access to specialist paediatric advice would mitigate but not eliminate the need for clinicians with appropriate paediatric experience'.[20] On staffing, it is suggested, 'Ideally this would comprise clinicians from primary, community and secondary care and mental health along with staff with novel roles and skills which cross traditional professional boundaries'.[21] These are intended to be major units. Who would not want one of these centres on their doorstep? The question is, however, are they viable in an area where the maximum patient activity is less than 15,000?[22]

Staffing proposals are perhaps a little less ambitious in the 'Staffing of UCCs' section of the paper[23], but the proposal is for GPs with additional training in emergency medicine, for Advanced or Extended Nurse Practitioners who will assess and treat the majority of patients, for nurses to support these staff, and for on-site practitioners to undertake plain film x ray and ultrasound. Co-location of mental health and social care professionals is deemed 'highly desirable'. These are extremely costly proposals. Again, the question is whether this 'all singing all dancing' model is viable for a target activity of less than 15,000?

> *'Staff who have the required skills and desire and aptitude to work in UCCs are likely to be relatively scarce. Therefore it will be important to be able to make the best use of relatively scarce skills and to ensure that skills are maintained and updated. This can be achieved by ensuring that staff are dealing with a sufficiently high volume of work to maintain their skills…'.*[24]

Consider the question of Sonographers. We have a stated need, in this prescriptive UCC model, for ultrasound to be available for 112 hours a week. With a working week of 37 ½ hours, and typical downtime of 20% for leave, public holidays, sickness absence, cpd and work-related meetings, this leaves 30 hours a week. For each UCC, we will require 3.73 wte Sonographers i.e. close to 4 wte highly specialist members of staff. Sonographers are relatively well paid. A trainee Sonographer might be a Band 6, but an experienced Sonographer – as would be required in an environment without immediate support from colleagues – would be a Band 7. Calculating costs, using the Government's 'Ready Reckoner for CCGs', this gives us an overall annual cost for Sonographers of £158,796 (including on-

[16] V6, p1
[17] V6, p3
[18] V6, p10
[19] V6, p2
[20] V6, p2
[21] V6, pp2-3
[22] V6, p8
[23] V6, p5
[24] V6, p5

costs). This is for 3.73 wte. If we realistically round up to 4.0 wte, this takes us to £170,291. This is without the costs of unsocial hours payments – and of course, without the costs of the equipment that Sonographers will need to do their jobs.

Out of our estimated foot fall of up to 2.5 patients an hour for our 'market town' UCCs, how many will actually require an ultrasound? One per cent? That would give us one patient every two and a half days. Two per cent? Even with what would probably be a gross over-estimate of five per cent, there would be between only two patients a day requiring an ultrasound. This is simply not sustainable. No self-respecting clinician would wish to be employed on this basis, this is overwhelmingly clearly not making the best use of scarce skills, and the cost of providing the service is not sustainable. Even if services are shared with a co-located community hospital, and the service is offered to GPs, this is not a viable service.

The same arguments apply, albeit a little less strongly, to the provision of X-ray facilities. Currently, Ludlow Hospital offers an X-ray service from 9.00 am to 3.00 pm, Mondays to Fridays. This is primarily by appointment only but includes three 1.5 hour unscheduled GP referral work sessions per week. In Whitchurch, the service is 9.00 am to 1.00 pm, three days a week. At other community hospital locations, the service is by appointment only. Any model that insists on an X-ray service being available at UCCs 112 hours a week must incorporate the sharply increased costs that will be incurred, even if co-location is assumed. There is a very substantial gap between the one part-time Radiographer required at our Community Hospitals now, and the four whole time equivalents who will be required at each UCC – if there is an insistence on that service being available 16 hours a day, 7 days a week.

If the standard model for UCCs must apply to each UCC in Shropshire, and the standard model includes all of the services outlined in the UCC proposal, it is simply impossible to have a sustainable UCC in towns the size of Ludlow, Bridgnorth, Oswestry or Whitchurch; still less in smaller towns such as Bishop's Castle. Perhaps, then, there is something wrong with the standard model.

MIUs

Telford and Wrekin currently has two Walk In Centres: one at PRH, and a second in Telford town centre.

Shropshire has four MIUs: Bridgnorth, Ludlow, Oswestry and Whitchurch. There are also four community hospitals: Bishop's Castle, Bridgnorth, Ludlow, and Whitchurch. In addition, Oswestry Health Centre offers diagnostic services akin to those of the community hospitals. (The Monkmoor Walk-In Centre closed in December 2014, replaced by an Urgent Care Centre at RSH). The wider range of provision in Shropshire reflects the rural nature of the area.

All of these facilities overlap, in terms of service provision, with the services that will be provided by Urgent Care Centres. The future of MIUs and diagnostic facilities provided from community hospitals becomes a very important question. In urban areas, patients will continue to have access to urgent care (albeit at Urgent Care Centres rather than Walk-In Centres or the A&E). In rural areas, options are more limited.

It has been stated repeatedly during Future Fit engagement events that Urgent Care Centres will replace Minor Injuries Units, with Minor Injuries Units closing down. This has been stated publicly by the Programme at a number of patient engagement meetings over the past year. This is one of the key reasons I have supported seven Urgent Care Centres, with whatever level of service is viable to meet the needs of a local community.

Concerns regarding this were raised at the most recent Evaluation Panel meeting, resulting in what appears to be a 'quick fix'. (The prototype approach to UCCs is in itself a 'quick fix' that artificially separates urgent and emergency care, instead of seeing them as part of an integrated whole).

The latest proposal on low acuity care, introduced after the 20th January meeting, seeks to introduce a third tier of urgent and emergency care, at least for rural areas – at odds with the two tier system proposed nationally, and introducing a significant level of confusion with a new name for a previously undiscussed service: '24/7 Local Care'.

On 22nd January this stands alone as the third tier of urgent care, with the Emergency Centre and Urgent Care Centres being the first and second tiers. [25] By 27th January, it is part of a shared tier: a Major Emergency Centre (out of county) is the first tier; a single local Emergency Centre is the second tier; and the 'third and largest tier consists of a range of urgent care offerings, including UCCs and primary care'.[26] The change appears to be a retrospective attempt to match the proposal against the tiered schematic representation in the national Transforming Urgent and Emergency Care reports. For a proposition that none of us had ever heard of before 22nd January, its evolution has been remarkably rapid.

The outline description for 24/7 Local Care states:

> *24/7 Local Care will be provided by a collaboration and integration of primary care (GP surgeries), Out of Hours GP services, pharmacies, community services, including community hospitals and Minor Injury Units (MIUs), the voluntary and third sector and local communities themselves. These services will be embedded in local communities, some as part of a 'community hub'. There are likely to be a range of combinations, collaborations and partnerships which will provide a consistent and easily accessible low acuity local urgent care service. This reflects*

[25] V5, p5
[26] V6, p10

the recognition that 'one size does not fit all' and that urban and rural solutions are likely to be different.[27]

Superficially, this sounds tremendously positive – but is so vague, that in reality it gives no meaningful picture as to where or by whom low acuity urgent care will be delivered outside Urgent Care Centres. Even more worryingly, low acuity urgent care is suddenly perceived as no longer part of Future Fit. The paper suggests:

It is important to recognise that, although 24/7 Local Care is a key element of the three tier model of urgent and emergency care and of the wider provision of health and social care as described in the Future Fit clinical design report, it lies beyond the strict scope of the current Future Fit programme and is therefore not considered in the long list and short list of options.[28]

In the Clinical Model, and at the multitude of engagement meetings that have taken place, low acuity urgent care has been a part of the Future Fit remit. What discussion has taken place with clinicians – or the public, or patient representatives – to warrant its removal?

There are two problems here. Firstly, MIUs get lost in the general fog. Currently, we have four Minor Injuries Units. The services they offer will be *'embedded in local communities'*[29] and/or, if not designated as Urgent Care Centres, *'subsumed into 24/7 Local Care'*.[30] We also know, *'In both cases, they will cease to be called MIUs'*.[31] Unless the financial and clinical resources released by subsuming or embedding the MIUs is identified, protected, and invested in low acuity urgent care as part of Future Fit – then this is almost certainly a verbose approach to closing MIUs.

The suggestion in the email from the Programme, that this is totally in line with the national approach,[32] is not backed up with any evidence. The quoted statement from NHS England's Five Year Forward View is aspirational, but there is no content, nor has there been any visible work by the Programme, to understand what its implementation would mean in our area.

The suggestion of 'prototyping one or more 24/7 Local Care models in different locations and environments'[33] is not particularly reassuring. We are seeing a Future Fit project that is steadily being whittled away. Urgent Care Centres will not be consulted on alongside the options for Emergency Care – because Urgent Care Centres are the subject of 'prototyping'. Now, the closure of MIUs will not be consulted on, and the provision of low acuity urgent

[27] V6, p10
[28] V6, p11
[29] V6, p10
[30] V6, p11
[31] V6, p11
[32] Email, p1
[33] V6. P11

care in rural areas will not be consulted on as part of Future Fit – because these things are suddenly deemed to be no longer a part of Future Fit at all. The strength of Future Fit was its vision – the breadth of the proposals in investing in and building community alternatives to acute care. The danger is that it is becoming a much lesser thing: an attempt to bail out a financially challenged acute trust.

Ambulance Service

Much play is made in the paper of the problems of the Ambulance service.

> *There is a strong view expressed by the Ambulance service and based on experience locally and elsewhere that the current MIU/WIC etc. services do not provide a consistent offer and this encourages patients and the ambulance crews to go straight to A&E.*[34]

The solution appears to be utilise the new UCCs as a standard destination for emergency (999) calls.

> *Ambulances responding to 999 calls will use UCCs as a destination, as long as service standards are precise and consistent, allowing the use of decision support algorithms.*[35]

Again this does not require a consistent service provision across all UCCs. The solution to enable taking advantage of different service provisions at different locations suggested by the Primary Care Foundation for NHS 111, quoted above, is equally applicable to Ambulance response centres, and through them Ambulance crews.

More importantly, using UCCs as a primary destination for 999 emergency calls seems in direction contradiction to the Emergency and Urgent care network model illustrated in the paper.[36] The illustration, taken from the NHS England proposals, shows all 999 calls having a destination of either an Emergency Centre or a Major Emergency Centre. The UCCs are accessed by NHS 111, GPs, walk in, etc.

Even in the current prototype UCC at RSH, all emergency ambulance arrivals go straight to A&E, bypassing the UCC triage.

There are problems with ambulance services in our area. They will not be solved by proposing alternative destinations with differing transport times. The lack of modelling of ambulance response within the Programme is of great concern. It was stated at the Evaluation Panel on 20 January that all necessary data from the Ambulance services had not yet been provided. This makes it more important to not go ahead with a proposal that is not evidence based.

[34] V6, p4
[35] V6, p2
[36] V6, p11

Conclusion

I have the strongest possible concerns regarding the proposals for urgent care.

As outlined, the proposals will almost certainly result in an outcome of only two Urgent Care Centres, rather than the 'network' of UCCs offering 'care closer to home' that has been sold to the public. I do not believe it is viable at any of the market town locations proposed as potential prototypes to reliable provide the range of services that have been suggested for the UCCs. With undifferentiated "maximum" service offerings, as outlined in the paper, UCCs would only be viable at RSH and PRH where, as well as a larger footfall, they already have available the resources of an acute hospital.

There is no guaranteed future for MIUs or for the diagnostic facilities currently available at our community hospitals (and Oswestry Health Centre), and these services will be replaced by the centralised UCCs. There will therefore be reduced access to urgent care for a high proportion of our population, especially those living in market towns and more rural areas.

The proposals also appear surprisingly ad hoc. The last two revisions have included major changes in content, rather than detail. The broad approach is in fact completely lacking in detail, and does not appear to be evidence based. This is not a good basis for a major reorganisation of Shropshire's urgent care.

I am also concerned that the paper does not talk about timescales for the prototypes. I understand, from the statement at the Evaluation Panel meeting, that it is now envisaged that formal public consultation on the preferred option will commence in December 2015. Unless the prototypes are completed before that date, and the conclusions embedded in the proposal for the consultation, the public will be faced with a consultation where the structures for emergency and urgent care are presented only half formed. The public would be entitled to make different judgements about the location of an EC based on the planned locations of UCCs. We need an approach where we can guarantee that a close to finalised proposal for UCCs will be included in the formal consultation process.

I propose that the Board makes the following decisions:

1. Not approve the paper in its current form.
2. Agree that UCCs may have different service provision based on the different potential footfalls.
3. Agree that, in principle, the Programme will work toward 7 UCCs in its preferred option to ensure that urgent care can be delivered closer to home in more cases.
4. Compete the modelling of UCC provision – activity, resource, access, and cost – and more fully evaluate evidence about urgent care provision, so that any prototyping is based on completed models and evidence rather than simply blue sky thinking. This should also include the modelling of shared facilities where there is co-location, having the advantage of bringing the other localised components of Future Fit into the model.

5. Prototype provision at a number of potential UCCs to refine the modelling. This does not need to be at all locations. One or two rural locations might be sufficient to learn applicable lessons.

6. Include both the principle of 7 UCCs and any detail derived from the modelling and prototyping activities in the documentation available during the public engagement over the shortlist and in the consultation on the preferred option.

This is not an argument about detail. It is fundamental. Good healthcare depends on access to healthcare. The proposal to move to a single Emergency Centre will potentially reduce access to emergency care and acute care. If we now embark on a prototype that 'proves' to people in our market towns and rural areas that they cannot be compensated by having better access to urgent care, this is surely unacceptable.

Pete Gillard
Chair, Station Drive Surgery Patient Group
Shropshire Patient Group representative on the Evaluation Panel
28 January 2015

Appendix 1: Email to Evaluation Panel, 27/01/2015

Dear All

Please find attached the further revised UCC proposal. Could you please let me know by the **end of Wednesday** whether or not you are content with it as a fair representation of where the panel got to. As agreed previously in relation to panel discussions, what is presented to Board will reflect the Panel consensus with any divergent views being separately noted.

Following circulation of the revised UCC paper, two comments were received.

1. One member suggested that the new text is placed inappropriately and better belongs with the 'Proposed Approach' section. This change has been made.

2. Another member felt that the revised paper had strayed from national guidance and from the clinical design report, and proposed changing to a 7 UCC offering (see attached). This change would not be in line with what the panel agreed. This response did, however, highlight the potential for misunderstanding the terminology used in the added section, so this has been revised to clarify matters and to reinforce alignment with national guidance and the clinical design report.

In addition to these changes, it also feels important to address the key challenges raised in the submitted responses:

<u>The Urgent & Emergency Care Network</u>

The Clinical Design Report proposes fully networked urgent and emergency care which is tiered (to reflect on acuity of need), consistent and branded. This aligns with the tiered model of care set out in the Keogh Review and is echoed in the Five Year Forward View which describes *Helping patients get the right care, at the right time, in the right place, making more appropriate use of primary care, community mental health teams, ambulance services and community pharmacies, as well as the 379 urgent care centres throughout the country. This will partly be achieved by evening and weekend access to GPs or nurses working from community bases equipped to provide a much greater range of tests and treatments; ambulance services empowered to make more decisions, treating patients and making referrals in a more flexible way; and far greater use of pharmacists.*

<u>The Need for Consistency of UCC Offer</u>

The proposed approach responds to the need to provide consistency of service offer. Whilst there can be variety between different urgent care services (e.g. between GP

Out of Hours and Community Pharmacies) there must be consistency of Urgent Care Centre offering. This has been emphasised in feedback from both patients and ambulance services. In addition:

a) The Primary Care Foundation UCC Report notes that *There is considerable confusion about what services are available to patients with an urgent need. This inconsistency increases the risk that a patient attends for an urgent condition that cannot adequately be treated.*

b) The recently published report of the West Midlands Clinical Senate Review into Future Fit proposals notes that *the model of EC and UCCs is both a good idea and in line with national guidance. The success of UCCs will be dependent upon ensuring a consistent and equitable service provision for all service users regardless of where they live (or whether the UCC is collocated with the EC).*

Modularity

Where the paper and the clinical design report refer to modularity, this does not mean to suggest that there are modules within an Urgent Care Centre, rather that a UCC is one module of local service provision. There are other modules relating both to urgent care and to other care needs. The proposed colocation of LPC and CU with UCCs is also an aspect of modularity which would increase workforce efficiency (e.g. in radiography) and provide access to beds. This colocation is currently described as ideal rather than essential, however.

The latest revision of this paper will now go to Programme Board on 4th February when it will consider this and the panel's other recommendations before determining the final shortlist. The confidential nature of these papers remains until that time.

With many thanks for all your input

David

David Frith

Senior Programme Manager

07720 341303

Appendix 2: UCC Paper, version 5, 22/01/2015

Urgent Care Centres

Proposal for Evaluation Panel 20 January 2015

Introduction

The purpose of this paper is to recommend to the Evaluation Panel a proposed approach to developing Urgent Care Centres (UCC).

This paper sets out:

- The options considered for UCCs
- The philosophy and role for UCCs
- UCCs in the context of tiered urgent and emergency care
- The staffing requirements for UCCs
- The proposed approach to developing UCCs.

Background discussion

A range of clinicians and patients have been involved in discussing the concepts of UCCs in a variety of forums. The discussions have taken place before and following the agreement of the Clinical Design report which set out the broad vision of UCCs.

The following is an extract from the Clinical Design Report that sets out the vision and description for UCCs.

The Future Fit Clinical Model set out the principle of a single Emergency centre and multiple Urgent Care Centres (UCCs), i.e. an Urgent Care Network:

> *UCCs, strategically placed across Shropshire and Telford and Wrekin, will provide low and medium acuity urgent care 24 hours a day (potentially open 16 hours and able to signpost for the remaining 8 hours). The exact number of centres is dependent on*

precise configuration, but each one must offer the same consistent services which patients understand and can rely on. A 'modular' design concept is adopted to reflect this need.

One UCC will be co-located with the EC. It is important that this UCC is not designed to be 'bigger and better' than the other UCCs. If this was the case, patients would by-pass other units and come to the UCC next to the EC (as is the case currently with people by-passing minor injury units and travelling much further to A&E).

Access will be 'walk in' or potentially by appointment made through 111 triage, GP practices and GP OOH. Ambulances responding to 999 calls will use UCCs as a destination, as long as service standards are precise and consistent, allowing the use of decision support algorithms.

UCCs will see and treat primary care urgent care problems and 'minors' (as described in A&E), but will also care for patients with higher acuity problems without necessarily transferring them to EC. For example this would include simple fractures, stable pneumonia and abdominal pain. The service standards would be based around those required to deal with 'ambulatory care sensitive conditions', excluding those requiring advanced imaging (CT and MRI scans)

The following is a list of conditions that could be treated by an UCC. The conditions that can be treated will depend on the configuration of the UCC; staffing, access to diagnostics, beds etc. (Note: list taken from Future Fit clinical model)

- *Intravenous antibiotics*
- *Palpitations*
- *'off legs'*
- *Stable pneumonia*
- *Stable anaemia*
- *DVT's*
- *Abdominal pain*
- *Feverish child*
- *Chest pain*
- • *Limb fractures*
- *Suicidal*
- *D+V – children*
- *Wheezing child*

Burns – child

- *Troponin/ECG*
- *Delirium*
- *Non life threatening*

At least one clinician in UCCs will require expertise to perform comprehensive geriatric assessments in order to care for patients presenting with frailty syndromes, many of whom would benefit from not being admitted to hospital. Therapy services will also be required to facilitate rapid holistic assessment, intervention and care planning.

Unwell children could be assessed and treated at UCCs but the skill set required is specific and not all GPs or generalists have these. Rapid access to specialist paediatric advice would mitigate but not eliminate the need for clinicians with appropriate paediatric experience.

The broad based skill mix required to manage UCCs gives strong incentive to draw staff from different care settings and organisations to collaborate in service delivery. Ideally this would comprise clinicians from primary, community and secondary care and mental health along with staff with novel roles and skills which cross traditional professional boundaries. There are big potential advantages to this approach – mutual and continuous learning, role and team development and co-responsibility for UCCs which then operate across a number of care setting, professional and organisational boundaries.

If a proportion of primary care urgent care activity is diverted to UCCs then a primary care workforce would be developed as part of the overall staffing of UCCs. This would allow practices to deliver some urgent care at scale and potentially free up resources for LTC management.

UCCs require an ultrasound and plain x-ray facilities, simple bloods (not necessarily point of care testing), an observation unit (up to six hours for children and up to 12 hours for adults) and a pharmacy for 'to take out' (TTO) stock items for OOH.

Usage of the ultrasound and plain x-ray facilities will be maximised by employing them for planned care as well as urgent care activity. Unlike plain x-ray, ultrasound is operator dependant and cannot be interpreted remotely. However, there are enough routine GP requested ultrasound scans to employ several sonographers for five or six days a week.

Other beneficial co-locations will be GP OOHs, although this could integrate and form part of the staff of the UCC, the Community Mental Health Team, with access to Social Services, a Community Hub with a range of community and voluntary sector services and possibly community beds providing medium acuity care to people with either medical or intensive rehabilitation needs. Co-location of ambulatory rehabilitation services would also improve the urgent care of people who are frail.

Key Objectives from Clinical Model

Patients need to trust that UCCs can meet their needs, whatever these are and however undifferentiated they may be. If they don't, they will not use them.

UCCs must provide a consistent 'common offer' in terms of services and access, wherever they are sited. If one UCC is perceived to provide better care, patients will bypass the others to attend 'the best one'.

Integration of systems to achieve an efficient and effective network urgent care network.

Effective support to manage broader demand and capacity across the system.

Since the Clinical Design Report was approved further clinical groups have been convened to refine thinking and provide more detail on the working of UCCs.

UCCs as Part of Tiered Urgent and Emergency care

In order to deliver a 'consistent offer', which gains patient trust and encourages appropriate [37]usage, there will be three tiers of urgent care, each clearly branded and it's services easily understood by patients, so they can make informed and appropriate choices about where to go when they need urgent assessment and care. Telephone and internet information and navigation services (111, 999, GP surgeries and out of hours, NHS choices) will also more triage and guide patients to the right level of care more easily and effectively.

The single emergency centre will form the top tier and receive patients conveyed by emergency ambulance (999 in the community and transfers from UCCs) and direct GP admissions. The EC will not offer a walk in service. It will provide the highest acuity urgent and emergency care with all the relevant clinical adjacencies in place to achieve this.

A small number of Urgent Care Centres will form the second tier of urgent care, and the services these will provide are explored in this paper. Current design work is focussing particularly on developing functional and efficient networking between UCCs and the EC to ensure the safe care of higher acuity patients at UCCs who require specialist clinical support from the staff at the EC. Some will require ambulance transfer from UCCS to EC. In conjunction with this, UCCs must also be configured to receive a significant number of patients conveyed by ambulance as a viable and safe alternative destination to ECs. These

[37] The highlights in this version of the paper were included in the copy provided to the Evaluation Panel and reflect the changes from version 4 of the document; the version considered by the Panel at its 20 January 2015 meeting.

requirements demand an emphasis on designing and then prototyping a medicalised, medium to high acuity model of urgent care centres, with all the accompanying constraints on staff, equipment, beds (for observation and short stay) and costs. Whilst prototyping will demonstrate the ideal configuration, it is for this reason that only four urgent care centres are being planned in the first instance. It does not preclude a different number in future.

The third tier of urgent care will be provided as '24/7 Local Care' (name to be approved / modified!), a collective name for the services provided by a collaboration and integration of primary care (GP surgeries), Out of Hours GP services, community services, including community hospitals and Minor Injury Units (MIUs), the voluntary and third sector and local communities themselves. These services will be embedded in local communities, some as part of a 'community hub', and, because 'one size does not fit all' and in recognition that urban and rural solutions will be different, there are likely to be a range of combinations, collaborations and partnerships which will provide consistent and easily accessed low acuity local urgent care services.

Although, from a service user perspective, there must be a clear demarcation between the three tiers, from an operational perspective there will be some overlap in services. Whilst the focus of the UCC design work is on the working relationship between UCCs and the EC, prototypes of 24/7 Local Care will explore the boundaries and working relationships between Local Care and UCCs.

Service Philosophy

The discussion points on purpose and service philosophy centred on the need for UCCs to command wide public and clinical confidence in their role as an alternative to A&E for some conditions and the extent to which they would need to be different from current MIUs and WICs.

There is a strong view expressed by the Ambulance service and based on experience locally and elsewhere that the current MIU/WIC etc. services do not provide a consistent offer and this encourages patients and the ambulance crews to go straight to A&E.

Clinicians are generally of the view that the current WIC/MIU services do not provide a comprehensive or consistent alternative to the non-life threatening elements of an A&E service.

There is broad clinical consensus about the overarching purpose and service philosophy for UCCs. This means that UCCs must:

> Command public and clinician confidence that they can assess and treat a wide variety of urgent but not life threatening conditions for at least 16 hours a day seven

days a week (with 24hr provision built in to the system so care does not default to the EC just because the 'lights are on').

In order to achieve this:

they must be staffed by clinicians who are skilled and trained to assess and treat a wide variety of presenting conditions

UCCs must be able to provide a consistent offer – all UCCs have the same capability wherever they are and each can deal with the variety of presenting conditions for all of the hours that they are open.

Clinicians in UCCs must be able to draw on specialist expertise and support in a short period of time (say within an hour) via telephone and imaging links

Clinicians must be able to observe patients for a period of time within a UCC

The UCC model should be consistent with emerging national guidance on networked urgent and emergency care

Staffing of UCCs

The view of the purpose and service philosophy of UCCs leads to a discussion on the appropriate staffing model for UCCs.

The discussion centres largely around the type of clinical leadership that UCCs require in order to deliver a comprehensive urgent care service that deals with most non-life threatening urgent care and which can quickly make a decision to transfer to an Emergency Care Centre if required.

The clinical consensus is that for the majority of the conditions and cases presenting to UCCs Advanced or Extended Nurse Practitioners (ANPs) will be the most appropriate person to assess and treat the patient.

However, more complex conditions and cases will present and for these might be up to 25% of the workload. For these more complex cases it will be necessary for a skilled generalist to be available to be able to manage and assess individual risk and treat accordingly. These

skilled generalists will also need to be able to access more specialist advice, e.g. for psychiatry, paediatrics, trauma and acute medicine by telephone within a short (less than one hour) period of time.

Theses skilled generalists are assumed to be GPs with additional training in emergency medicine, building on their general medical training to assess and manage undifferentiated need and clinical risk, although as plans are developed in more detail different workforce options such as Physician Assistants should be considered.

To support the skilled GPs/PAs and ANPs nurses will be required to support observation of patients and undertake simple to medium complexity care tasks and undertake simple blood tests.

In addition to point of care pathology testing it is assumed that on site practitioners will need to be able to undertake plain film x ray and ultrasound.

It is also assumed the co-location of mental health and social care professionals would be highly desirable.

Staff who have the required skills and desire and aptitude to work in UCCs are likely to be relatively scarce. Therefore it will be important to be able to make the best use of relatively scarce skills and to ensure that skills are maintained and updated. This can be achieved by ensuring that staff are dealing with a sufficiently high volume of work to maintain their skills and through a staff rotation programme that means staff have the opportunity to work in different settings.

It is also assumed that co-locating UCCs with other community elements of the Clinical Model such as Local Planned Care facilities and Community Units would allow more efficient use of staff and facilities but this has not yet been planned or analysed in detail. This co-location was recommended both in the Clinical Design report and endorsed by the Evaluation Panel and therefore the planning of UCCs will take this into account.

It is also assumed that, by bringing together professionals from a range of disciplines, UCCs will be offer an opportunity to foster collaborative working.

Assumed Levels of Activity in UCCs

The activity and capacity group has considered a range of conditions that could be treated in UCCs as opposed to Emergency Care Centres. The activity assumed to be treated in UCCs in the future is drawn from the following existing services:

Less serious conditions that currently present to A&E

Current walk in centre activity

Current MIU activity

GP out of hours activity

DAART activity

If all of these are added together in total it is assumed that some 150,000 patients could be seen in UCCs.

The table below is taken from the Phase 2 modelling. It provides **an indication** of the likely diagnoses of 61,000 of the 150,000 patients who might attend UCCs. These are the patients who are assumed to be able to be seen in a UCC rather than an EC. It also shows the types of conditions that are expected to continue to be treated in the EC. It shows that for most conditions patients may attend either the UCC or EC depending on the severity of their condition and highlights the need for UCCs to be staffed with skilled clinicians able to deal with a wide variety of conditions and able to triage expertly. These figures should be viewed as indicative of the type of work flowing to each type of facility rather than a firm prediction.

Primary Diagnosis	Emergency Centre	Urgent Care Centre
Allergy (including anaphylaxis)	708	0
Bites/stings	95	550
Burns and scalds	157	682
Cardiac conditions	4,082	1,976
Central nervous system	3,006	2,675
Cerebro-vascular conditions	1,690	0
Contusion/abrasion	584	5,673
Dermatological conditions	87	242
Diabetes and other endocrinological conditions	241	138
Diagnosis not classifiable	158	210
Dislocation/fracture/joint injury/amputation	5,216	4,685
Electric shock	32	0
ENT Conditions	1,777	2,411
Facio-maxillary conditions	1,185	0
Foreign body	118	401
Gastrointestinal conditions	3,626	2,812
Gynaecological conditions	1,237	0
Haematological conditions	297	0
Head injury	1,383	3,078
Infectious disease	195	194
Laceration	1,545	7,297
Local infection	353	844

Muscle/tendon injury	881	4,459
Near drowning	7	0
Nerve injury	1	0
Nothing abnormal detected	20	55
Obstetric conditions	163	0
Ophthalmological conditions	11,583	0
Other vascular conditions	370	0
Poisoning (including overdose)	2,630	0
Psychiatric conditions	334	463
Respiratory conditions	3,587	2,107
Septicaemia	343	0
Social problem	149	111
Soft tissue inflammation	112	464
Sprain/ligament injury	1,628	14,119
Urological conditions	1,320	1,447
Vascular injury	2	0
Visceral injury	11	0
No diagnoses	2,831	3,991
Totals	**53,744**	**61,084**

However, this activity is unlikely to be split evenly across all potential UCC sites. Patients are likely to travel to their nearest UCC which means that the UCCs assumed to be at RSH and PRH will have a much larger natural catchment population than the UCCs in smaller communities. In addition it is possible that patients will choose to travel to an urban UCC believing that they may receive a better service because of the proximity to the EC.

Setting aside the latter risk, the following table sets out the assumed distribution of activity in a seven site UCC model. It is assumed that in a model that has fewer UCCs more patients will attend the two urban UCCs rather than a different rural UCC because the travel time to the urban UCC will be shorter than to an alternative rural UCC and because it is more likely that patients will naturally gravitate towards the urban centres if a local alternative is not available.

Potential UCC patient numbers in 7 site model, assuming patients travel to nearest centre (13,000pa = 2.2ph)

UCC	Bishops Castle	Telford 2
Royal Shrewsbury	31,744	31,706
Princess Royal	56,847	15,252
Bishop's Castle	4,853	-
Bridgnorth	11,382	9,086
Ludlow	13,436	16,090
Oswestry	14,539	14,539
Whitchurch	12,856	12,856
Telford alt.	-	44,280

The relatively low numbers of patients assumed to travel to the rural UCCs present a challenge both in terms of the resulting cost per patient attendance and also in terms of the ability to recruit and retain staff with the necessary skills who may be deterred by the lack of work flowing to smaller UCCs.

The catchment analysis above suggests that the second Telford site would predominantly take work from the first Telford site and would not achieve significantly improved access for communities who have further to travel to UCCs.

The analysis also suggests that the likely activity in three of the four remaining locations is similar with the fourth (Bishops Castle) being considerably smaller.

Proposed Approach

There is more work to do to understand in detail how UCCs will work and to define their relationship with other components of the Clinical Model.

The staffing model and the activity model are untested and built on a range of assumptions. This suggests that we need to proceed with caution and adopt a prototyping approach in setting up UCCs.

This would allow us to test:

- whether we can recruit staff with the right skills
- whether we can build public confidence in the model
- how a variety of patient pathways will work in a networked EC/UCC model
- How UCCs will link to 24/7 primary care services
- What services envisaged in health hubs could be provided from UCCs
- the need for co-location with beds and with Local Planned Care services
- whether we have estimated accurately the number and type of patients who will attend UCCs

Therefore it is proposed that we develop a plan to prototype a total of four UCCs initially, one each in Shrewsbury and Telford and two in more rural areas to test the quality, deliverability and viability of the models.

This does not mean that we would definitely rule out any further UCCs at this stage. The provision of additional UCCs would depend on the outcome of prototyping the initial four UCCs.

At the same time we propose to undertake an additional piece of work to clarify the potential for prototyping one or more '24/7 Local Care' models in different locations and environments, probably focusing initially on smaller dispersed communities across Shropshire, including those served currently by community hospitals. For the avoidance of doubt, the aim of this work will be to increase rather than to reduce the range of services provided in more rural locations.

It is important to recognise that, although 24/7 Local Care is a key element of the three tier model of urgent care and of the wider provision of health and social care, as described in

the Future Fit clinical design report, it lies beyond the strict scope of the Future Fit programme and is therefore not considered in the long list and short listed options.

Whilst one or more current MIUs will become part of UCC prototypes, where there is an MIU currently that is not designated to be a UCC, it is envisaged that these MIUs will be subsumed into 24/7 Local Care. In both cases, they will cease to be called MIUs, but their services and resources will be fully incorporated into the various prototypes.

Overall the catchment analysis suggests that the potential sites for the initial two remaining UCCs should be:

Oswestry

Whitchurch

Bridgnorth

Ludlow

It is therefore proposed that more detailed planning is undertaken for each of these sites so that a final decision can be taken on the location of each of the four initial UCCs as part of the identification of a preferred options for both acute and community facilities.

Appendix 3: Comments on Version 5 of the UCC Paper

Comments on *Urgent Care Centres: Proposal for Evaluation Panel 20 January 2015*

There are so many quick fixes in this document that it becomes inherently contradictory, it is significantly at odds with the Clinical Model, and it fails to reference a clinical protocol or evidence base that would underpin its safety. I cannot approve it in its current form.

What is the national vision?

The 'Keogh Review' (*Transforming urgent and emergency care in England*) sets out the national vision for urgent and emergency care. A useful distinction between Urgent Care Centres and Emergency Care Centres is made in Chapter 3, 'Proposal for improving urgent and emergency care services in England' (page 25). The proposal is to:

> *Support the co-location of community-based urgent care services in coordinated Urgent Care Centres. These will be locally specified to meet local need, but should consistently use the "Urgent Care Centre" name, to replace the multitude of confusing terms that are available at present. Urgent Care Centres may provide access to walk-in minor illness and minor injury services, and will be part of the wider community primary care service including out-of–hours GP services...*

The next section, D, deals with more seriously ill patients:

> *D. Ensuring that people with more serious or life threatening emergency needs receive treatment in centres with the right facilities and expertise to maximise chances of survival and a good recovery.* ***Where people have more serious or life threatening emergency care needs then they must receive treatment at centres with the necessary facilities and expertise, 24/7, to maximise their chances of survival and a good recovery.*** *To achieve this, we intend to:*
>
> ***Introduce two levels of hospital based emergency centre.*** *For the purposes of this report we have called these "Emergency Centres" and "Major Emergency Centres".*

It is of course regrettable that Shropshire is intended to not have a Major Emergency Centre (or the equivalent rebranding of Specialist Emergency Centre.

The intentions are really quite clear. There is no requirement for UCCs to offer a standard service; rather, it is emphasised that they should be locally specified and should meet local need. A recognition of this would overcome many of the problems currently built into this proposal.

This is confirmed by the reported Programme Board decision (Evaluation Panel Shortlisting Pack, p5):

> *The Board approved a Long List of eight options comprising:*
>
> *…*
>
> *c) A range of between four and seven Urgent Care Centres which should ideally be co-located with Local Planned Care facilities and Community Units, and should be scaled to serve local need.*

This is also recognised in the Future Fit Clinical Design (pp29-30):

> *Urgent Care Centres (UCCs), strategically placed across Shropshire and Telford and Wrekin, will provide low and medium acuity urgent care 24 hours a day (potentially open 16 hours and able to signpost for the remaining 8 hours). The exact number of centres is on precise configuration, but each one must offer the same consistent services which patients understand and can rely on. A 'modular' design concept is adopted to reflect this need.*

The implication of this modular design concept is surely that each of the 'modules' implemented at each UCC should be of a consistent service design, but not that each UCC needs to implement all modules.

The suggestion by Bill Gowans at the Evaluation Panel meeting that the **network** of EC and UCCs would provide the services (not necessarily individual UCCs) is neither reflected in this document nor has any work be done at this stage to model the proposal in relation to clinical safety and access.

It is made clear in the national guidance that it is appropriate for part of the work of UCCs to include the treatment of low acuity patients; we are told that they *'may provide access to walk-in minor illness and minor injury services'.*

The existence of two levels of urgent and emergency care service is meant to eliminate confusion; to overcome the plethora of names that exist within the NHS now (locally, MIUs, Walk-In Centres etc.).

So the national model would suggest a network of Urgent Care Centres, varied according to local requirements, to provide urgent care to low acuity patients, and perhaps some

medium acuity patients, while those with *'more serious or life threatening conditions'* should attend the Emergency Centre. Note that it is not just patients with life threatening conditions who are deemed to require access to the specialists and expertise available at an Emergency Centre. It is also everyone who has a 'more serious' condition.

The First Problem

The local proposals for Urgent Care Centres seem to have changed fundamentally in this amended document. These have leapt from being Urgent Care Centres for low to medium acuity patients, to becoming hospitals for medium to high acuity patients. We are told, for example (amended Proposal for Evaluation Panel, page 4; my emphasis),

> *'These requirements demand an emphasis on designing and then prototyping a medicalised, medium to high acuity model of urgent care centres, with all the accompanying constraints on staff, equipment, beds (for observation and short stay) and costs.*

This has become a hospital, offering in-patient beds – not just observation beds - to medium and high acuity patients. This is not the UCC model as conceived in the Clinical Model, described absolutely explicitly as providing *'low and medium acuity urgent care'* (the very first sentence of 6.1.4 outlining the nature of UCCs). The emphasis on A&E 'Minors' and DGH 'zero length of stay' (Clinical Model, 6.1.4) has vanished. What is proposed here is something very different.

Low acuity patients are directed elsewhere, to a newly thought of '24/7 Local Care' service, that is not part of 'Future Fit' at all (amended proposal, page 11). This seems to be a quick fix intended to deal with patient concerns over the loss of valued MIU facilities – but surely the way of resolving those concerns is to be far more flexible about the number and nature of Urgent Care Centres? A 24/7 Local Care model has at no stage been discussed or consulted on. The introduction of this third tier of care is completely at odds with national proposals, and introduces an unnecessary level of confusion.

The single Emergency Centre is now to provide the ***'highest acuity** urgent and emergency care'* (amended proposal, page 4), rather than being the ***'high acuity'*** unit discussed in the Clinical Model. There is a difference.

In each respect, these strands of care have changed quite fundamentally. These proposals are at odds with the Clinical Model. This is a *new* model of care. It is not the model that has been consulted on with local clinicians. It has not been discussed either at patient engagement meetings. The references to *'clinical consensus'* in the amended proposal need to be clarified. Was the consensus developed on the basis of the previous low to medium acuity vision of UCC, or on the new medium to high acuity in-patient facility model of UCC?

Other Issues

What is the relationship intended to be between Urgent Care Centres offering in-patient beds to medium and high acuity patients and existing Community Hospitals? One of the proposed sites for a UCC, Oswestry, does not currently have a Community Hospital. No realistic provision has been made in the financial model we have been provided with to support the creation of extra in-patient beds.

Are the staffing proposals for these new Urgent Care Hospitals safe? The proposal is for most UCC patients to be seen by Advanced or Extended Nurse Practitioners, with more complex patients being seen by GPs with additional training (amended proposal, page 6). Is this still appropriate, now that low acuity patients are stripped out, and high acuity cases are to be seen and treated (in some cases as in-patients) at UCCs? Are GPs comfortable with this changed model? Will the staffing costs increase, with a need for more staff or more highly skilled staff? Given the shortage of GPs in Shropshire and the overall thrust of Future Fit to shift care from acute hospitals to the community (under the medical supervision of GPs), has any modelling be done to examine whether the additional workload is sustainable?

Importantly, do the new proposals provide patient safety? Is there any evidence base or clinical protocol for the new proposal for UCCs? This really is fundamentally important.

If the UCCs are to see high acuity patients, there must be surely be dedicated specialist expertise – Consultants or Specialist Registrars with protected time - available off-site (not the *'say within an hour'* suggested here) (amended proposal page 5). There may well be a need for specialist support staff on-site given the proposed change in the patient population to a higher level of acuity. There must also be dedicated ambulance provision for the rapid transfer of patients to the Emergency Centre.

The revised document makes UCCs a major destination for the ambulance service:

> *In conjunction with this, UCCs must also be configured to receive a significant number of patients conveyed by ambulance as a viable and safe alternative destination to ECs.*

This in itself implies that UCCs will be responsible for high acuity patients. This does not fit with the clinical model and does not even fit with the prototype UCC currently underway at RSH. Patients who arrive by ambulance at RSH are taken immediately into A&E and bypass the UCC triage. Is the implication in the document that this will not happen in future?

There has also been no modelling of ambulance provision with UCCs as a destination. Given that WMAS regularly misses notional target response times in Shropshire, and that the CCG

has recognised that they will not be met with the current level of funding, do we know whether any additional risks have been introduced through the model contained in this paper?

This revised proposal – with its three levels of urgent and emergency care – is of course at odds with the two tier national proposals from Sir Bruce Keogh (Transforming urgent and emergency care in England). Low acuity urgent care is still urgent care; it is recognised as such in the national proposals, has been recognised locally until now, and it needs to remain an important part of the 'Future Fit' proposal for urgent and emergency care. References to 'various prototypes' (amended proposal, page 11) that are assumed to absorb existing MIUs into alternative local care provision give little reassurance that adequate low acuity urgent care will remain.

The suggestion that UCCs will be prototyped based on the model contained in this document adds further resourcing concerns. The patient numbers at UCCs located in market towns (the "rural UCCs") imply a rate of patient arrival of between 1.95 and 2.49 per hour. The model for Bishops Castle shows substantially less but the potential numbers there are almost certainly, from what we were told at the Panel meeting, an underestimate of the potential with Newtown and Welshpool not being realistic alternatives in the short term. It is impossible to have the complete range of specialisms which might be possible in a larger UCC in one serving a rural population. The requirement in the document that all UCCs have to offer the same range of services ("consistent offer") effectively rules out rural UCCs unless the overall level of service provision at each is made flexible to reflect local need down. The alternative would be an unacceptable "lowest common denominator" model. As an example, the provision of x-ray facilities for 16 hours per day at a UCC implies a staffing at each UCC of a minimum of 4 FTE radiographers. This is not sustainable with the expected patient throughput at a rural UCC. Bill Gowans suggested at the Evaluation Panel meeting that the result of the prototype might be that we finish up with only two UCCs. It seems that this is guaranteed unless we recognise that differing UCCs can provide different services. It was recognised in the Keogh report that there should probably be more UCCs in rural areas. This cannot be implemented if the design of UCCs in Shropshire is only supportable in the urban centres of Shrewsbury and Telford.

The document does not talk about timescales for the prototypes. I understand, from the statement at the Evaluation Panel meeting, that it is now envisaged that formal public consultation on the preferred option will commence in December 2015. Unless the prototypes are completed before that date, and the conclusions embedded in the proposal for the consultation, the public will be faced with a consultation where the structures for emergency and urgent care are presented only half formed. The public would be entitled to make different judgements about the location of an EC based on the planned locations of

UCCs. Can we guarantee that the finalised proposal for UCCs will be included in the formal consultation?

The amended proposal is now quite a contradictory document and simply not ready to be signed off.

For example:

> An Urgent Care Centre that is open 16 hours a day can admit patients for observation, but not as short stay in-patients. A rather obvious question: who looks after the patients at night?
>
> On page 3, there is merely an observation unit. On page 4, beds are required not just for observation, but also for short stay patients.
>
> On page 7, we are told that the activity to be treated in UCCs includes current walk-in centre activity and current MIU activity – but this is inconsistent with a model that assumes these will be medium to high acuity centres. And on page 11, we are advised that MIU activity will be fully incorporated into the new '24/7 Local Care' strand of care - unless there is a UCC on site, in which case MIU activity will be part of the UCC. This does not avoid confusion for patients. It guarantees it.

The service provision and philosophy are based on an earlier and different model. There will be other contradictions inherent in this.

Conclusion

The thrust of this paper leads to a conclusion that there will, in the end, only be two UCCs, located at RSH and PRH. Although the shortlist includes green-field site options, I think most members of the Evaluation Panel recognised that they were likely to be ruled out after detailed modelling as unaffordable and probably too difficult to deliver in a reasonable timeframe. With a single Emergency Centre (not a Major Emergency Centre), the result will effectively be a downgrading of one of the existing sites to a UCC and a functioning EC at the other. Because there are no plans to have a Major/Specialist EC in the county, we cannot expect to see any additional emergency services in the county with patients requiring specialist treatment continued to go out of county.

The Future Fit area has a majority of its population who live in rural locations (2011 Census definition). NHS England have recognised that urgent care requires a different model in rural areas. This paper seeks to defer consideration of this to the future by suggesting that urgent care in rural areas is primarily the concern of a "third tier" which is stated as outside the scope of Future Fit.

I believe we should commit to going ahead with the 7 suggested UCCs offering differing services based on the sustainability of the services in local catchment areas. From an access point of view this will be optimal and will better meet the concerns of the population of Shropshire as a whole.

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