A Proposition for Healthcare in southwest Shropshire and east Montgomeryshire

A submission to the NHS Shropshire and Telford and Wrekin Future Fit Programme Board, Shropshire CCG, Shropshire Community Hospitals Trust, Powys Teaching Health Board and Shropshire Council.

'NHS Future Fit gives us an opportunity to transform … Community Hospitals … by making them community hubs, which could offer walk-in services, in-patient beds and GP-led urgent care centres.'

Future Fit, Clinical Design Report Summary, page 14, September 2014

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Acknowledgments and BCPG chair's Introduction

Bishop's Castle Patients Group views the Future Fit programme with optimism believing that it offers the possibility of improving care for patients and bringing that care closer to home. We particularly embrace the community services implications of the Clinical Design Review and seek to develop this element to the benefit of patients in southwest Shropshire and east Montgomeryshire.

We would like to express our thanks to those with whom we have have had detailed discussion, to those who contributed in a variety of ways to the development of this proposition and to those who put it together. We are also grateful for financial support from Bishop's Castle Town Council.

We are excited about the prospect of working with local GPs and health and social service providers to bring to reality the promise of more care closer to home.

*Nick Hutchins, chair, Bishop's Castle Patients Group: **www.bcpg.org.uk**. 16 January 2015*

1 Executive summary

'NHS Future Fit gives us an opportunity to transform … Community Hospitals … by making them community hubs, which could offer walk-in services, in-patient beds and GP-led urgent care centres.'
Future Fit, Clinical Design Report Summary, page 14, September 2014.[1]

This is a proposition to pilot a prototype of a fully integrated Urgent Care Centre / Local Planned Care Centre / Community Health Hub serving the deep rural area of southwest Shropshire and east Montgomeryshire.

This transformational demonstrator of a new model of fully integrated non-emergency or life threatening care will be GP-led and with system leadership embracing all service providers and patients. It unleashes the potential of the existing, well-resourced Bishop's Castle Community Hospital and the talent of local GPs and NHS staff. From a patient's perspective it will:

- 'Feel like part of the hospital';
- 'Feel like part of my GP surgery'; and
- 'Feel like part of my community'.[2]

The practical proposal is set within the framework of the NHS Future Fit Clinical Model.[3] It is about the 'art of the possible'. It delivers the policy directions and best practice for local urgent care and greater cohesive local healthcare provision and preventative interventions. Better local care will result in reduced demands on central emergency, diagnostic, treatment and planned care hospital departments.

The cross-border area of southwest Shropshire and east Montgomeryshire is one of the most remote rural areas in England and Wales, especially so in terms of access to acute and urgent care. Its population is disproportionately elderly so demand exceeds simple population numbers. This patient characteristic serves to reinforce the poor accessibility to acute services and the need for fully integrated local health and social services. Without the developments proposed here, health services for this locality will not be improved.

The demand for service improvement is clear and present. Major policy and capital investment decisions are required to achieve the Future Fit Clinical Model. The best time horizon for these decisions is 2 years, to be followed by a minimum further 2 to 3 years for design, development and construction. Furthermore, the possible Ludlow Urgent Care Centre would serve only the southern fringes of southwest Shropshire and likewise the delivery time for a fully-fledged Urgent Care Centre here looks incapable of being delivered within a five-year time frame. This proposal therefore will fill a long-term void and will deliver real service improvements quickly by building on under-utilised assets.

A pilot prototype would not be prejudicial to other long-term decisions to be made in Shropshire and Powys. Indeed, it could be a best practice model and a test bed for modern health and social care services in more remote rural areas. The success of the new models of emergency and urgent care require major changes in patient behaviour, attitudes and trust, integrated service provision and highly committed and motivated staff, not just new construction. This pilot can be implemented, we believe, without major capital expenditure and what expenditure is required would not be excessive should the prototype prove unsatisfactory.

Rather than seeking to design a blue print for the locality at the outset and having a master plan, the pilot should be implemented progressively, as there are no quick, total solutions towards the shared vision of integrated community care. All NHS service aspects must

be addressed, and this will require the consideration of collaborative ways of funding.

It is proposed that Future Fit commissions this concept to be taken to the next more detailed design stage and that a fully specified pilot prototype is ready for decision in summer 2015.

2 Delivering Future Fit

We endorse fully the Future Fit analysis [4] of healthcare demands, the need for change and of the special delivery issues arising in large, sparsely-populated, rural areas. We agree that there is 'a strong network of community hospitals that … could be used to provide more care near people's homes'.

We support the Future Fit aims, notably:

- 'Joining up local services with social care and voluntary organisations to provide a better experience for patients';
- 'Making sure people only go into hospital and stay there if there is no better alternative, otherwise looking for them to be treated more locally, ideally as close to their home as possible';
- 'Look after most people with long term conditions in their homes – where they would prefer to be – by making sure their care is properly planned and regularly assessed'; and
- 'Keeping patients well and responding rapidly to unexpected changes will work best if doctors and nurses working in the community can communicate easily with specialists'.

We agree that 'the safest way to treat the most seriously ill patients is through investment in a network of Urgent Care Centres' and applaud the commitment 'to make sure there is geographic spread'.

Likewise, we agree that everyone prefers the option of local services, where possible, and we welcome 'the idea of using community hospitals to offer better planned care' and that people should 'need to travel to the major diagnostic and treatment centres only when they need their operation … they would receive the rest of their care closer to home … this could be a GP surgery or their local community hospital'.

We welcome especially the statements that 'Future Fit gives an opportunity to transform … [community hospitals] by making them community hubs, which could offer walk-in services, in-patient beds and GP-led urgent care centres' and 'we would like to put these hubs at the heart of their communities, with local residents involved in designing and running services'.

Our concept for healthcare in southwest Shropshire and east Montgomeryshire is totally in line and supportive of the Future Fit ethos, vision and aims:

- A GP-led Urgent Care Centre, integrated into the Bishop's Castle Community Hospital;
- A Community Hospital which offers local planned care and excellent after care for those patients who experience major surgery; and
- A Community Hub, centred in the Community Hospital which brings together health and social care and has a strong focus on prevention, with patients in control of their well-being and health.

The contested area is that whilst we agree it is important that patients understand what an Urgent Care Centre can offer and there is a close consistency of offer across all Urgent Care Centres we believe that Future Fit must not be 'a one size fits all' plan, but adaptive to the real issues of delivery in deeper rural areas. The determination of the number and location of Urgent Care Centres cannot be largely by 'footfall'. What is important is that they should be more relevant for more of the people most of

the time. We believe that – with advances in technology and a clear imperative for all health and social care providers to adopt fully aligned systems – a GP-led Urgent Care Centre, as an integral part of the Bishop's Castle Local Planned Care Hospital and Community Hub, warrants Future Fit investment in piloting this prototype for rural healthcare.

3 Delivering NHS policies and best practice

In presenting this proposition we have sought to understand current NHS policies and to learn from the evidence, especially the excellent rapid evidence reviews for Future Fit [5,6] about major clinical change, to ensure our ideas are consistent with NHS polices and take the best of best practice and lessons on rural health care. We believe this is the case.

Redesigning healthcare services

As a voluntary patients' group we know that there is much patient confusion and frustration with what seems to be a constant state of flux, reconfiguration and reorganisation of the NHS. Future Fit proposes more change. In proposing an adaptation of the Future Fit clinical model we are wary that we may add to the 'problem'. So we sought to see if there are any general lessons to guide us. The King's Fund's report 'The reconfiguration of clinical services: What is the evidence?' [7] has been a timely publication. It provides new insights into the drivers of reconfiguration based on a strong evidence base. The main findings of the analysis and implications for the NHS are, and our thoughts are:

- 'The reconfiguration of clinical services represents a significant organisational distraction and carries with it both clinical and financial risk. Yet those who are taking forward major clinical service reconfiguration do so in the absence of a clear evidence base or robust methodology with which to plan and make judgements about service change';
- 'Reconfiguration is an important but insufficient approach to improve quality. It should be used alongside other measures to strengthen delivery of care and to instil an organisational culture of improvement';
- 'No hospital is an island. Hospitals are part of an interconnected web of care stretching from the patient's home to the most specialist tertiary-level service. Clinical networks and new technologies offer opportunities to strengthen that web and deliver more coordinated care, but those planning services need to look across that web to ensure the most efficient distribution of services, to remove duplication, and to ensure that patients receive the right care, in the right location, at the right time';
- 'There are new and evolving opportunities to sustain local access to services, particularly for lower-risk patients, with more flexible use of current staff and greater use of non-medical staff and digital technologies';
- 'The local context and the specialty-specific balance between access, workforce, quality, finance and use of technology need to be the deciding factors in determining how local services are configured, recognising that there is no "optimal design"';
- 'Systems and processes to accurately triage and rapidly transport patients should be a key part of any proposal'; and
- 'Any proposal needs to have come out of a process with strong engagement from clinicians, public and politicians'.

NHS policies

The Future Fit model has been framed by NHS England policies set out in 'The Keogh Review' [8] which states that for 'those people with urgent

but non-life threatening needs the NHS must provide highly responsive, effective and personalised services outside of hospital. These services should deliver care in or as close to people's homes as possible, minimising disruption and inconvenience for patients and their families.'

In order to move from the current to the future system the Keogh Review proposed five key elements of change to apply to all patients, regardless of their age, location, co-morbidities or physical and mental health needs:

- 'Providing better support for people to self-care;
- Helping people with urgent care needs to get the right advice in the right place, first time;
- Providing highly responsive urgent care services outside of hospital so people no longer choose to queue in A&E;
- Ensuring that those people with more serious or life threatening emergency needs receive treatment in centres with the right facilities and expertise in order to maximise chances of survival and a good recovery; and
- Connecting urgent and emergency care services so the overall system becomes more than just the sum of its parts.'

NHS England has published an update report on the review of urgent and emergency care in England [9]. This reinforces the Keogh system which envisages 'local care in or as close to people's homes as possible for urgent but non-life threatening needs – including GP services, Urgent Care Centres, telephone advice, pharmacy and paramedic services.'

In this diagrammatic representation (Fig. 1) of the system, the Urgent Care Centre is placed firmly as an integral part of local care and not in a hierarchical tier of care sitting below the Emergency Centre (as may be perceived in the

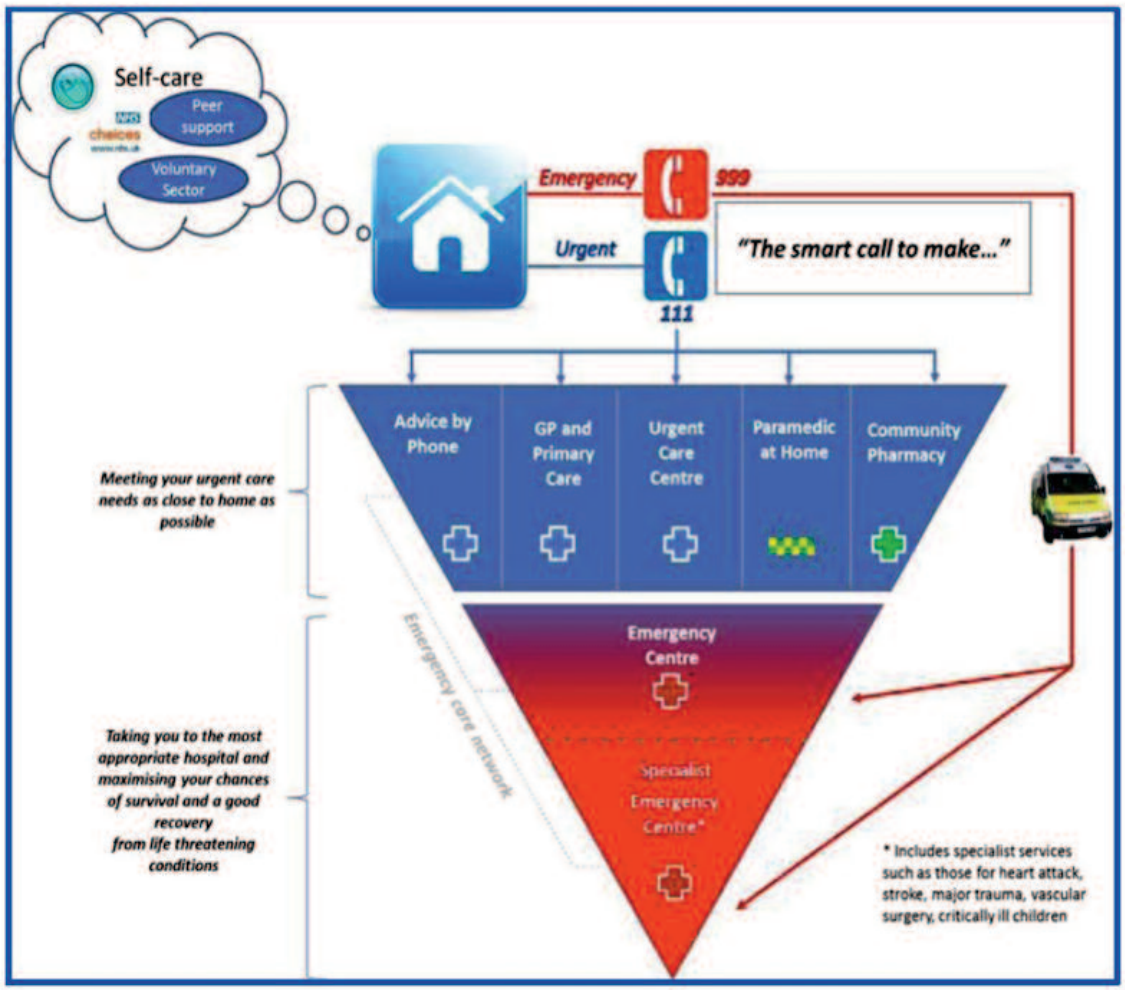

Figure 1: Representation of the future urgent and emergency care system in England [10]

Future Fit Clinical Model).

This policy approach is reinforced by the more recent 'NHS Five Year Forward View' or 'Stephens Review' [11], which sets out the service's own views on the radical action it, the government, local councils, employers and the public need to take in order to ensure that it can survive the growing pressures. The Forward View:

- Considers the unhelpful divisions in the NHS – between the different places care is delivered, such as hospitals and GP surgeries, for example – and states that these barriers need to be dissolved, to improve care;
  'The NHS will take decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care.'
- Envisages much less healthcare being provided in hospitals and much more in community settings;
  'The future will see far more care delivered locally but with some services in specialist centres, organised to support people with multiple health conditions, not just single diseases.'
  'NHS England will expect, embrace and fund "new models of care" to look after specific groups of patients, such as diabetics or the frail elderly. One option could see the creation of a so called "multispecialty community provider" in which GPs could come together with nurses, hospital specialists and potentially also mental health and social care services to provide integrated care outside of hospitals.'
- Commits that urgent and emergency care services will be redesigned so that the array of different services are integrated and A&E units, out-of-hours GP services, urgent-care centres, walk-in centres, the NHS 111 telephone advice line and ambulance service work together better;
- Promises smaller hospitals, which some fear have a very uncertain future:
  'New options to help them remain viable, including partnerships with other hospitals further afield'; and
- Recognises that there needs to be a 'new deal' for GPs because many are struggling to cope with growing demands from patients, many of whom are more medically challenging than before.
  'The service will tackle the recent shift in NHS funding away from family doctor services.'
  'The NHS will invest more in primary care … New incentive schemes will try and boost the number of GPs, especially those prepared to work in deprived areas'.

Learning and applying best practice

In the creation of our proposition we have been interested to develop some understanding of best practice and particularly in smaller scale care models and those operating in remote areas. We have looked, in turn, at key elements of the healthcare system that we propose – small, local urgent care, the GP practice and community care.

Monitor (the Government Regulator of hospitals in England) has published two helpful reports on acute care[12,13]. Two of the three main insights are:

- 'The importance of technology, particularly to deliver care remotely, through ideas such as electronic intensive care units (eICU) which are hubs of the central Emergency Hospital'; and
- 'The greater use of GPs as the gatekeepers to emergency care and providers of out-of-hours urgent care. This approach is prevalent in the Netherlands where A&E attendances are about 120 a year per 1,000 people, compared with 278 in England. In the

Netherlands 39% of patients attending A&E are referred by GPs, compared with 5% in England.'

Monitor identifies that 'these ideas are already used in some areas of the NHS, but evidence from other health systems suggests that wider use across the NHS could support efficiency or quality improvements'. *Monitor* suggests 'more work could be done within NHS England to identify and adopt alternative clinical models and that these models need to be better understood before they are widely pursued in the NHS'. We suggest that our proposition could be developed and tested in this important national context.

The King's Fund's study of urgent and emergency care [14] is based on extensive research to identify and understand the learning from successful organisations and systems of urgent and emergency care. Intriguingly, The King's Fund, said that a key question is 'why, when so much is known, does it appear, so difficult to do and then to sustain'. Key findings, which are integral to our proposition, are:

- 'The evidence of what works, points to a need for more integrated services able to adjust capacity and based around the hospital footprint and locality.'
- 'Clear strategic oversight and drive to tackle the main challenges important to patient care and efficiency';
- 'Matching demand and capacity and by implication not adopting a "one size fits all" model by arbitrary specification of a minimum or maximum size for Urgent Care Centres';
- 'Great leadership and management at all staff levels that understand the system and make it work'; and
- 'All parts of the system – triage, ambulance, first responders, social care – must be able to collaborate effectively to ensure patients can flow through the system.'

Hence, our proposition to centre a solution on the existing Community Hospital and a geographical area which shares a similar mental map and community of interest';

We believe that our proposition must be part of the wider Shropshire network, but there must be a local board to provide oversight, scrutiny, evaluation and communication to all parts of the system supported by a clear vision for the clinical system.

Future Fit's vision is of a holistic system, but it identifies many divisions in the current system. Our small-scale demonstrator will aim to show what can be achieved.

The King's Fund has examined also the contribution of the GP practice [15], which draws in part on its earlier analysis of GP service [16]. The review argues for a new approach because doing nothing will not be sufficient. In doing so it states that 'general practice is widely recognised to be the foundation on which NHS care is based. It is well trusted and patients generally express high levels of satisfaction'. Nonetheless the report argues that the 'GP practice needs to change to meet patient demand and expectations of service performance'. And to do so by liberating 'GPs to enable them to innovate in how primary and urgent care is provided in the community and to extend service well beyond what is available now'.

Community care, which is the essence of the Community Hub concept in Future Fit, has been the subject of another valuable study by The King's Fund [17]. The review starts from the longstanding policy ambition to shift more health care from hospitals to settings closer to people's homes, and from reactive care to preventive and proactive models based on early intervention. It identifies some progress, but says that 'frequent reorganisations – which have often been poorly thought through and not always skillfully

executed – have created problems, delayed progress, and undermined leadership in the sector'.

Despite incomplete evidence, the review identifies an emerging consensus about the impact that community services can have and what is needed to improve their effectiveness. The main steps identified are:

- 'Reduce complexity of services;
- Wrap services around primary care;
- Build multidisciplinary teams for people with complex needs, including social care, mental health and other services;
- Support these teams with specialist medical input and redesigned approaches to consultant services – particularly for older people and those with chronic conditions;
- Create services that offer an alternative to hospital stay;
- Build an infrastructure to support the model based on these components including much better ways to measure and pay for services; and
- Develop the capability to harness the power of the wider community'.

The review states that this approach requires 'locality-based teams that are grouped around primary care and natural geographies, offering 24/7 services as standard, and complemented by highly flexible and responsive community and social care services'. This is an essential element in our proposition.

Southwest Shropshire and east Montgomery-shire are sparsely populated so we have been interested in research looking specifically at the issues of healthcare delivery in rural areas. A very recent study for the Welsh Government [18] includes a research evidence review on rural health and care systems. An earlier report by the Institute of Rural Health [19], similarly includes an extensive evidence review. Key findings include:

- 'Countries with strong primary healthcare systems have demonstrably more efficient, effective and equitable healthcare;
- There is a general consensus that "one size does not fit all" and there is no one model capable of servicing the diverse needs of all communities. The common enablers include multi-disciplinary practice, community participation, improved health information systems, vision and leadership and adequate funding and appropriate financing mechanisms;
- An approach is one that balances economies of scope with economies of scale, by the integration of services;
- The importance of designing services around a coherent geography; and
- Replacing the current push model with one that actively pulls patients towards high quality organised services closer to home'.

4. Serving the population and patients

The Future Fit programme team has collated and analysed the full range of economic, social and health related data for southwest Shropshire and east Montgomeryshire. We hope this information will be made available to us after the shortlisting of options. Therefore, we make no attempt to complete a parallel analysis. We do highlight some key features and rural health issues which we contend support the case for an adaptation of the Future Fit tiered model – of 'one size fits all' health care provision with GPs at the bottom of the hierarchy – into a model which is flexible and is focused on service integration at the local level. We do not see this as a 'bottom-up 'versus 'top-down' approach but one that is responsive to the particular circumstances of the local region. This is totally in line with Future Fit, which says [20] 'Whilst this option [the tiered model] may be attractive in urban settings, it will be more challenging in rural areas where travel distances may be too great.'

Accessibility for Patients	Quality of Care
1. a) Total miles travelled 2. b) Total time travelled 3. c) Net gain (loss) by area (overlaid with index of multiple deprivation) 4. d) Comparison against average national travel times to A&E 5. e) Impact on ambulance services	1. a) Change in number of people who are more than 45 minutes from an Emergency Centre (potential to allow for differential Ambulance access should be explored) 2. b) Ability to recruit & retain key clinical staff 3. c) Extent of consultant delivered high acuity services 4. d) Potential for better enabling partnership working
Deliverability	**Affordability**
1. a) Timescale for delivery (the shorter, the better) allowing for phasing of benefits 2. b) The amount of disruption for existing services (the less, the better) 3. c) Ability to flex in response to future service needs beyond Future Fit (the greater, the better) against 3 scenarios 4. d) Extent of remaining backlog maintenance	a) Can be accommodated within projected future resources b) Net revenue cost impact

Fig 2. Future Fit Evaluation Criteria

Our observations here are structured as far as possible using the evaluation framework established by Future Fit (see Fig. 2).

On all measures this is a sparsely populated area and many parts are 'deep rural areas' being more than a 20-minute drive to a settlement of 10,000 people or more. In terms of poor accessibility to a major hospital, the area is comparable with other more remote parts of England and Wales.

The patient population of the 20-minute catchment area of our proposed integrated Urgent Care Centre / Local Planned Care Hospital and Health Community Hub, centred on the existing Community Hospital in Bishop's Castle is in the region of 14,000 people.

However, local health care demand is greater than this suggests because of the much greater proportion of older people, the number of whom is increasing because of inward migration and ageing. The area is characterised also by a high incidence of long-term illness.

If nothing is improved locally, patients in many parts of our region will continue to experience poor accessibility to urgent care because they live more than 20 minutes from an Urgent Care Centre in Shrewsbury and similarly from the longer-term possibility of a new facility at Ludlow. This is a particular concern for patients with injuries and mental health problems. Whilst there is a regular 2 to 3 hour interval bus service from Bishop's Castle to Shrewsbury Hospital (journey time 50 minutes) this is neither useful in cases of urgent care requirements nor accessible to the high proportion of patients living some considerable distance from bus routes or who are frail. There is a very limited bus service from Bishop's Castle to Ludlow town centre and many parts of the region have no public transport whatsoever. Whilst this lack of public transport may be seen as a weakness in the selection of an Urgent Care Centre located at the Bishop's Castle Community Hospital, it highlights the need for the region to have a local, central facility irrespective of that because the alternatives of Shrewsbury and Ludlow are remote. Such a facility would also be a welcome option for First Responders and the ambulance service.

5 Proposition

We recognise and applaud that Future Fit is trying to provide leadership right across the medical system rather than trying to fix individual components. We want to go further.

Our approach to meet the health and social care needs of southwest Shropshire and east Montgomeryshire is to take a more personalised, and a longer term, prevention-orientated view that could transform provision by being less complex and integrated within the community. We want to see all medical services properly though-through alongside fully-integrated community services in our excellent, existing community hospital (which adjoins a major care home). Our vision includes urgent care provision delivered by hospital staff and GPs from within the locality, with rapid on-line access to senior expert opinion at the main Shropshire Emergency Centre and other specialist hospitals. We envisage midwifery services and mental health services in our Community Hospital and wish to see our District Nurses based at the hospital. This more strategic approach will reduce complexity, reshape primary care and chronic disease management, support patients in their own homes and change the way that nursing and residential care are incorporated into and wrapped around the system. This flexible community team approach will involve new relationships between the different providers.

There will be:

- Shared access to patient records, anticipatory care planning for all those that need it and other aspects of chronic care;
- Enhanced discharge arrangements with community teams being able to pull patients out of hospital;
- Effective relationships with nursing and residential homes;
- More emphasis on patient self-care; and
- There will better scope for ambulance services to meet local needs such as supporting primary care.

Such a model, we believe, will not only treat patients more effectively, efficiently and equitably but will also reduce substantially, and in a short time-frame, the demand on the Emergency Hospital by reducing admissions.

This integrated approach is part of the Future Fit vision. We divert from Future Fit particularly in relation to the role Future Fit envisages for GPs. Whilst seeing GP surgeries and GP out-of-hours services as a part of the urgent care network Future Fit, so far, has a more limited perspective on their role within an Urgent Care Centre. Future Fit states [21] 'GP surgeries will continue to triage and see their patients who require same day assessment. They will however have *the option* of providing some of their urgent care services through the nearest Urgent Care Centres, offering the potential of freeing up the primary care team to deliver more LTC care. Whilst this option may be attractive in urban settings, *it will be more challenging in rural areas* where travel distances may be too great' (italics, our emphasis). Also, Future Fit states, 'If GP urgent care is provided at Urgent Care Centres, then this will require co-location, but would probably use separate consulting rooms'. This latter statement does not match with our picture of an integrated single service. Indeed, our model is for a GP-led Urgent Care Centre which we believe is actually the right approach in rural areas and easier to deliver.

'Models of Care' [22] describes what an Urgent Care Centre would be like and what conditions could be treated:

- Intravenous antibiotics;
- Palpitations;
- 'off legs';
- Stable pneumonia;
- Stable anaemia;

- DVTs;
- Abdominal pain;
- Feverish child;
- Chest pain;
- Limb fractures;
- Agitated – brought in by police;
- Suicidal;
- D+V – children;
- Wheezing child;
- Burns – child;
- Troponin/ECG;
- Delirium;
- Non life threatening.

We are not clinicians. We are advised that the Bishop's Castle Community hospital is well equipped already to meet many of these urgent care needs and treatments. Ultrasound equipment is in the process of being provided. X-ray facilities are required but in the scale of things relatively little capital investment is required to unleash the hospital's potential to provide:

- Observation unit;
- Diagnostics;
- Medium intensity community inpatient beds;
- Planned care facilities;
- Therapy services;
- Pharmacy;
- Co-location with GP out of hours services, community mental health teams, social care and voluntary sector support services;
- Community ambulatory services; and
- Community hub.

In 'Models of Care' [23] it is recognised that community hospitals provide an obvious estate to co-locate services and that 'To view this from an estate, cost and efficiency perspective transforming community hospitals through a co-location of a community hub, ambulatory services, inpatient beds and Urgent Care Centre would be logical'. Future Fit recognises fully the strong characteristics and latent potential of community hospitals to achieve:

- 'A "cared for", non-institutional environment which was welcoming to everyone, whether there by appointment or "walk in";
- A strengthening of "community spirit" which values the hub as an integral part of the local community (and which mitigates the risk of this being lost through a more strategic design and use of beds);
- Consistent services, many open 24/7, which are sustainable through achieving a "critical mass";
- Local people involved in the design and running of the services;
- A co-location of services carefully designed to improve the overall quality of care in a cost efficient way;
- An emphasis on prevention, self-management and patient empowerment;
- More help for carers to help them cope, rather than purely the provision of respite;
- A more timely access to expert opinion, responding earlier to need even if it is undifferentiated and of low acuity;
- A "way of doing things" that reduces social isolation and enhances inter-generational mixing (e.g. co-locating Sure Start children's services in an environment catering largely for the elderly);
- Enabling community services to be more effective and better integrated with services which require beds; and
- A range of community services'.

From an estates perspective we have identified the need for better signposting to the Community Hospital from all major roads and within Bishop's Castle and for more car parking. There is a requirement also for a clearly marked helipad in close vicinity. None of these issues are insurmountable and not major cost items.

We do appreciate there will be a need for additional staff with training in and experience of

emergency care. The costs of these staff will need to be considered against the benefits to patients locally and the offset costs of reduced demand at A&E. Sir Bruce Keogh, speaking to the House of Commons' Health Select Committee stated that one example of an Urgent Care Centre was reducing overnight stays at the main hospital by between 30 and 50% [24].

Future Fit [25] acknowledges 'A potential for tailoring services in different areas of the county according to demographic need'. We agree, so let's pilot a prototype of a fully integrated urgent care network, in line with the NHS England model, in southwest Shropshire and east Montgomeryshire. In doing so we acknowledge some of the challenges of the cross-border nature of the region and the existing protocol between NHS England and NHS Wales. Any 'boundary issues' should be resolved in favour of patients wherever they live.

We ask for Future Fit to have greater ambition for southwest Shropshire and east Montgomeryshire, to commission the further exploration and development of this concept and to complete this exercise by summer 2015. We are more than willing to assist in this exercise and to mobilise the wider patient voice of the locality.

Footnotes

1 Future Fit, Clinical Design Report Summary, September 2014.
2 Future Fit, Clinical Design Work stream, Models of Care, section 7.4, page 56, May 2014
3 Future Fit, *ibid*.
4 Future Fit, *ibid*.
5 Future Fit, Rapid Evidence Review – Acute and Episodic Care, NHS Central Midlands Commissioning Unit, February 2014.
6 Future Fit, Concise summary of rapid evidence reviews to support the case for change, NHS Central Midlands Commissioning Unit, March 2014.
7 The King's Fund 'The reconfiguration of clinical services: What is the evidence?' November 2014.
8 NHS England, Transforming urgent and emergency care services in England: Urgent and Emergency Care Review End of Phase 1 Report, November 2013.
9 NHS England, Transforming urgent and emergency care services in England, August 2014,
10 *Ibid*
11 NHS England, The NHS Five Year Forward View, September 2014.
12 Monitor, Facing the future: small acute providers, 2014.
13 Monitor, Exploring international acute care models, 2014.
14 The King's Fund, Urgent and Emergency Care – a Review for NHS South of England, March 2013.
15 The King's Fund, Commissioning and funding general practice – Making the case for family care networks, 2014.
16 The King's Fund, Improving GP services in England: exploring the association between quality of care and the experience of patients, November 2012.
17 The King's Fund, Community services: How they can transform care, February 2014.
18 Welsh Institute for Health and Social Care, The Mid Wales Health Study report for the Welsh Government, September 2014.
19 Institute of Rural Health, Health in Rural Wales, December 2008.
20 Future Fit, Clinical Design Work stream, Models of Care, May 2014
21 *Ibid* (section 6.15)
22 *Ibid* (section 6.14)
23 *Ibid* (section 1.3)
24 Quoted in Pulse, 23 January 2014.
25 Future Fit, Clinical Design Work stream, Models of Care, May 2014

