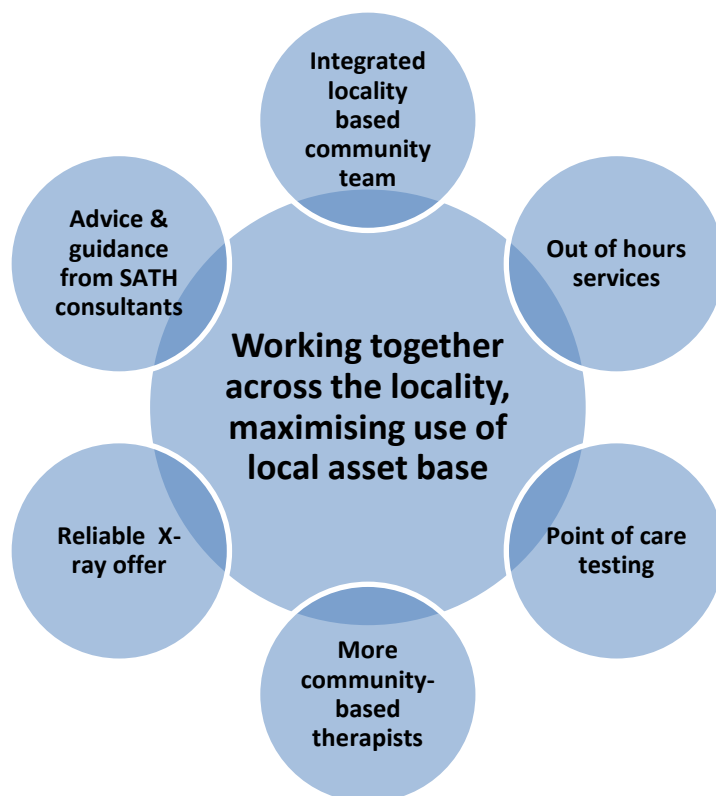


Rural Urgent Care Service

Sub Group Proposal v 1.1, April 2016

Submitted to Future Fit Clinical Design for further development on 12/5/16



Underpinning:

IT (shared care records), culture of integration, enhanced co-ordination and access point

Changes made since version 1.0 circulated to board members:

- Radiologist and radiographer references corrected.
- Clarification that increased GP direct access x-ray service may have resource implications.

- Additional information explaining data analysis at appendix C inserted, mainly opening times of services.

Contents

1	Introduction.....	3
2	Executive Summary	4
3	Recommendations.....	6
4	Background.....	8
5	Existing Developments in Enhancing Local Urgent Care	9
6	Proposed Rural Urgent Care Prototype.....	12
7	Considerations.....	15
8	Locality Workshops, March 2016	19
9	Coproduction of Prototype.....	20
	Appendix A	22
	Appendix B.....	26
	Appendix C.....	28
	Appendix D	33

1 Introduction

The Rural urgent Care Working group presented its initial report to the Future Fit Programme Board in October 2015. It examined the feasibility of locating a rural Urgent Care Centre (UCC) at each of its existing community hospitals and MIU sites with an assumption that there would be a single consistent model applied across the county. It concluded that, apart from Bishops Castle Community Hospital, each of the existing sites could, with some capital investment, provide suitable facilities for the provision of a rural UCC as described in the clinical model. However, the report also raised concerns about the clinical and financial viability of the proposed centres and the potential for them to have a detrimental impact on existing rural primary care services.

In response, locality workshops were held with GP practices and a further working group was established to develop more appropriate and deliverable plans for urgent care provision in rural areas. The group agreed to undertake a further range of activities in order to produce a draft set of options or recommendations regarding the rural urgent care service in Shropshire by March 2016. The activities included:

- Collation of relevant work previously completed.
- Review of existing urgent care services currently provided at each locality.
- Review of current rural urgent care workforce to include a review of competency requirements of roles currently in development.
- Oversight of the plans for engaging with locality groups at five locations (Ludlow, Bridgnorth, Bishops Castle, Whitchurch and Oswestry), to ensure consistency of approach across the localities and make recommendations based on the findings of their work.

This report from the Future Fit Rural Urgent Care sub-group therefore summarises the results of those activities.

It also describes linked key pieces of work currently ongoing in collaboration with all health and care providers and commissioners to develop a more integrated urgent care system; examining processes at both ends of urgent care pathway with a focus around care closer to home, early supported discharge and avoiding where appropriate an acute episode of care. This will contribute to a wider understanding of what care could look like in a locality setting in future.

2 Executive Summary

The rural urgent care sub-group believes that alongside existing initiatives to improve urgent care pathways, there are opportunities to enhance the urgent care offer in rural communities in a way that has the potential to meet the requirements of the Future Fit clinical model and to be both clinically and financially viable.

During the review period, we have moved away from a focus on examining existing facilities or infrastructure and specifically evaluating in isolation, the location for rural urgent care centres. We are now looking at enhancing and developing more integrated local urgent care solutions that will address patient's needs and allow care to be provided in the most appropriate setting, as close to home as possible. This is a combination of bringing in new approaches eg point of care testing and more urgent care practitioner roles as well as and building on existing service improvements already in train.

We propose therefore that a prototyping approach should be used to take forward the development of rural urgent care, engaging front line staff and patients in the implementation of new ways of working and learning from prototype successes and challenges. We further propose that a rapid-cycle evaluation approach is adopted whereby elements of the prototype are tested and adjusted according to real time feedback and evaluation.

The main findings of the work include:

- Activity numbers in the four current Minor Injury Units (MIUs) are variable. Previous work by Shropshire CCG in 2012 determined that standardising the service, with a view to diverting urgent activity from A&E, did not represent value for money at that time. Latest modelling performed by SATH suggests that an additional 4072 patients a year could be treated in total across the 5 localities with an enhanced rural urgent care service offer to include x-ray and some diagnostics. This would be in addition to existing MIU activity of circa 19,000 patients per year.
- There is a strong appetite in local communities for a wider range of local health services that minimise visits to the acute hospitals. Urgent care should be co-located with other healthcare services at local level, to optimise use of diagnostic, outpatient and other facilities.
- There are a number of developments already underway within the county to improve urgent care pathways within a community setting: implementing the new national commissioning standards for integrated urgent care will look to introduce a "clinical hub"; the development of an integrated end to end frailty pathway that provides responsive needs based care in the correct setting; building on the Shropshire ICS programme roll out focusing on integrating health and social care teams; further evaluation of the physicians response unit pilot with WMAS and consideration for a rural model.
- That the solutions we are proposing for rural urgent care should be prototyped alongside existing developments currently being explored to improve the urgent care pathway. Particularly examining how they contribute to keeping people in the community wherever possible and only involving conveyance to the acute site where this is deemed clinically necessary and assessment cannot be performed using technology-supported virtual assessment processes.
- The rural urgent care proposal is consistent with the Future Fit Clinical Model and the ambulatory care pathways and urban urgent care centres described in the Future Fit Strategic Outline Case. We believe that the solutions we are proposing should be prototyped are affordable and deliverable, and

will contribute to keeping people in the community wherever possible and only involving conveyance to the 'hot' acute site where this is deemed clinically necessary and assessment cannot be performed using technology-supported virtual assessment processes.

- Access to local diagnostics with rapid availability of results is seen as essential to increase avoidance of hospital admission and better manage patients at home. 'Point of Care Testing' in the form of a *POCT-Pack* is currently being piloted by ShropDoc in Telford and Wales, in partnership with SATH laboratories and technicians, and should be included in the prototypes we are recommending.
- There are variable career pathways for 'urgent care practitioner' type roles currently employed across providers in Shropshire and Telford & Wrekin. Work to harmonise these pathways is underway, overseen by the workforce work stream.
- The health economy deficit reduction plan assumes that investment will be available for the development of essential community infrastructure and services to support the projected changes in acute activity. In line with the programme assumptions of Future Fit, it is thereafter assumed that the money will follow the patient.
- Evaluation of the prototype approach should 'test' whether provision of community alternatives results in fewer visits to urban urgent care centres / A&E departments. However, some of the proposed changes, e.g. reorganising existing services so that they work more closely together, will require a more sensitive evaluation methodology than purely impact on acute sector activity.
- A point of care testing sub-group, chaired by the Support Services Care Group Director of SATH, and with membership including partners from SATH, Shropdoc, CCGs, IT, GPs and others is operating effectively. We propose that this should continue learning lessons from the Shropdoc pilots underway and the proposed rural urgent care locality prototype(s) as part of the development of the rural urgent care solution.

3 Recommendations

The recommendations from the subgroup are:

- a) That the solutions we are proposing should be prototyped alongside existing developments currently being explored to improve the urgent care pathway. Particularly examining how they contribute to keeping people in the community wherever possible and only involving conveyance to the acute site where this is deemed clinically necessary and assessment cannot be performed using technology-supported virtual assessment processes.
- b) Evaluation of the prototype approach should 'test' whether provision of community alternatives results in fewer visits to urban urgent care centres / A&E departments. However, some of the proposed changes, e.g. reorganising existing services so that they work more closely together, will require a more sensitive evaluation methodology than purely impact on acute sector activity
- c) Continued commitment from all partners to work together to refine and implement the prototype. The core components of the prototype being:
 - Integrated locality based community teams (building on the ICS) able to offer a wider range of service to manage frailty, long-term conditions and urgent care pathways in community settings, e.g. UTIs, falls, IV antibiotics, frailty service.
 - Enhanced community-based therapy provision
 - Local access to diagnostics including
 - Point of care testing (using model currently being tested by SATH/Shropdoc partnership)
 - Extended x-ray offer at each the existing MIUs to cover at least 5 days a week
 - Increased telephone, and other means of access, to advice and guidance from SaTH consultants.
 - Consideration to the co-location of community teams with GP out of hours
- d) Explore the potential for community mental health access out of hours, to enhance the prototype.
- e) Seek transformation funding, through the STP process, to support the development of the prototype.
- f) Clarify that investment is available as part of the health economy deficit reduction plan, to fund development of services in the community, and that finance and resources will follow the patient as more care moves out of an acute setting.
- g) Explore through the further development of the prototype with the ambulance service
 - the assurance needed to ensure WMAS convey patients to the rural urgent care service
 - any further support WMAS may be able to offer through more innovative ways of working.
- h) Submit this report and its recommendations to Shropshire CCG's Clinical Advisory Panel to secure clinical support and select the prototype location(s). Submission of a resource paper for approval to the CCG Finance and Performance Committee to secure to proceed with the prototype development, implementation and evaluation.
- i) Acknowledging that the current acute Strategic Outline Case does not distinguish between the quantum of urgent care work that would be treated in urban and rural settings, the prototype should

seek to test assumptions regarding the extent of care that could be made available in localities and the factors which encourage patients to make use of facilities more locally.

- j) Robust evaluation of the prototype should be undertaken throughout with clear outcomes and metrics to inform learning. Criteria to be evaluated should encompass workforce, quality and safety, sustainability, access and patient and public feedback. Consideration should be given to evaluation approaches such as the co-production and experience-based design approach, whereby all stakeholders provide specific information about their experiences of the current service through a variety of methods and this experience is built into the support and evaluation. All stakeholders are then jointly involved in prioritising actions and implementing changes to the service and reviewing those changes, thereby ensuring that the project meets the needs of patients commissioners, staff and other stakeholders at each stage of its progress.
- k) Governance – the sub group proposes that prototype(s) are selected, and their development is overseen, by a sub group reporting into the Community Fit phase 2 work, within the overarching STP structure. Terms of reference should be agreed that include the production of outcomes that can inform the formal Public Consultation on acute hospital proposals planned as part of Future Fit. Consultation is scheduled to commence at the end of 2016 but initial high-level information would be required by the Autumn.
- l) Recommended next steps
 - Ask the existing Future Fit Clinical Design Group to progress planning on the scale and content of the prototype(s) and the links with exiting urgent care pathway development work associated with locality based care/care closer to home. This can then be progressed to secure the required support through existing CCG governance structures.
 - Rapidly mobilise resources to support full testing of all elements of the prototype, with associated clinical leadership, management, evaluation and project management support. We suggest a locality team is quickly established to develop a programme plan and describe the resources required. Initial outputs to be available by Autumn 2016 to inform Consultation documentation.
 - All localities across Shropshire, Telford and Wrekin are engaged and informed of progress and learning as the prototype develops.
 - Establish work stream as part of STP governance processes, to ensure related developments in primary care and other areas inform prototype development and rapid evolution.

4 Background

The Future Fit clinical model describes the need for new ways of working that embrace integrated care through a multidisciplinary team approach and acknowledged that if targeted on the right level of acuity of patients, they will have the greatest impact eg admission avoidance and complex case management. It also describes a partnership care approach, setting out a need for better continuity of care and to redefine the role of generalists and specialists in community settings.

The model sets out the proposals for the future provision of urgent care services to be fully networked, coordinated and needs led with clear signposting to the correct level of care to meet patient need. A key feature of the model is a local urgent care network comprised of the following components:

- A web based 'partnership portal' providing information and signposting
- Telephone triage and advice services (999, 111, GP surgery triage, GP out of hours triage)
- Ambulance services
- Local pharmacies
- GP surgeries
- GP out of hours services
- 'Some' urgent care centres
- One emergency care centre.

All of the acute site options assume that both of the existing acute hospital sites would have an Urgent Care Centre, one co-located with the Emergency Centre. In addition, it was suggested that there could be further Urgent Care Centres serving rural areas of the county. It was recognised that further work was needed to explore the feasibility of a rural Urgent Care Centre model and a working group was set up to look at this. This followed a decision by the Future Fit Programme Board in February 2014 to proceed to work on:

- Prototyping two urban Urgent Care Centres, one in Shrewsbury and the other in Telford; and
- Exploring the most appropriate rural urgent care solutions in partnership with local communities and considering current facilities/services. All existing Minor Injuries Units will be considered as potential sites for Urgent Care Centres.

The working group therefore examined the feasibility of locating a rural urgent care centre at each of the existing community hospital and MIU sites, starting with an assumption that there would be a single model across the county, i.e. that rural UCCs would have the same opening hours and range of staffing and facilities as each other and as the urban UCCs. The consensus view of the working group, which has been tested in discussion with local GPs and patients, is that this consistency constraint should not be applied to the design of rural urgent care services.

One of the initial factors in support of a consistent single model was a view from the ambulance service that they would wish to see standardised services across the county meeting a minimum 'kitemark' standard, with that standard set at a level broadly equivalent to the urban UCC model. The ambulance service has since indicated a change in their position on this: provided that the services are reliable (see below) then

they would recognise that there may be good reasons for a variation of service offer and opening times between different areas.

The working group reported to the Future Fit Programme Board in October 2015. It concluded that, apart from Bishops Castle Community Hospital, each of the existing sites could, with some capital investment, provide suitable facilities for the provision of a rural UCC as described in the clinical model. However, the report also raised concerns about the clinical and financial viability of the proposed centres and the potential for them to have a detrimental impact on existing rural primary care services.

In response, locality workshops were held with GP practices and a further working group was established to develop more appropriate and deliverable plans for urgent care provision in rural areas aligned with local need. The outcome of this review forms the basis of this report.

A rapid evidence review (Aldridge, 2015) found that studies of urgent care provision were of variable quality and that evidence to demonstrate an impact of alternative urgent care provision on A&E attendances was underdeveloped. Furthermore, the literature fails to identify any relevant evidence relating to impact on patient experience or equity of access.

5 Existing Developments in Enhancing Local Urgent Care

In considering any further proposals for enhanced rural urgent care solutions, it is critical that we acknowledge developments already underway within the county.

5.1 NHS 111/GP Out of Hours

Some parts of the NHS are already a long way towards functional urgent care integration, however, for the most part in Shropshire there are limited joint working arrangements between NHS111, GP Out of Hours and other urgent care services. This makes accessing urgent advice and treatment very confusing for a large number of patients.

New national commissioning standards for integrated urgent care were published at the end of September 2015 and represent a fundamental redesign of the NHS urgent care 'front door', improving out of hospital services so that we deliver more care closer to home and reduce hospital attendances and admissions.

The offer for the public will be a single entry point – NHS 111 – to fully integrated urgent care services in which organisations collaborate to deliver high quality, clinical assessment, advice and treatment and to shared standards and processes and with clear accountability and leadership.

Central to this will be the development of a 'clinical hub' offering patients who require it access to a wide range of clinicians, both experienced generalists and specialists. It will also offer advice to health professionals in the community, such as paramedics and emergency technicians, so that no decision needs to be taken in isolation. The clinicians in the hub will be supported by the availability of clinical records such as a 'special notes', Summary Care Record (SCR) as well as locally available systems. In time, increasing IT system interoperability will support cross-referral and the direct booking of appointments into other services.

It should be noted, however, that the expectation remains that 'in-hours' the main point of contact for patients requiring urgent healthcare will be their GP practice.

This year Shropshire CCG has taken the first step towards delivering these standards with revised service specifications for NHS111 and GP Out of Hours which require these services to functionally integrate and work collaboratively, together with the introduction of the clinical hub in NHS111 as described above.

5.2 Integrated Frailty Pathway

Population ageing is a 'game changer' for health and social care services and getting services right for people living with frailty has become the 'must do' for health and social care communities nationally. While many people remain well, engaged and active well into later life, increasing age also brings an increasing chance of long term medical conditions, frailty, dementia, disability, dependence or social isolation.

Locally rising emergency admissions, particularly in the over 75's, is putting a huge strain on the local acute hospitals' ability to cope with demand. One of the key projects within the Local Health and Social Care Economy (LHSE) A&E Performance Recovery Plan 2016-17 is the development of an integrated end to end frailty pathway. This work is in its early stages but a multi-stakeholder workshop in March 2016 agreed the following vision and aims for the project within Shropshire:-

Vision: "An integrated frailty pathway that identifies and supports individuals in the right place, by the right people through 24/7 appropriate personalised health and social care response, to prevent decompensation and promote greater health and wellbeing"

Aims

1. There is a common understanding across the LHSE of what Frailty is.
2. Consistently identify/flag 100% of patients with frailty in all settings.
3. 100% of patients who are identified as frail have an active care plan which is shared as they move from one provider to another on their patient journey.
4. Responsive needs based care in the correct setting.
5. Reduce length of stay for frailty patients when they are admitted.

5.3 Integrated Community Services for Admission Avoidance and Early Supported Discharge

The development of locality based community teams links with existing initiatives being progressed by the Community Trust as part of their Rural Healthcare Solutions development work through which they seek to address problems of providing equitable access and quality of care to rural populations by increasing the level of services provided in the community. The Trust is working with partners, patients and public to define, develop and deliver high quality, sustainable Local Enhanced Community Services:

- Urgent Care (aligned to the Urgent Care clinical model).
- Development of Community Hubs.
- Teams Around the Practice and Integrated Community Services.

Urgent Care (aligned to the Urgent Care clinical model)

The Trust is committed to support people of all ages to remain in the community preferably in their home and is developing services to reduce demand for acute care through;

- Admission prevention and avoidance by providing simple access to enhanced out of hospital urgent care services so we can avoid an emergency admission where possible.
- Right care, right time and right place by delivering the best care in the best place without delay.

- Effective patient flows by promoting rapid discharge to the most appropriate place for recovery in a planned, timely manner.

Development of Community Hubs

Work is underway to develop new models of care to support a shift of services from an acute to a community setting and where possible in the home through utilising the community trust's network of services, including the Community Hospitals and redesigning of services to improve local access through the provision of health hubs.

This work will utilise existing infrastructure, and develop our workforce, to provide a range of planned and unplanned pathways to reduce demand on local emergency services, improving assessment, diagnosis and intervention for people of all ages, including the frail elderly, in community settings.

We will develop community based pathways wrapped around these hubs to support people at home using planned or intermediate care pathways. Additionally we will develop, with our partners, sub-acute ambulatory care pathways within these Community Hubs to provide care close to home, building on the skills of DAART, our Minor Injuries Units and local

Teams Around the Practice and Integrated Community Services

In order to enable people to remain at home, we are developing robust integrated admission avoidance pathways whilst maintaining support for those with long term conditions. A focus for 2016/17 will be to provide proactive, rather than reactive, care to anticipate and prevent deterioration for people who are frail or have long term conditions.

We will develop and extend the alternatives to hospital admission across 7 days, with a focus on the frail elderly and patients with complex needs and chronic illness and those at End of Life. We will provide the right care at the right time in the right place in line with the Community First principle. For patients who are unwell this will include wrap around short term support in their usual place of residence.

We will redesign our community pathways to better support the needs of neighbourhood populations. Our care model will focus on improving the impact of the management of long term conditions to better empower people to self-manage. These models will be delivered by a workforce that is skilled to deliver a range of interventions. We will further educate our patients, partners and the population about our services to ensure care is optimised and exacerbations and/or crises are minimised, e.g. COPD, Diabetes, End of Life. We will support the development of models of care that deliver services through multi-disciplinary teams, made up of people with expertise in health, social care, voluntary services and mental health; who use tools to assess the risks to people's health needs to guide care. Working with General Practice teams we will deliver care wrapped around the patient in their own home. We will work to break down the barriers between practice and community workforce placing the patient at the centre of our care. Integrated Community Services (ICS) has been a key transformational programme of work within the LHSE. Its implementation has been phased over the last 3 years with the final phase of admission avoidance introduced in all 3 localities in November 2015. ICS delivers care activity in a different way, offering an immediate alternative to acute/ community hospital services.

Operating 7 days a week ICS is a locality based health and social care, community and voluntary sector integrated team with responsibility for complex patients who require support to prevent an acute hospital admission or to facilitate discharge from an in-patient bed. It provides an integrated holistic rapid response to care delivery in the right place at the right time to maximise a patient's independence with the default position being for the patient to remain at, or return to, their home.

A core component of the model is workforce redesign and the development of generic roles.

5.4 Physician Response Unit – Ambulance Service

Preventing cases (often complex frail elderly) presenting via ambulance at the ED is a local priority. In Shropshire, West Midlands Ambulance Service (WMAS) convey an average of 1619 patients per month to PRH and RSH and of these an average of 55% are admitted. This summer the CCG has commissioned WMAS to introduce a 12 month proof of concept GP-led Pre-Hospital Acute Medicine Service. The GPs in the service have enhanced skills in the clinical management of pre-hospital medical emergencies and will respond as a primary resource to 999 calls. The intention is to see and treat patients with the aim of finding alternate treatment pathways (including treatment at home) other than conveyance to the Emergency Department.

This is a 7 day service operating 10am-8pm. Whilst it will initially operate in Shrewsbury and its surrounding areas, the evaluation of the 12 month project will include consideration of and recommendations for a next phase rural model.

5.5 Management of Long Term Conditions

The CCG has a number of programmes of work to develop community based pathways for the management of long term conditions including heart failure, respiratory and diabetes. Dedicated out of hours phone lines providing access to urgent advice and guidance from specialists to support admission avoidance has been successfully established for moderate to severe risk COPD patients, with seamless handover to the community respiratory team. This is also in place but less developed for heart failure and diabetes.

6 Proposed Rural Urgent Care Prototype

The sub group has been successful in raising the profile of the rural urgent care work, and providers are now working in collaboration and willing to put forward proposals to support an integrated offer. Some of these developments are not focussed specifically on providing rural urgent care, and, as described in the Future Fit clinical model, the sub group has concluded that rural urgent care services cannot be viewed in isolation from other health and social care provision in the community whether that be planned care or management of long term conditions

Co-location and mixed provision will enhance awareness and utilisation of services, enabling a broader range of services to be offered in community settings in a way that is efficient for the tax payer and convenient and accessible for local residents. A key component of this approach would be enhanced care co-ordination, effectively integrating services from a patient and practitioner perspective.

As set out in the recommendations, the rural urgent care sub-group suggest that a prototype should build on the integrated approach described above and further comprise of the following services:

6.1 Locality based community teams able to offer a wider range of service e.g. UTIs, falls, IV antibiotics.

Working in partnership with other providers, and the work of the existing ICS transformation programme, the range of services that the community trust currently provide could be extended. This is based on two key assumptions; point of care testing for blood samples would be available in rural locations and all plain film x-ray exams would be undertaken where equipment was available. Use of technology to access specialist support and teams would enhance the offer. Service delivery would be through an integrated locality-based community team built on skills and competences rather than different service providers, including medicines administration support to improve medication compliance and reduce exacerbations. Retraining of the workforce would ensure that there are generic competences for core workers. Services would be simplified to remove current team boundaries to form integrated locality teams and improve workforce utilisation as a whole. Following on from an admissions avoidance workshop, Community Trust staff have proposed a list of a range of conditions, not currently commissioned from the Trust, that they believe could be managed by their staff in the community and it is proposed that these are tested through the prototyping process.

6.2 Enhanced community based therapy provision

There is evidence that the current provision of therapy service inside our acute hospitals is disproportionately high, and there is appetite to test whether having a greater number of these therapists available to support patients in the community both to prevent admission and to support rapid discharge, would result in enhanced care for patients.

Current and previous work to develop a more robust way of managing people with frailty has identified the benefit of having integrated therapy teams across acute and community and both providers have agreed in principle to progress this initiative. This will be progressed through the Frailty Project described in 5.2 with the proposal being the therapists rotate their work patterns between community and acute as this adds significant benefit to both the patient experience and optimising the available workforce.

The introduction of the Discharge to Assess model in 2015 also means that less therapy assessments and interventions are undertaken in acute hospital as the patients are discharged earlier and have their assessments at home or an alternative community interim bed. The therapy resource in acute which has been freed up from discharge to assess therefore needs to follow the patient into the community and the creation of integrated therapy teams would be a way of enabling that.

6.3 Co-location of community teams with GP out of hours

Where it is not already the case, explore the potential benefits of co-locating GPs and others working with the out of hours (OOH) service with other rural urgent care service staff, to maximise the benefits of integrated working.

Local OOH provider models of service delivery are changing. For example, Shropdoc is currently consulting on a new strategic plan and service delivery model to ensure it remains 'fit for purpose' to deliver health care 24/7. Their new model responds to the increasing shortage of GPs and offers an alternative clinical career pathway as an Urgent Care Practitioner (UCP) who are highly skilled and capable of providing a significant proportion of patient needs OOH. They are not GPs but have been through a comprehensive accredited selection and training programme and will be able to consult with an OOH GP when needed. Expanded skill mix in GP Practices has helped manage patient demand in-hours since 2004, this model applies the same philosophy to urgent care.

6.4 Local access to diagnostics:

(a) Point of care testing, (using model currently being tested by SATH/Shropdoc partnership)

We know that patients flow between the different parts of our healthcare system based on diagnostic uncertainty on the part of the referrer. This could be any community-based health or social care worker, patient or carer. Timely access to diagnostics and expert advice can inform this uncertainty keeping patients closer to home.

The rural nature of Shropshire and Powys results in many small communities being far away from diagnostic facilities, with long drive times and very poor public transport. This 'rurality' increases the decision making cycle time and in the acute setting often necessitates conveyance of patients to secondary care for simple blood tests. This increases the length of time it can take to make decisions and often means patients have to attend an acute hospital for relatively simple things – like blood tests or plain X-rays. A few days delay in diagnostic results can lead to frail, elderly patients losing muscle, cognitive ability, independence and function. There are obvious advantages to making speedier decisions, but clinicians need to be assured that the tests they use to help reach these decisions meet the national standards.

Point of Care (POCT) testing represents a solution to these challenges. In collaboration with Shrewsbury and Telford Hospitals NHS Trust (SaTH) and Shropdoc, the prototype will test whether POCT delivers benefits to patients. This will help to scope out the level to which POCT can:

- Support earlier diagnostic assessment for Ambulatory Emergency Care (AEC) pathways (for example; deep vein thrombosis, pulmonary embolism, community acquired pneumonia, acute kidney injury)
- Assist clinicians' working diagnosis to avoid admissions or ambulance transfer to hospital
- Apply in place of lab-based assays to monitor long term conditions

Shropdoc has developed a number of tests to pilot in its current initiative as part of a *POCT-Pack* approach. The tests that will be included in the POCT-Pack include blood tests for anaemia, diabetes control, inflammation/infections, kidney function, acute heart disease, deep vein thrombosis.

We anticipate that most savings made would come from safe avoidance of (ambulance) conveyance and admission of patients, due to the shorter times to make clinical decisions in the locality. The results of tests taken by health care assistants could be sent directly to a clinician – or wherever else they are needed.

In 2013 the MHRA published its guidance on the Management and use of IVD Point of Care Test Devices. IVDs are medical devices and accessories used to perform tests on samples, (e.g., blood, urine and tissue that has been taken from the human body) in order to: help detect infection; diagnose a medical condition; prevent disease or to monitor drug therapies. The guidance sets out a large range of considerations to be taken into account when implementing point of care testing including: infection control, record keeping, maintenance and accreditation. In order to support pilot work currently being implemented by Shropdoc in Telford and Powys, SATH have already done some of the ground work to support remote testing. However, should this be rolled out at a larger scale across multiple localities, some essential infrastructure will need to be put in place. A Point of Care Testing sub-group has been established, chaired by SATH Support Services Care Group Director, to guide this work and ensure consistency of approach and shared learning across providers in Shropshire, Telford

and Wrekin. SATH will play a key role in providing assurance and support for diagnostics across the whole economy and enabling confident clinical decision making. Anticipated benefits will include:

- Consistent results and reduce duplication of tests
- Continuity across providers
- Better acute episode assessment
- Spot trends (lab can cut hours/days/weeks from lead times)
- Potential to support more out-patient services in the community
- Minimises patient travel
- Facilitates virtual clinics
- Reduced admin (chasing-up results unnecessarily)

(b) Extended x-ray offer at each the 4 MIUs to cover at least 5 days a week

Our analysis has shown that there is potential to redirect a proportion of activity that currently takes place in the acute trusts to the rural urgent care centres to ensure the viability of a 5 day a week x-ray service. This will provide a significantly enhanced service and support more routine use of the MIUs (see data in Appendix C). Appendix C demonstrates the existing X-ray resource utilisation in the community, and both the data and radiology staff feedback that more work could be performed in rural localities. The prototype will test this.

6.5 Telephone, and other means of access, to advice and guidance from SaTH consultants

The acute trust is aware of the need to develop the routine capability to support their own proposed urban urgent care centres with consultant level remote support and this should also be made available to staff in rural centres who may need a consultant opinion in order to ensure patients are directed to the most appropriate service. Such support will include access to radiologists to assist with interpretation of results where required. This could be supported by additional outpatient clinics in the community.

The underpinning philosophy is a shared care approach so that no clinical decision has to be taken in isolation. Access to an acute consultant as a means of admission avoidance was trialled as an additional winter capacity scheme in 2014. During the short time it was in operation this telephone advice route for GPs demonstrated its effectiveness in reducing the number of emergency admissions. The only reason this scheme ceased was that the medical workforce recruitment and retention challenges in SaTH meant that it was not sustainable.

The introduction of the 'clinical hub' in the NHS111 service as described in 5.1 will provide wider access for patients and health care professionals to telephone clinical advice including GP, mental health, dental and pharmacy.

7 Considerations

7.1 Utilisation and viability

There are conflicting views regarding whether the provision of rural urgent care services will successfully redirect activity from the urban UCCs. It has been noted that the more remote areas of the county are

lighter users of A & E currently, and also that rural and market town GP practices tend to offer a wider range of minor injury and urgent care services. Several clinicians have pointed to Oswestry MIU as an example of where a new service delivered against previously unmet need, rather than reducing A&E attendances.

Data from the four minor injury units (MIUs) show very different levels of activity and patient outcomes, see Appendix B. There is clearly a risk that introducing rural urgent care centres might serve a currently unmet need or cater for patients who are currently receiving care at their practice, without actually reducing demand on the two urban urgent care centres.

Our latest estimates on the numbers of additional patients who could shift from the urban UCC to a rural urgent care services based on the opening hours of 8am to 8pm with availability of plain film x ray and near patients testing between the hours of 9am-5pm are detailed in the table below. These estimates need to be further tested through the prototype process.

Locality	Total A&E activity	UCC appropriate pts	UCC as a % of total A&E activity	RUCC activity based on latest model of care	RUCC as a % of total potential UCC activity
Bishops Castle	3,385	1,546	46%	735	48%
Bridgnorth	2,956	1,401	47%	580	41%
Ludlow	2,772	1,366	49%	723	53%
Oswestry	6,656	2,929	44%	1383	47%
Whitchurch	2,492	1,301	52%	651	50%
Grand total	18,260	8,543	47%	4072	48%

*assumes that RUCC accepts patients between 08:00-18:00 and investigations that can be carried out include: Pregnancy Test; Arterial/Capillary blood gas; Biochemistry; histology; ECG; Serology; Urine examination; Bacteriology; Immunology; Ultrasound; Blood culture. X ray between the hours of 09:00-17:00.

7.2 Financial assumption

This report has been written on the understanding that where activity shifts from one sector to another there is a corresponding shift in resource. This resource could simply be a shift in staffing resource rather than additional funding. There will be limited amount of additional funding available for investment in the community whilst recognising that service change will not be successful without some financial priming possibly though Transformation fund. It is intended that the proposed developments will need to be cost-neutral in terms of re-shaping existing service delivery. When describing the community response to the re-distribution of hospital activity, this document has assumed that the money will follow the patient, which may involve some innovative commissioning approaches.

7.3 Rural urgent care services and their relationship with urban urgent care centres

During the summer of 2015, a series of locality engagement events took place, based on the premise that there needed to be the same level of service provision in rural urgent care centres as have been proposed for the two urban centres to be based on the PRH and RSH sites. The sub group has now moved away from an attempt to provide equivalent services, and is instead exploring what it is practicable and desirable to provide in each locality. These ideas will be informed by the existing services, 'local assets', as well as demand and local appetite from patients and health and social care professionals for the development of existing service provision.

What has been recognised as important is that services in rural areas should be reliable. By this we mean that patients and other professionals should be able to rely on the service being available during specified opening hours. Anecdotally, we heard that some services provided in Minor Injuries Units and by District Nursing Teams (e.g. IV antibiotics) are dependent on which members of staff happen to be working, resulting in an unreliable service offer.

It should be noted that the two urban centres currently specified in the Strategic Outline Case have the space and staffing required to treat all urgent care requirements of the population. Additional service provision through rural urgent care services is not essential to provide urgent care but is seen as desirable to provide more convenient and timely access to care, and potentially to reduce emergency admissions.

7.4 Is it a centre or a service?

At its first meeting in October, the re-convened rural urgent care sub-group agreed to focus its work around the services that could be offered in rural settings, recognising that it could subsequently form a view whether the delivery of those services would necessitate a single, physical 'centre' or whether they could be made available through a variety of existing facilities within each locality. As discussions have continued, it has become apparent that locality solutions may differ, with some potentially being consolidated in an existing community hospital/MIU and others being dispersed around other service locations including large GP practices.

7.5 Rationale for focussing on five localities

The rural urgent care work has focussed on the five geographic areas where there are existing minor injury units and/or community hospital facilities. Clearly some of the elements of the proposed changes are not reliant on this type of infrastructure and therefore, should prototyping and evaluation show the new integrated approach to rural services to be successful, there may be scope to spread it to additional localities.

7.6 Workforce

There is no nationally-recognised qualification for working in urgent care settings, and in Shropshire and Telford & Wrekin the ambulance service, Shropdoc, the acute trust and the community trust all have different approaches to staffing the urgent care services they provide. We worked with Health Education West Midlands to review the job specifications and career pathways for 'urgent care practitioner' type roles currently in place or under development across Shropshire. This has now been passed to the Future Fit workforce workstream to inform development of an approach to harmonising the person specifications and carer pathways for these types of roles, building on established work such as the experience from the time-limited projects established through the Shropdoc Prime Minister's Challenge Fund approach examining the introduction of UCPs more widely.

7.7 Existing services and facilities

- Data from the four minor injury units (MIUs) show very different levels of activity and patient outcomes (see Appendix B). There were 19,293 total MIU attendances in 12 months, ranging from 2,000 at Whitchurch to almost 7,500 at Oswestry.
- The Shropshire Clinical Commissioning Group carried out an evaluation of standardising the MIU service, in order to divert activity from A&E to the MIUs in 2012. However the CCG concluded the proposed solution would not represent value for money.
- Shropshire Community Trust has provided some information about the physical facilities in each MIU but this is not currently linked to other services such as outpatient clinics on these sites.
- A report on staff competencies, and opportunities for West Midlands' educational establishments to develop a programme for a single urgent care practitioner grade, is ongoing. In summary there is considerable variation in the skills and competencies of current staff in the four MIUs. This results in different services being available, both within and between the units, and which may vary on different days, depending on staff rotas.
- Discussions about diagnostic services (X-rays, blood tests) available at the MIUs led to a piece of work on Point of Care Testing (POCT), which is detailed below.
- Minor Injuries Provision
 - With the exception of Whitchurch Hospital, the current minor injuries provision across the county provides services in the evenings and with some opening at weekends.
 - Most units have a full complement of Band 5 and 6 nursing staff, supplemented in some places by Band 3s. Many of these staff have skills and experience beyond that required in their current role.
 - Levels of utilisation are low, with average attendance ranging from 8-24 per day with variable opening hours
 - Medical support is provided either by GPs (Whitchurch, Bridgnorth and Ludlow) or by telephone from SaTH (Oswestry). The working group did not investigate the nature or level of demand for medical support or undertake an evaluation of the services provided to each of the current units. It is recommended that the community trust should undertake such a review.
- X-Ray
 - There is currently limited radiographer time available to maximise the use of x-ray equipment in community hospitals.
 - SaTH has reviewed GP direct-access activity and believes that there is potential to increase the proportion of x-ray activity undertaken in the community hospitals and the Oswestry unit. This has the potential to increase the times at which x-ray would be available in community settings, though may require additional resources.
 - Having multiple providers of x-ray services potentially reduces the flexibility of the local provision. RJAH currently provides x-ray services at Oswestry, and our work has shown that there may be scope to review operational arrangements to ensure that organisational barriers do not prevent the system from maximising the cost-effective utilisation of local x-ray provision.

8 Locality Workshops, March 2016

In March 2016 a further series of workshops were held in the five localities to report on the work to date. There was a mixed reception at the locality briefings regarding the proposed rural urgent care service offer. There was support, in the main, for point of care testing although some scepticism was expressed as to whether such technology was deliverable, despite operational examples elsewhere in the country. There was also some disquiet regarding the use of the terminology of 'service' rather than 'centre', particularly in localities where the community hospital is the most logical and viable base for services. It was clear that careful signposting and messaging will be required as we move towards locality prototypes in order to avoid confusion. A full report on these locality meetings is attached below as Appendix A.

8.1 Integration and admission avoidance.

Two strong messages came from the previous round of public rural urgent care workshops last year:

- 'Don't take our existing locality services away', and
- 'Urgent care services are used occasionally - they need to be integrated with other local health services we use more regularly'.

The sub group initiated an Admission Avoidance workshop for staff working in the community to tell us about current services: what works well, what needs improvement. This was held in February 2016 and was well attended by a full range of health and social care practitioners and patient representatives. The key findings from the workshop influence the potential rural urgent care offer and are listed below.

- There was general consensus that looking at the rural urgent care offer in each locality and ensuring consistency was more important than focusing on having various building-based centres throughout the county.
- Local access to key diagnostics, with immediate results (point of care testing), is vital to admission avoidance.
- Shared/integrated patient record is a fundamental and key enabler.
- There are many local services currently available but they:
 - Need to be more joined up to maximise efficiency and effectiveness, perhaps through commissioning specific integrated pathways. Consistency in availability of services such as the Early Discharge Team, Integrated Care Service and other opportunities for integrated working across acute and community would be the priority.
 - Need to be easier to navigate for both the patient and the professional – single point of access should mean single, both for professionals and the public (role of NHS111, triaging, assessing and streaming to the right service first time). Too many services are very similar, yet have different names; there is scope for providers to work in a more collaborative way.
 - Would benefit from extra capacity in some services - e.g. more slots or extended working hours to include later in the day and weekend.

- Opportunities that IT can offer need to be further explored, and soon - e.g. home monitoring of LTCs, Skype, remote review of test results.
- Developing the workforce to provide alternatives to GP is required – e.g. advanced nurse practitioner (see note about the education of urgent care practitioners in 2.1) and ‘someone who could do effective assessment/streaming/reassurance’.
- Developing integrated, responsive pathways for frail and complex patients is important.
- Enhancing the clinical support to residential care homes should be continued.
- Whilst maintaining patients at home is important, if patients are well enough to travel it may be a better deployment of specialist and generalist skills, capacity and availability for patients to receive their assessment and treatment (if needed) from a base within the community, with better facilities e.g. there will be circumstances where home treatment is not possible (IV antibiotics and the cleanliness of home environment).
- The voluntary sector has an important role to play. The impact of Local Authorities reducing voluntary sector grant allocations should not be underestimated.

9 Coproduction of Prototype

9.1 Developing the prototype

Our work has confirmed the view in the clinical model that rural urgent care should be seen as part of a networked service, taking into account health and care services already being provided in the localities. Indeed, with the availability of point of care testing and 5 day access to x-ray, we are confident that existing staff and services will be able to work in a more integrated way to provide a broader range of care, including urgent care services, in the community.

Attendees at the briefing events in March 2016 welcomed the opportunity to test within localities which approaches would be most successful and locally appropriate. Suggested measures of success as discussed at the briefings are detailed later in this report. There was a clear desire to develop proposals locally to maximise the use of existing local assets, e.g. voluntary community transport services. As such, we are proposing some form of development in each locality, to be developed in close co-operation with the patients, volunteers, GPs, nurses and other health and social care professionals in that locality.

Building on the co-production approach and acknowledging that the success of the services will be dependent on the professional and patient buy-in to their success, the first step for each locality will be to locally refine the proposed prototype. Prototypes should be in a position to report early findings by the end of the year to inform the Future Fit consultation.

We would like to test the modelled numbers through establishing at least one prototype encompassing:

- POCT trial and learning from the current Shropdoc POCT pilots
- Reliable offer of X-ray, at least 5 days per week
- Links into advice and support from SATH e.g. develop Skype or virtual consultations
- Testing the skills required for the urgent care practitioner role e.g. an ambulance paramedic seconded to the prototype

- An integrated locality-based community team, including more therapists e.g. design (or modify existing services) a rapid response service to enable people to have the care to keep them at home
- Liaison with SSSMHT to develop a mental health service offer
- Explore potential for integration of urgent care with out-of-hours services
- Community resilience – developing voluntary sector ability to interface with statutory services.

We recommend that all localities complete a 'readiness review' to assess any training, development or other needs that could be filled in parallel to the prototype, and that evaluation includes analysis of any unforeseen consequences on other services, for example GP practices.

9.2 Process for selection of prototype

There are a range of factors that should be taken into consideration when deciding which locality is most suitable to immediately commence prototyping the rural urgent care service approach:

Criteria	Rationale for that criteria
On-site clinical leadership	A GP or other senior clinician who is willing to lead the prototype
Nurses and other support staff in the locality willing to embrace integrated working	To increase likelihood of successful implementation of integrated model.
Patient representatives and members of the public in support of the prototype	Sufficient public support to ensure awareness and availability of services is publicised.
x-ray facilities on site	Some of the activity is predicated on the presence of an x-ray suite

9.3 Evaluation of prototype

It is proposed that, in line with good practice as currently adopted by NHS England in relation to new models of care, evaluation should be built into new developments from the outset. It should reflect an iterative approach, involving both quantitative and qualitative elements. Evaluation plans should allow for an early iteration to inform Public Consultation on acute proposals from late 2016. They should also include the evaluation of current MIU caseload against the desired shift from acute hospitals to assess appropriateness of staffing and facilities. A favourable evaluation will inform the development of any business case to support wider roll out of elements of the rural urgent care service approach to other localities.

Appendix A

Highlights of locality briefing feedback

The following table illustrates the location and date of each event held.

Table 1. Schedule of workshops

Location	Day	Date	Venue
Whitchurch	Tuesday	15/03/2016	Whitchurch Community Hospital, Claypit Street, Whitchurch SY13 1NT
Bishop's Castle	Wednesday	16/03/2016	Bishop's Castle Community Hospital, Stone House, Union Street, Bishop's Castle, SY9 5AJ
Ludlow	Monday	21/03/2016	Ludlow Conference Centre, Lower Galdeford, Ludlow, SY8 1RZ
Bridgnorth	Tuesday	22/03/2016	Bridgnorth Endowed School (Library), Northgate, Bridgnorth WV16 4ER
Oswestry	Wednesday	22/03/2016	Oswestry Town Council, The Guildhall, Oswestry, Shropshire, SY11 1PZ

1. Evaluation

At the locality briefings, attendees were asked for their views on what would constitute a successful rural urgent care service from their perspective. These are summarised below. These will form the basis of an evaluation framework which will operate across the localities to ensure learning is shared and what is proven to work is quickly adopted elsewhere. Attendees were asked to discuss on their table:

1. Questions from pre-reading and presentation
2. Add to list of services currently available in the locality.
3. What would a good rural urgent care service look and feel like for patients?
4. How can we engage the local population to maximise appropriate use of these services?

The first discussion has been captured in the Q&A section in table 6 of this report. The full outputs for questions 2-4 collected across the five events can be found in **Error! Reference source not found.**. A summary of the workshop outputs for questions 2-4 is provided below.

2. Additional services

The outputs show that conversation largely started with what are the existing services before discussing potential additional services. Key themes included:

Table 2. Key themes identified in discussions regarding additional services

Key themes	Example supporting comments
Clarification – what is already on offer	“People don't understand the offer”; “Bradbury centre – ‘half way house’ - what's delivered there?” (Whitchurch) “Publicise what the MIU (Urgent care) offers”; “Communication - what service offers what?” (Oswestry)
Use existing services	“Use existing community capacity e.g. primary care nurses, nurses MIU. A local arrangement to take it forward.” (Bishop's Castle) “We have skills in the community to facilitate patient care - GPs, nurses etc. - they can manage the higher level patient.” (Ludlow)
Additional existing staff e.g. GPs	“More staff and having more services here at Bishops Castle Community Hospital (as in the offer of services slide).” (Bishop's Castle)

Key themes	Example supporting comments
	"GP - potential to support rural service but currently insufficient staff - will need additional staff." (Oswestry)
Nurse practitioner	"Emergency Nurse Practitioners" (Whitchurch) "Nurse practitioner service" (Bishop's Castle) "Acute patient demand (non-injury) could be managed by an urgent care practitioner rather than the GP practice." (Bridgnorth)
Link to consultant / 2nd opinion	"Opportunity to communicate with consultants if necessary. Essential to get this in a timely fashion." (Whitchurch) "Important to have a link to secondary care opinion e.g. ECG being reviewed." (Ludlow) "Orthopaedic consultant has a weekly clinic at Bridgnorth - really helpful support to GPs - benefits from the co-location and the same nursing staff in OPD/MIU." (Bridgnorth)
Additional local services	"Pharmacy minor ailment scheme" (Whitchurch) "New services: Chemotherapy; Ultrasound; X-ray; IV antibiotics; Step down beds; District nurses base; ShropDoc base; Dermatology; Pre-op assessment; Post op; GP service; Nurse practitioner service" (Bishop's Castle) "Voluntary car service in Bridgnorth and Cleobury"; "POCT would significantly improve DAART and lead to better ambulatory care"; "Podiatry services from Hereford to work in Bridgnorth." (Bridgnorth) "Keep current service e.g. DAART, plus: IV antibiotics; Transfusions; Some chemo", "Improved parking" (Oswestry)
Integration / bring services together	"Organisational barriers to integrated working should be identified and systematically tackled"; "111 - making sure the integration and directory of services needs to be clearer/better" (Bishop's Castle) "Keep the local hospital as a base and bring services together." (Ludlow) "Close working between GPs/MIU means 53% do not need follow up - much better outcome than other MIUs (e.g. number managed by GP, not number by clinic)." (Bridgnorth)

3. What does good look like?

Table 3. Key themes identified in discussions regarding 'what good looks like'

Key themes	Example supporting comments
Defined service that patients know about	"Education to community on what services are actually here." (Whitchurch) "A defined place to go and what would be there e.g. GP, nurse, practitioner." (Bishop's Castle) "People knowing the service exists." (Oswestry)
Patient have confidence in the service	"Patient confidence in the rural urgent care service.", "People need confidence in what is being offered." (Whitchurch) "Must have confidence of patients"; "Must deliver good care / better than being in hospital." (Bishop's Castle) "Accessible, safe, effective"; "People needn't go to A&E if care is available locally, appropriately." (Ludlow) "Do people feel safe / treated appropriately?" (Oswestry)
The service provided is consistent at the site and consistent across the patch	"Consistency in urgent care services i.e. opening hours - so people have confidence in what's available - 'knowing what you are going to get.'" (Whitchurch) "Not fair to ask patients what they would like it needs to be consistent across the board." (Ludlow) "Open predictable set hours that everyone knew - including into the evening." (Oswestry)
The service is accessible and provides a range of services	"Extended hours for pharmacy and other advisory services"; "More minor surgical procedures delivered locally." (Whitchurch) "Look like an MIU with a few extras - additional services addressing the right population e.g. X-ray daily, consultant opinion, POCT, plastering (not available in Ludlow currently)." (Ludlow) "24 hour on call service - linking with ShropDoc"; "Good ambulance service"; "Opening 8.30-6 7 days a week - with X-ray aligned"; "Well-staffed" (Oswestry)

Coordinated care that signposts patients correctly	<p>"If patients turn up at a rural service 'inappropriately' they are helpfully and kindly redirected - patients can't be in the wrong place"; "Front door / point of access for rural urgent care - is this 111?" (Whitchurch)</p> <p>"Be reassured that you have a 'go to' place (i.e. 111)." (Bishop's Castle)</p> <p>"Care coordination centre (ShropDoc) and directory of (urgent) services via 111." (Bridgnorth)</p> <p>"111 to redirect to rural urgent care centres." (Oswestry)</p>
Makes use of enabling technology	<p>"IT shared record / patient access"; "New technology covering/connecting RUC to SATH/Acute." (Whitchurch)</p> <p>"Improve digital communication between sites - we have no joined up approach." (Ludlow)</p> <p>"Joined up IT service." (Oswestry)</p>
Develops a market for carers, both domestic and care home services	<p>"Market for home care needs to be developed - insufficient staff." (Bishop's Castle)</p> <p>"Carers are appallingly paid - need a market." (Ludlow)</p> <p>"Care provision and carers - lack of providers." (Oswestry)</p>
Evaluates the service	<p>"Must be cost benefit analysis." (Bishop's Castle)</p> <p>"Audit the number of patients/outcomes in the observation ward (asthmatics, renal colic) in terms of DGH admissions avoidance." (Bridgnorth)</p> <p>"Measure quantitative feedback – evaluation." (Oswestry)</p>
Provides education and training	<p>"Consistent training for workforce so high standard across." (Whitchurch)</p> <p>"Education is key - promotion" (Ludlow)</p>

4. How can we engage the local population?

Table 4. Key themes identified in discussions regarding how to engage the local population

Key themes	Example supporting comments
Provide clarity / education on what's available and what is 'urgent care'	<p>"Firstly show what is actually here." (Whitchurch)</p> <p>"The public needs clarity about the current services e.g. does the service called Urgent Care Centre at RSH provide the urgent care services being discussed tonight?"; "The public is confused as to what constitutes 'urgent'" (Bishop's Castle)</p> <p>"Need to advertise that these test are available"; "People have to know exactly what service are available"; "Bullet points what is available - timings current and up to date, be clear what isn't available." (Ludlow)</p> <p>"Importance of accurate, consistent information." (Bridgnorth)</p> <p>"Clear information on where you would need to go." (Oswestry)</p>
Deliver good services	<p>"Provide a good service and word of mouth will spread it." (Whitchurch)</p> <p>"Rural urgent care must be able to diagnose and treat the condition/health problem." (Bishop's Castle)</p> <p>"People need services that they trust"; "Good quality services – word of mouth." (Ludlow)</p> <p>"Improved car parking." (Oswestry)</p>
Undertake publicity activities (including: big launch; local public services e.g. school, libraries; social media; local media / press; public meetings; charities; care agencies)	<p>"Big launch"; "Newspapers e.g. Shropshire Star, Whitchurch Herald"; "Social media"; "Voluntary groups"; "Care agencies" (Whitchurch)</p> <p>"Public meeting opportunities"; "Local media/press"; "Social media"; "Community college - students (Bishop's Castle)"</p> <p>"Advert in local newspapers - regular article or update" (Ludlow)</p> <p>"Bridgnorth LOF – promote the hospital as well as fund-raising"; "Domiciliary care agencies"; "Parish councils" (Bridgnorth)</p> <p>"Local papers, radio"; "Libraries and Schools" (Oswestry)</p>
Provide publicity materials (prescriptions, fridge magnet, leaflets, posters, recorded messages/telephone)	<p>"Red books"; "Take home advice"; "Shropdoc number" (Whitchurch)</p> <p>"Leaflets to every household about services" (Bishop's Castle)</p> <p>"Fridge magnet with basic info on there"; "Central number for signposting people" (Ludlow)</p> <p>"Leaflets, Posters"; "Need signposts to MIU"; "Put on GP repeat prescriptions" (Oswestry)</p>
Engage with clinicians	<p>"Doctors/pharmacists/providers key to point of access to services." (Whitchurch)</p> <p>"More information in GP practices." (Bishop's Castle)</p> <p>"Communicate with the clinicians they pass down to patients, families and friends";</p>

Key themes	Example supporting comments
	<p>“Make sure clinicians understand it.” (Ludlow)</p> <p>“Wider 'selling' of the local prototype to GPs in rural practices.” (Bridgnorth)</p> <p>“Notice in surgery and in ED”; “Practice newsletters” (Oswestry)</p>
Involve patient groups	<p>“PPG” (Whitchurch),</p> <p>“PPG in all practices – need to enrol their enthusiasm” (Bridgnorth),</p> <p>“Patient groups” (Oswestry)</p>

Appendix B

Minor Injury Units - Analysis of activity (Shropshire patients only) - 12 months from December 2014 to November 2015

	All MIUs	Bridgnorth	Ludlow	Oswestry	Whitchurch
Total number of attendances in 12 months	19293	6220	3583	7485	2005
Opening hours		8am-9.30pm Mon-Sun	8am-8pm Mon-Sun	8.30am-6pm Mon-Fri 8.30am-1pm Sat & Sun	9am-5pm Mon-Fri
Total hours open weekday	215	67.5	60	47.5	40
Total hours open weekend	60	27	24	9	0
Total number of attendances on weekdays	15941	4959	2676	6301	2005
% of total attendances	83%	80%	75%	84%	100%
Total number of attendances on weekend	3352	1261	907	1184	
% of total attendances	17%	20%	25%	16%	
Average number of attendances per day weekday	61	19	10	24	8
Average number of attendances per hour weekday	6	1.4	0.8	2.5	0.9
Average number of attendances per day weekend	32	12	9	11	
Average number of attendances per hour weekend	4	0.9	0.7	2.5	
Busiest day of the week		Monday	Monday	Monday	Friday
Busiest hours of the day (% of total activity)		9am-10am (17.8) 8am-9am (12.3)	10am-11am (10.8) 9am-10am (10.4)	10am-11am (15.7) 9am-10am (15.5)	9am-10am (21.9) 10am-11am (13.7)

Outcome/Disposition of total attendances by %	All MIUs	Bridgnorth	Ludlow	Oswestry	Whitchurch
Discharged - Did Not Require any Follow Up Treatment		53.0	34.3	11.8	57.5
Discharged - Follow Up Treatment to be Provided by GP		18.7	39.5	62	17.2
Referred to other Health Care Professional		13.6	5.4	3.5	11.7
Referred to A&E Clinic		10.1	6.7	3.8	4.7
Referred to other Out-Patient Clinic		2	0.2	1.9	0.1
Transferred to other Health Care Provider		1.2	4.2	2.4	2
Referred to Fracture Clinic		0.7	4.6	6.6	5.3
Left Department Before Being Treated		0.2	0	0.9	0
Other		0.1	4.4	6.3	0.7
Telford registered patients attending Shropshire MIUs	283	243	8	19	13
Welsh patients attending Shropshire MIUs (7 months figure April - Oct 2015)	1190				

Appendix C

Contextual information X-Ray

Scope of Referral for the MIU nursing staff in the Community setting.

Referrals to x-ray to be carried out by either the Community Medical Advisor or Registered Nurse The scope of referral is as follows:

- Children over 5 years of age
- Referrals will only be accepted from a named list of Registered Nurses with up to date IRMER Training working in the four minor injuries units throughout Shropshire Community Health NHS Trust and the supporting radiology departments will hold the signatures. That includes Robert Jones and Agnes Hunt Orthopaedic Hospital Diagnostic Department for Oswestry Minor Injuries Unit and Shrewsbury and Telford Hospitals (SATH) for Bridgnorth, Ludlow and Whitchurch Minor Injuries Units.
- Plain radiography requests can be made, to include:-
- Shoulder girdle to digits,
- Knee to foot, including the knee
- Referrals will only be accepted for recent incidents/injuries of less than two weeks old or if there is high clinical suspicion.
- The clinical details plus a clinical diagnosis of query fracture/dislocation or query foreign body should be written on the request for x-ray.

Community Hospitals X-ray current opening hours:

- **Bridgnorth** – Mon and Friday 9-4; Tues – Thurs 9-5. By appointment
- **Ludlow** - Monday to Friday, 09:00 - 15:00 Walk-in access for patients with a GP referral for a chest X-ray: Monday, Wednesday, Friday, 13:00 - 14:30.
- **Whitchurch** - Monday, Tuesday, Wednesday and Friday 09:00 - 13:00, by appointment only or via the Minor Injuries Unit.
- Both Ludlow and Whitchurch have said that if there were outpatient clinics then there was a potential to increase the capacity 9-5 but they would need more staff. They are not convinced that people would use the hospital at night for x-rays. Also the staff would not want to be on call at night as there are too few of them to cover the on-call they would have to be on a 1 in 1 or a 1 in 3. If out of hours service was to be provided then there would have to be discussions between the two Trusts to provide that service. This would require a process of change management and the identification of staff that work at SaTH but lived close to the community hospitals i.e. no longer than 20 minutes away.

SaTH has open access for GP patient Monday to Friday 9am – 4pm.

Analysis of X-Ray Activity

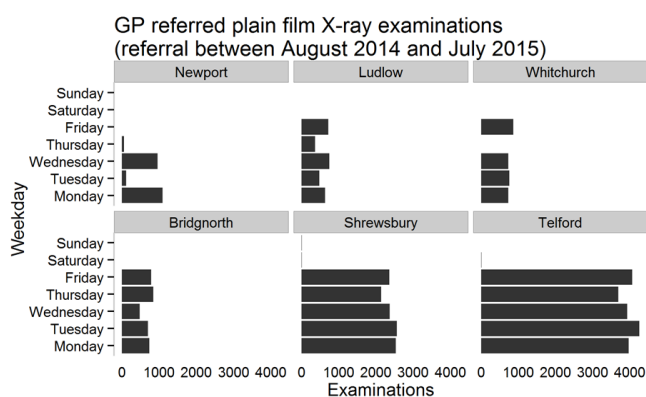
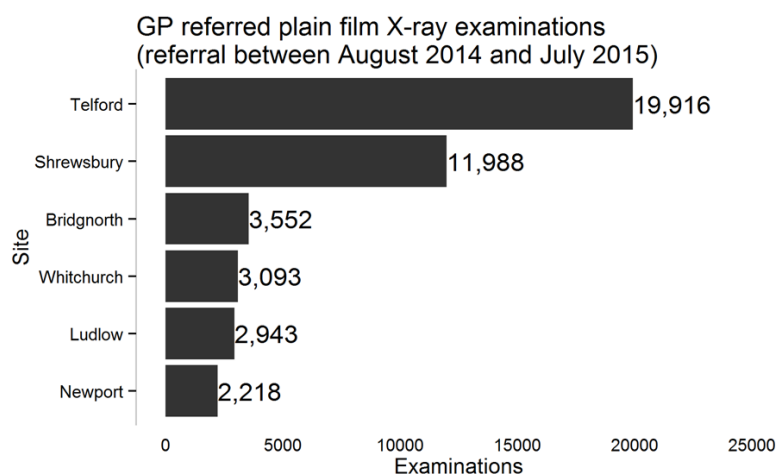
The Strategy Unit was asked by the Future Fit team to analyse a dataset of plain film X-ray examinations. The primary question to be answered was 'How many X-rays that took place at Royal Shrewsbury or Princess Royal hospital sites would it have been closer (by drive time) for patients to attend a UCC alternative?' This report provides a short descriptive analysis of the dataset we received, followed by the drive-time analysis.

A dataset of 43 thousand plain film X-ray examinations taking place at 6 sites across Shropshire, and Telford and Wrekin, covering patients referred by GP between August 2014 and July 2015. The six sites covered are:

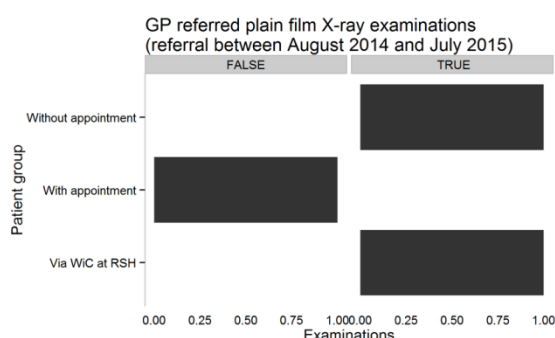
- Royal Shrewsbury Hospital
- Princess Royal Hospital
- Newport community hospital
- Whitchurch hospital
- Bridgnorth hospital
- Ludlow hospital

It should be noted that the dataset does not include X-rays that took place at Oswestry. The data was provided by Debbie Jones – Radiology care group manager at Shrewsbury & Telford Hospitals NHS Trust

Most X-rays took place at Telford. Among the smaller sites, Bridgnorth had the highest number of examinations as it is opened for more hours than any of the other Community Hospitals.



When looking at the distribution by day of week, we immediately note that there are almost no X-rays taking place at the weekend, any weekend x-rays are due to data errors as the GP x-ray service doesn't operate on these days. We also note that there were no X-rays taking place at Whitchurch on Thursdays, or at Newport on Fridays as the services are closed on these days.. Also of interest at Newport is that there were much reduced numbers of examinations on Tuesdays and Thursdays compared to Mondays and Wednesdays, due to opening hours.



Drive times were calculated using Visography TRACC software¹. The road network used was the Ordnance Survey MasterMap Integrated Transport Network (ITN) layer, 'the most current and complete network view of Great Britain's roads available today.' Attached to the ITN road network was INRIX road speed data (May 2014) – providing bidirectional² speed data at 5 times of day:

- AM peak (07:00 – 09:00)
- PM peak (16:00 – 19:00)
- average peak
- off peak (09:00 – 16:00)
- night (19:00 – 07:00)

The following settings were used when calculating the drive times:

- Road only accessibility
- Walk speed from origin to road network = 4.8km/h
- Fastest journey (as opposed to shortest)
- Maximum journey distance = 200km
- Maximum journey time = 120 minutes
- Road network envelope + 5km

Journeys exceeding any of the bottom 3 conditions would return a NULL journey time.

We considered 5 alternative destinations for these X-ray examinations. We grouped these in to 2 sets, based around the inclusion of Bishops Castle.

- Main destination set: Bridgnorth, Ludlow, Oswestry, Whitchurch
- Alternative destination set: Bishops Castle, Bridgnorth, Ludlow, Oswestry, Whitchurch

Under each of the five times of day or night, for around 10% (3200 - 3700) of the examinations, it would be closer for the patient to drive to one of the four UCC destinations. When Bishops Castle is included in the destinations, this rises to around 12% (3800 – 4000).

		Excluding Bishops Castle		Including Bishops Castle	
Time of day		Examinations	%	Examinations	%
AM peak	(07:00 – 09:00)	3373	10.6%	3899	12.2%
Off peak	(09:00 – 16:00)	3220	10.1%	3801	11.9%
PM peak	(16:00 – 19:00)	3338	10.5%	3925	12.3%
Average peak		3355	10.5%	3910	12.3%
Night	(19:00 – 07:00)	3642	11.4%	3929	12.3%

By looking at the totals by the original destination, we can see that the inclusion or exclusion of Bishops Castle is only affecting X-ray examinations originally carried out at Shrewsbury. We can also see from this analysis that, at Shrewsbury, there are more examinations with a shorter drive time at night time, this effect seems more pronounced when Bishops Castle is not a potential destination.

Telford		Excluding Bishops Castle		Including Bishops Castle	
Time of day		#	%	#	%
AM peak	(07:00 – 09:00)	2140	10.8%	2142	10.8%
Off peak	(09:00 – 16:00)	2062	10.4%	2066	10.4%
PM peak	(16:00 – 19:00)	2131	10.7%	2134	10.7%
Average peak		2150	10.8%	2152	10.8%
Night	(19:00 – 07:00)	2120	10.7%	2121	10.7%

Shrewsbury		Excluding Bishops Castle		Including Bishops Castle	
Time of day		#	%	#	%
AM peak	(07:00 – 09:00)	1233	10.3%	1757	14.7%
Off peak	(09:00 – 16:00)	1158	9.7%	1735	14.5%
PM peak	(16:00 – 19:00)	1207	10.1%	1791	15.0%
Average peak		1205	10.1%	1758	14.7%
Night	(19:00 – 07:00)	1522	12.7%	1808	15.1%

We can see that including Bishops Castle as an alternative destination affects the numbers at Ludlow, and also includes new patients. Note that these tables show the redistributed examinations only.

Time of day		Bridgnorth	Ludlow	Oswestry	Whitchurch
AM peak	(07:00 – 09:00)	871	371	373	1758
Off peak	(09:00 – 16:00)	783	306	360	1771
PM peak	(16:00 – 19:00)	848	343	363	1784
Average peak		862	348	362	1783
Night	(19:00 – 07:00)	833	652	375	1782

Time of day		Bridgnorth	Ludlow	Oswestry	Whitchurch	Bishops Castle
AM peak	(07:00 – 09:00)	871	76	373	1758	821
Off peak	(09:00 – 16:00)	783	66	360	1771	821
PM peak	(16:00 – 19:00)	848	63	363	1784	867
Average peak		862	77	362	1783	826
Night	(19:00 – 07:00)	833	81	375	1782	858

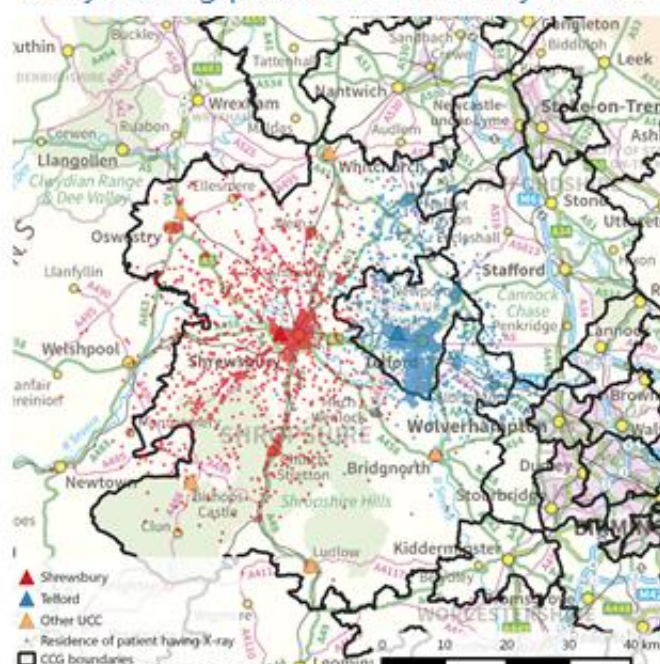
How many X-rays that took place at Royal Shrewsbury or Princess Royal hospital sites would it have been closer (by drive time) for patients to attend a UCC alternative?

- Approximately 10% (3,200 – 3,700) when Bishops Castle is excluded.
- Approximately 12% (3,800 – 4,000) when Bishops Castle is included.

Of those that took place in Shrewsbury, either 1,100-1,500 (Bishops Castle excluded), or 1,500 – 1,700 (Bishops Castle included), could have gone to a closer site.

Of those that took place in Telford, 2000-2200 could have gone to a closer site (the inclusion of Bishops Castle made no difference). However, it should be noted that a significant number of patients who live in the periphery of the county coming to SaTH as they work in either Telford or Shrewsbury area.

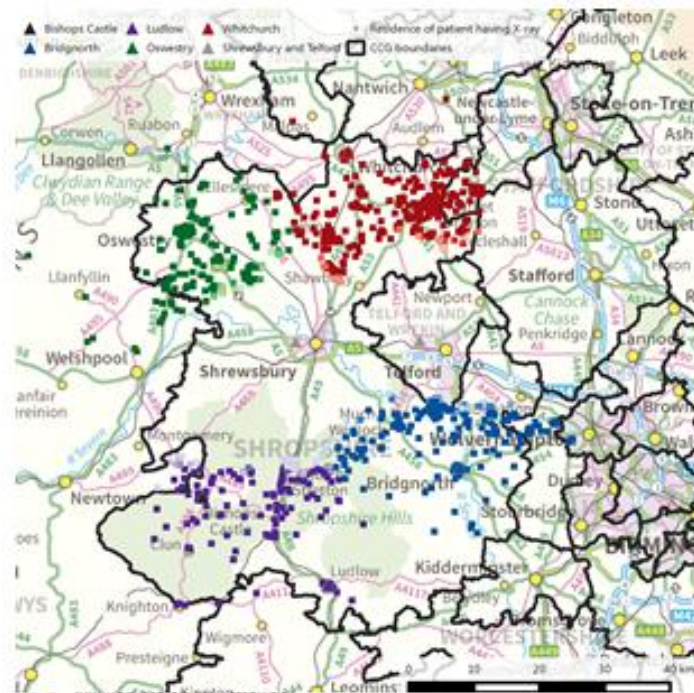
X-rays taking place at Shrewsbury or Telford



This map shows the X-ray examinations taking place at Shrewsbury (Red) or Telford (Blue) by residence of the patient.

Note that a couple of extreme outliers are not shown (e.g. living in Cornwall, London, or the North East).

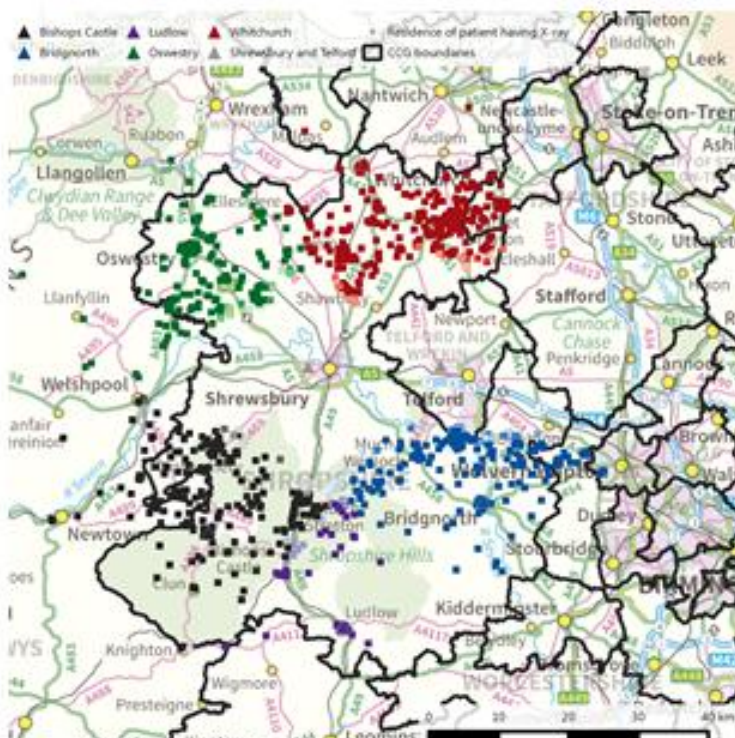
Map by closer alternative – excluding Bishops Castle



This map shows the X-ray examinations that took place in Shrewsbury or Telford, where Bridgnorth, Ludlow, Oswestry, or Whitchurch were closer by car drive time.

Note that where the drive time was not closer than Shrewsbury / Telford for all road speed data time of day options, the shading is lighter, but in the same colour.

Map by closer alternative – including Bishops Castle



This map shows the X-ray examinations that took place in Shrewsbury or Telford, where Bishops Castle, Bridgnorth, Ludlow, Oswestry, or Whitchurch were closer by car drive time.

Note that where the drive time was not closer than Shrewsbury / Telford for all road speed data time of day options, the shading is lighter, but in the same colour.

We can see that including Bishops Castle as an alternative destination adds some points to the map, but also crowds out Ludlow.

Appendix D

DRAFT TERMS OF REFERENCE Revised February 2016

Rural Urgent Care - sub group

The Rural Urgent Care sub group is accountable to the Future Fit Programme Board-and will report progress regularly to the Future Fit Programme Team/STP Operational Group.

The Rural Urgent Care sub group will undertake a range of activities in order to produce a recommendation regarding the rural urgent care service in Shropshire by March 2016. These activities will include:

- Collation of relevant work previously completed.
- Review of urgent care services currently provided at each locality.
- Review of current rural urgent care workforce to include a review of competency requirements of roles currently in development.
- Oversight of the plans for engaging with locality groups at 5 locations (Ludlow, Bridgnorth, Bishops Castle, Whitchurch and Oswestry). The sub group will ensure consistency of approach across the localities and make recommendations based on the findings of their work.

Within the sub- group there is a core team that would then work with each locality. Locality groups will be invited to workshops and will include a mix of clinicians and local stakeholders. A recommendation from the sub-group will report to relevant CCG bodies and the Future Fit Programme Team/STP Operational Group in March 2016.

The sub-group membership is set out in the table below.

Table 1 Sub-group Membership

Name	Role	Organisation
Paul Tulley (chair)	Deputy Accountable Officer	Shropshire Clinical Commissioning Group
Dr Karen Stringer	Associate Medical Director (Strategy)	Shropshire Community Health NHS Trust
Emma Pyrah	Programme and Service Redesign lead	Shropshire Clinical Commissioning Group
Russell Muirhead	Chairman	Shropshire Doctors' Co-operative Ltd
Sally-Anne Osborne / Mel Duffy	Deputy Director of Operations Director of Strategy	Shropshire Community Health NHS Trust Shropshire Community Health NHS Trust
Kate Shaw	Associate Director of Transformation	Shrewsbury and Telford Hospital
Debbie Jones	Diagnostics Lead	Shrewsbury and Telford Hospital
Ruth Lemiech	Project manager	Commissioning Support Unit
Richard Chanter	Patient Rep	(Trust patient Group)
Jane Niblock	Patient Rep	(North Locality)
Peter Gillard	Chair	Ludlow PPGs
Vanessa Barrett	Representative	Health watch Shropshire
Kate Ballinger	Representative	Healthwatch Telford & Wrekin
Debbie Vogler	Future Fit Programme Director	

