

## **Cornwall is to have Urgent Treatment Centres – so will Minor Injury Units disappear?**

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*The planning of Urgent Treatment Centres for Cornwall reveals a great deal of confusion within NHS Kernow. It is now evaluating all Minor Injury Unit sites for 'upgrading' to UTCs, but saying nothing about what will happen to MIUs that are not being upgraded. There is a draft proposal from Cornwall GPs for UTCs which has much to commend it, but it is a one-size-fits-all model for UTCs only, so further work is needed. 'Co-production workshops' are supposed to be contributing, but the latest briefing paper for these is deeply flawed, and the approach that the workshops take amounts to 'Planning by Post-It Note'. And yet again, NHS Kernow is calling in consultants despite, it appears, not being clear how they could help.*

### **Background**

In January this year, NHS Kernow (the Kernow Clinical Commissioning Group) took umbrage at the suggestion that it was poised to close most of Cornwall's minor injury units (MIUs) in pursuit of NHS England's aspiration to see urgent treatment centres (UTCs) covering the whole country.<sup>[1][2][3]</sup> NHS Kernow has now said that it will evaluate as potential sites for a UTC all 14 MIUs in Cornwall, including the Emergency Department at Treliske (which serves as a minor injury unit for the local population) and two MIUs that are currently closed.

Presumably, then, some of the existing Minor Injury Units will be upgraded to Urgent Treatment Centres. But what will happen to the others? It appears that no thought is being given to them.

This news emerged at the recently-held third wave of 'co-production workshops' held across Cornwall by NHS Kernow as part of the Shaping our Future (SoF) programme. This is the programme aimed at producing a Sustainability and Transformation Plan (STP) for Cornwall and the Isles of Scilly.<sup>[4]</sup> An insight into NHS Kernow's thinking is given by two documents that were circulated in advance of the workshops: a briefing paper and a draft specification for UTCs drawn up by a group of Cornwall's GPs and other clinicians.

### **What our GPs would like to see**

The GPs' plan is for a UTC led by GPs.<sup>[5]</sup> While it is still at the draft stage, and has not as yet been costed, the services it proposes would be a significant improvement on the national specification set out by NHS England<sup>[6]</sup> (which also would be GP-led). Having been produced by medics who are familiar with the locality and existing health services, it does draw on their detailed knowledge of how the system works at present and where inefficiencies occur. But the plan doesn't draw on any survey of patients, to gather their views as 'consumers' of the system and learn from their experiences. And the specification is as yet uncoded, and we don't know how the expenditure involved would be viewed by NHS England. Moreover, while a well-equipped UTC will doubtless provide a splendid service, if only four or five or six MIUs are to be upgraded, what is to happen to the others? Are they to be closed? Could they become mini-UTCs? Is any work being done to investigate this possibility? The final version of the specification needs to address these questions. The system *must* be treated as a whole.

## NHS Kernow's briefing paper

The other document provided to the workshops is a 9-page briefing paper, *Briefing on Shaping Our Future urgent care work stream progress*.<sup>[7]</sup> Among other things, this document reported on learning from previous co-production workshops, and included this statement:

The key challenge facing our emergency departments is not [that there are] too many people walking in with minor injuries and illnesses as these people can be seen relatively easily and quickly, but [that there are] too many people arriving, often by ambulance, with complex health needs requiring an assessment in a hospital. Therefore, this is the cohort of people we should be trying to support to receive care closer to home in a more local urgent treatment centre. For patients this will mean shorter travel times to receive care for more serious conditions currently only available in acute hospitals. (Para 3.2)

As we can see, this sweeping statement makes light of the workload created by 'people walking in with minor injuries and illnesses', even though NHS England is very keen to discourage such people from turning up at Emergency Departments.<sup>[8]</sup> And – crucially – it confuses assessment with care, by equating 'too many people ... requiring an assessment in a hospital' with 'the cohort of people [requiring] care closer to home'.

Assessment and care are different, as the GPs' draft specification for UTCs recognises. Their specification provides for short stay assessment beds in a UTC, enabling frail patients in particular to stay overnight while diagnostic examinations and tests are carried out and the results awaited. In effect, the GPs are querying the implication in the briefing document that assessment necessarily takes place 'in a hospital'.

The briefing paper also asserts that people with 'complex needs [should] receive care closer to home in a more local urgent treatment centre'. But is it appropriate for someone with complex needs to be taken to an *urgent* treatment centre? Arguably, for someone with complex needs to get better they require a period of time in a restful environment, not one where the staff are under the pressure of urgency and the need for a rapid turnover of beds.

### Basic research needed

The lesson here is that health policy decisions, which involve massive expenditure on staff, equipment and buildings, need to be based not on casual, unsystematic observation but on organized research, asking insightful questions and carefully studying the processes at work. In the case of urgent treatment in Cornwall, the place to start would be the Emergency Department at Treliske. And we would need to ask questions about the *flow* of patients through the Department.<sup>[9]</sup> Questions like these:

Is it the case that patients typically see the most junior members of an emergency team before they access senior decision makers in emergency care? (It is the latter who are best able to ensure that patients quickly get on the right pathway.)

Is the assessment unit 'processing' patients speedily, or is it really operating more as a 'holding bay' in a bid to ease pressure on emergency care, while potentially adding delay and confusion at a point which could be critical to the overall outcome of a patient's care?

When assessment requires a procedure extending beyond the assessment unit, as when a sample has to be sent to a laboratory for analysis, is the patient kept waiting, possibly requiring an overnight bed, for the result? (Do delays arise because patients tend to arrive later in the day while laboratory staff go home at 5? In which case, can something be done to alter working hours?)

Are patients kept in hospital for their discharge assessment even when they are medically fit and the assessment might be more meaningful in their own home?

### **Confusion in the briefing paper**

Sadly, the briefing paper provided to the Wave 3 workshops contains more examples of confusion. For example, we find a reference to

A cost benefit analysis of West Cornwall Hospital which will seek to identify if the current additional investment in the GPs and enhanced diagnostics which set it apart from a nurse-led Minor Injury Unit makes a difference in terms of reducing ambulance journeys and Emergency Department attendances and admissions. (Para 3.6.1)

'Cost-benefit analysis' is a technical term. It is the name given to a well-established technique for comparing alternative courses of action in terms of a single criterion, usually the equivalent money value of the costs and benefits that would be entailed.<sup>[10]</sup> That is clearly not what is meant here. The term has been used without its meaning being grasped.

And again, we read that it is proposed to use

a modelling tool known as "Channel Shift" to evidence the impact of national Vanguard systems piloting new ways of delivering service. It has been endorsed by NHS England and the London School of Economics. (Para 3.6.2)

Suffice it to point out that the model is correctly known as the Consolidated Channel Shift Model, that the 'national Vanguard systems' referred to are seven pilot projects up and down the country in which local organizations (such as A&E Delivery Boards and Urgent & Emergency Care groups) took part,<sup>[11]</sup> and that the London School of Economics does not endorse models or 'modelling tools'.

Another example: the briefing document presents a diagram that purports to show a 'critical path' of steps involved in identifying 'options for the configuration of urgent care services' (Para 3.7). 'Critical path' is another technical term with a very specific meaning: in project management, the technique of critical path analysis involves finding the sequence of steps through an often complex network that necessarily takes most time (this is the critical path), and then ensuring that when actually implementing the project no other sequence will take up more time.<sup>[12]</sup> That is clearly not what the diagram in the briefing document does.

Garbled and inaccurate descriptions of methodology and inappropriate citations of authorities do not inspire confidence. Nor does the fact that the briefing paper does not carry a date of publication or the name(s) of the author(s).

### **Mixed messages from NHS England**

In a previous report<sup>[13]</sup> I pointed out how NHS Kernow was attempting to help satisfy NHS England's ambition to roll out 'standardised new Urgent Treatment Centres'.<sup>[14]</sup> Having heard from patients and the public about 'the confusing mix of walk-in centres, minor injuries units and urgent care centres, in addition to numerous GP health centres and surgeries offering varied levels of core and extended service [with] a confusing variation in opening times, in the types of staff present and [available] diagnostics', NHS England started off by determining that UTCs should be governed by a core set of standards to establish as much commonality as possible.

Subsequently, however, the message became more nuanced:

'There will inevitably be variation in what each urgent treatment centre may provide as the needs will be different for different populations and geographies. [Moreover, we know] that there will be some exceptions where ... a service that does not meet [our] standards [will be justified], most likely in more rural or sparsely populated areas.'<sup>[15]</sup>

So NHS England is now being flexible. This flexibility presents an opportunity for Cornwall.

### **What will NHS Kernow do now?**

People who attended the latest co-production workshops were informed (in a photocopied handout) of another new development. NHS Kernow has commissioned a study of travel times between people's homes and the fourteen MIU sites. Because a 'common concern [is] how long will I have to travel if you move a service that provides my care from A to B? ... it's really important that we ... calculate how long it takes to travel by all methods of transport'.

Careful consideration should be given to a study of this kind before a contract is entered into. In particular, the question needs to be asked: How will the results be used? Clearly in any calculation the travel times will need to be weighted by population numbers, so will it be possible for a sizeable town to outweigh a group of small villages? And there is more to travel than distance and modes of transport. For example, Camborne is midway between Penzance and Treliske, but if Camborne doesn't have its own UTC, can we expect half the inhabitants of the town to choose to attend the UTC at Penzance? Unfortunately NHS Kernow appears, as it has done in the past, to have seized on a project offered by consultants without seriously questioning it, with a consequent risk that decisions will be taken on the basis of crude theories of 'geographical determinism'.

### **A planning role for GPs**

It can only be a good thing that (so far as we can tell) local GPs are on board with the UTC project, because of the experience and local knowledge that they bring, and their draft UTC specification is a valuable contribution. However, the fact that it is only a single specification brings with it the risk of it being seen as a 'one size fits all' solution.

Interestingly, in Devon it is well understood that a range of provision is needed. As NEW Devon CCG has pointed out:

National guidance has suggested the development of Urgent Care Centres to replace Minor Injury Units. This new model of much bigger units suits large urban settings, but will not be viable either clinically or financially in many rural areas including our Devon market towns and communities.[16]

Exactly the same is surely true of Cornwall, and it now seems to be appreciated by NHS England. So it would be good to see the guiding principle, adopted in Devon, of meeting local needs rather than going for standardization and consistency, adopted so far in Cornwall too by our GPs, which must mean reaching beyond their single draft specification.

### **Can 'co-production workshops' contribute more than 'Planning by Post-It Note'?**

What have the co-production workshops yielded so far? At the February 2018 Wave 3 workshops, participants were shown a Powerpoint presentation. The Agenda slide showed 'Lessons Learned in Wave 2': these were based on three lists of 'Pan-Cornwall Wave 2 Themes', which are shown below:

#### **Prevention & Self Care**

- It's everyone's responsibility
- Target children and those most at risk
- Early intervention
- Provide more in the community & be holistic
- Reduce access to unhealthy choices
- Reduce isolation & increase social prescribing
- Work with Voluntary Sector (VCSE)

#### **Integrated Care**

- Be holistic(housing, finance telehealth etc.)
- Integrate teams (trust, co-location shared MDTs)
- Workforce (capacity training, Terms & Conditions, blended roles)
- Governance (trust, budgets, clinical & info. governance)
- Estates (expanded usage of community & care settings)
- Model of care (time to think beds, mental health, transport, Single Point of Access (SPA), 111, Out of Hours (OOH), discharge)

#### **Location**

- Arterial routes
- Parking
- Congestion
- Seasonal fluctuations
- Rurality
- Fear of change (keep services local)

What we see here is a classic example of 'thinking in themes'. This way of thinking may lend itself to structuring an undergraduate essay in sociology, but it is of limited use in solving practical problems, and it gives rise to a 'fragmentary' way of thinking. Hundreds of contributions from workshop participants have been recorded,[17] but around two-thirds of

them are of only one or two lines, and would fit comfortably on a Post-It Note. No indication has been given of how these fragments will be put to use.

## Conclusion

The process of planning Urgent Treatment Centres in Cornwall reveals some confusion within NHS Kernow. The draft proposal from Cornwall GPs for GP-led Urgent Treatment Centres has much to commend it but is a one-size-fits-all model, and needs further work. The briefing paper for the latest 'co-production workshops' is deeply flawed, and the approach taken by the workshops amounts to 'Planning by Post-It Note'. Most worryingly, NHS Kernow is calling in consultants despite, it seems, not being clear how they could help.

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