Meeting: Strategic Commissioning Board			
Meeting Date	07 December 2020	**Action**	Approve
Item No	11	**Confidential / Freedom of Information Status**	No
Title	LCO Business Case for the Further Development of the Urgent Treatment Centre (UTC)		
Presented By	Will Blandamer, Joint Executive Director of Strategic Commissioning, Bury Council & NHS Bury CCG		
Author	Samantha Merridale, Interim Programme Lead – Bury Urgent Care Programme		
Clinical Lead	___		
Council Lead	____		

Executive Summary

The purpose of this paper is to present an outline business case describing the additional workforce and IM&T requirements to support the new Urgent Treatment Centre at Fairfield General Hospital, Bury. The business case also gives a summary position of the required capital development with respect to changes to the estates requirements to provide the capacity for increased patient demand and deliver safe waiting and clinical treatment areas with respect to infection prevention and control.

The Business Case has been discussed and supported via the LCO Governance structures which has included discussions at the Urgent Care Programme Board and LCO Board.

The CCG Finance, Contracting & Procurement Committee considered the Business Case at its meeting on the 19th November 2020 and the recommendations are included within the relevant section of this report.

Recommendations

The Strategic Commissioning Board are asked to: -

(i) Support the outline business case which describes the additional workforce and IM&T requirements to support the new Urgent Treatment Centre at Fairfield General Hospital, Bury in the context of the recommendations made by the CCG Finance, Contracting & Procurement Committee on the 19th November 2020 which: -

- Recognised the reprovision of current UTC and WIC contractual income into the new operational model and that moving to operational delivery is dependant on the development of the capital business case and estates model.
- Recognised that current funding requirements may change subject to longer term decisions regarding mental health and digital funding streams

• Recognised the delivery of the operational model will be phased in line with development of suitable estate. • Recognised that work will move to focus on developing a full business case for the UTC to appraise the capital options • Remained open-minded about option 4 as being the preferred option and it was a credible option however they said there were a number of next steps required before they could fully support this option at this stage which were detailed as above • Agreed with the recommendation that the green car service is commissioned recurrently to help deliver the new urgent care pathways at a cost of £219,700

Links to Strategic Objectives/Corporate Plan	Choose an item.
Does this report seek to address any of the risks included on the Governing Body / Council Assurance Framework? If yes, state which risk below:	Choose an item.
Add details here.	

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☐	N/A	☒
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☒
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☐	N/A	☒
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☒
Are there any financial implications?	Yes	☐	No	☐	N/A	☒
Are there any legal implications?	Yes	☐	No	☐	N/A	☒
Are there any health and safety issues?	Yes	☐	No	☐	N/A	☒
How do proposals align with Health & Wellbeing Strategy?	See attached report.					
How do proposals align with Locality Plan?	See attached report.					
How do proposals align with the Commissioning Strategy?	See attached report.					
Are there any Public, Patient and Service User Implications?	Yes	☐	No	☐	N/A	☒

Implications						
How do the proposals help to reduce health inequalities?						
Is there any scrutiny interest?	Yes	☐	No	☐	N/A	☒
What are the Information Governance/ Access to Information implications?						
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☒
Are the risks on the CCG /Council/ Strategic Commissioning Board's Risk Register?	Yes	☐	No	☐	N/A	☒
Additional details	*NB - Please use this space to provide any further information in relation to any of the above implications.*					

Governance and Reporting		
Meeting	**Date**	**Outcome**
Finance, Contracting and Procurement Committee		

Title: **FGH Urgent Treatment Centre – Business Case**

Report of: **Samantha Merridale**

Report to: **Bury LCO Board**

Date: **18 November 2020**

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1. Background and Purpose

The purpose of this paper is to present an outline business case describing the additional workforce and IM&T requirements to support the new Urgent Treatment Centre at Fairfield General Hospital, Bury. The business case also gives a summary position of the required capital development with respect to changes to the estates requirements to provide the capacity for increased patient demand and deliver safe waiting and clinical treatment areas with respect to infection prevention and control.

One of the key deliverables within the Bury Urgent Care strategy includes the redesign of urgent care at Fairfield General Hospital including building a brand-new purpose-built urgent care facility, and implementation of pre-ED triaging/streaming as part of the GMUEC by appointment model. The ability to be able to triage / stream patients away from the front door, by deflecting them into other more appropriate clinical pathways (e.g primary and community care) has been tested in a number of different localities, including Bury, using an experienced Band 7 ENP, and it is confidently assumed that the introduction of this, combined with the introduction of NHS 111 First to encourage patients to "call before you go" will deflect around 18,000 patients away from the front door. From a total figure of c.58,060 self-presenters to Bury ED each year, this leaves around c.40,060 patients to be managed onsite through a variety of different pathways, with an estimated 30,000 to be treated in the new Urgent Treatment Centre, which is an increase from the current patient throughput of around 17,000 annually.

This paper describes the potential options for the development of the existing staff model to deliver clinically safe treatment for the 30,000 patients described above. Option 4, which will deliver the increased level of demand within the proposed operating model, and which will achieve the standards described in both the national UTC specification and the requirements of Greater Manchester Urgent Care by Appointment, is our preferred option.

In order to deliver the increased patient demand through the proposed operating model, the existing estates infrastructure will require some redesign to expand the physical environment and reduce clinical risk associated with infection prevention and control, and the safe treatment of vulnerable patients. This paper gives a summary position in terms of those requirements with outline, estimated capital costs. This will be developed into a full business case.

2. Green car

The Green Car scheme was set up in 2016 to help address several well documented interrelated urgent care system pressures which impact on the system being able to provide people with the right care at

the right time and in the right place. Primarily the scheme was designed to help reduce failure demand and support more patients to remain at home by:

• Reducing unnecessary conveyance of people to A&E; and

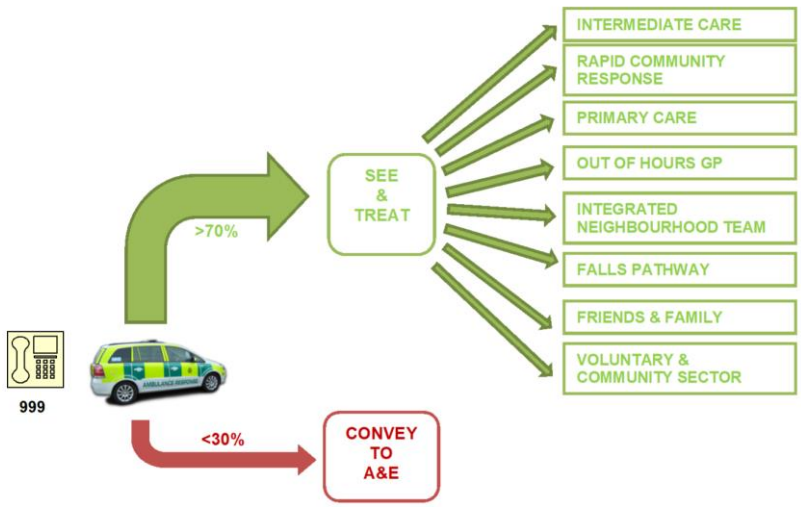
• Reducing unnecessary emergency admissions.

It has achieved this through the deployment of experienced community paramedics who respond to certain categories of 999 calls to provide a 'see and treat' response avoiding the need for transfer to A&E. Key to the success of the model is the high level of awareness and integration with the full range of primary and community health services in Bury with the ability of the paramedics to efficiently link the person they attend with appropriate services that can respond to their health, but also social care needs.

Key Outcomes

- A reduction in ambulance conveyance to A&E compared with a standard ambulance attendance.
- A reduction in non-elective admission compared with a similar cohort of patients receiving a standard ambulance response.
- More patients are supported to remain at home through referral and liaison with wider community-based health and social care services.
- A reduction in repeat 999 calls by identified frequent callers engaged with by the Green Car service.

NWAS monitoring and evaluation has demonstrated a see and treat response of around 70% for all patients attended by the Green Car paramedic. This compares with a see and treat rate of about 20% for a routine ambulance response. Evaluation suggests this is because of the Green Car paramedic's knowledge of local services and pathways enables a far higher proportion of patients to be supported at home through referral and linking in with other local services such as Rapid Response, local GPs, District Nursing etc. The majority of patients attended have been frail elderly patients and in a significant proportion of cases if these patients were conveyed to A&E there is a high likelihood of admission to ACU or on to the medical wards.



Activity Deflections

The table below shows the activity for the Green Care between April 2019 and December 2019. It shows that the see and treat response for the Green Car is 77%, which is higher than forecasted.

	Apr-19	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Number of incidents attended	159	202	194	212	200	191	218	194	204	1774
Total 18_19	66	78	88	70	165	157	171	176	173	
Number of incidents treated at home	118	165	155	162	158	150	172	141	148	1369
Number of 'other' incidents not conveyed to A+E			14	21	15	12	14	18	14	
% Non-Conveyance 19_20	74%	82%	87%	86%	87%	85%	85%	82%	79%	77%
% Non-Conveyance 18_19	71%	86%	70%	77%	79%	83%	77%	82%	83%	79%

It shows a total of 1,774 referrals, of which 1,369 were seen and treated at home. Pro Rata for 12 months this would be 1,825 patients. Assuming these patients would have been admitted after a A&E attendance would demonstrate a saving of £1.9m if this activity was costed at PbR with average cost of £1,052.

The current cost of the service is £219,700. During 2020, the service has been suspended at certain times due to NWAS current resourcing pressures particularly in relation to staff self-isolating. Therefore, the activity reviewed is for 2019.

3. Recommendations

The Board is asked to:

a) Support the recommendation of the Urgent Care Programme Board that Option 4 of the UTC staffing model is the preferred option as the re-defined operating model for the Bury UTC to deliver the increased patient demand.
b) Note the reprovision of current UTC and WIC contractual income into the new operational model and that moving to operational delivery is dependant on the development of the capital business case and estates model.
c) Recognise that current funding requirements may change subject to longer term decisions regarding mental health and digital funding streams.
d) Recognise that delivery of the operational model will be phased in line with development of suitable estate.
e) Recognise that work will now move to focus on developing a full business case for the UTC to appraise the capital options.

f) The **Green Car** has been funded non recurrently for the last 5 years. It has demonstrated the activity deflection from A&E and NEL admissions and established links with primary care, rapid response and other community health services. It is recommended the service is commissioned recurrently to help deliver the new urgent care pathways at a cost of £219,700.

Samantha Merridale

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Outline Business Case

Urgent Treatment Centre
Fairfield General Hospital

PART 1: Workforce/staffing and IM&T requirements
PART 2: Estates / capital requirements

FINAL

V2.2

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Version control:

Version	Author	Changes	Date
1.0	SM	Initial draft version produced	5th September 2020
1.1	SM	Options considered	23rd September 2020
1.2	SM	Further development of costs and options	30th September 2020
1.3	SM/MW	Finance breakdown	8th October 2020
1.4	SM/MW/CR	Staffing profiling	15TH October 2020
1.5	SM	Summary paper to LCO Board	15th October 2020
1.6	SM/MW/CR	Finance and capital options	23rd October 2020
1.7	SM	Final draft for initial circulation	2nd November 2020
1.8	SM / MDB	Revised costings IM&T	3rd November 2020
1.9	SM/MW	Capital costs added	11th November 2020
2.0	SM/MW	IM&T update – final circulation	11th November 2020
2.1	MW	Portering costs added and financial assumptions	12th November 2020
2.2	MDB/MW	IM&T revisions and finance update	13th November 2020

Table of contents:

1. Executive summary

1.1 Purpose

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1.2 Context

The NHS Long Term Plan published in 2019 outlined the NHS's ambitious commitment to continue the transformation of urgent and emergency care services. Over the next 10 years, NHS organisations will work together to ensure that patients get the right care, in the right place, at the time. One of the key objectives within the delivery of urgent and emergency care services was to confirm that by December 2019 each area should have an Urgent Treatment Centre, delivered to the standards set out in the national specification which had been published in 2017.

The Bury response to Urgent Treatment Centre review and implementation culminated in a system-wide review of urgent care provision in totality in Bury at the beginning of 2020, with a public consultation as to how this should be delivered locally, which included a review of the Walk in Centre provision. A local urgent care strategy was produced with the outputs of the review, along with a Programme Charter.

One of the key deliverables within the strategy includes the redesign of urgent care at Fairfield General Hospital including building a brand-new purpose-built urgent care facility, and implementation of pre-ED triaging/streaming as part of the GMUEC by appointment model. The ability to be able to triage / stream patients away from the front door, by deflecting them into other more appropriate clinical pathways (e.g primary and community care) has been tested in a number of different localities, including Bury, using an experienced Band 7 ENP, and it is confidently assumed that the introduction of this, combined with the introduction of NHS 111 First to encourage patients to "call before you go" will deflect around 18,000 patients away from the front door. From a total figure of c.58,060 self presenters to Bury ED each year, this leaves around c.40,060 patients to be managed onsite through a variety of different pathways, with an estimated 30,000 to be treated in the new Urgent Treatment Centre, which is an increase from the current patient throughput of around 17,000 annually.

1.3 IM&T Requirements

In order to achieve the national standards around UTC implementation and also facilitate the introduction of the NHS 111 First and pre-ED Streaming models, we will need to upgrade the IM&T infrastructure in the UTC. This is part of the NCA wider strategy and will mirror what has been agreed for the Rochdale Infirmary UTC. Using the same blueprint for the redesign as Rochdale will enable us to save costs as project management time does not need to be replicated.

1.4 Financial context

The operational planning process for 2020-21 was suspended in March 2020 to allow the system to prepare for the COVID pandemic. Temporary financial arrangements were put into place. These gave NHS providers a guaranteed a fixed minimum level of income.

As such the business case sets out the financial envelope for the Urgent Care Review based on the current contractual income for Moorgate Walk in Centre and The Urgent Treatment Centre as opposed to income from a tariff based system for A&E attendances and NEL admissions.

The contractual income for Moorgate WIC and UTC is £469k and £1,322k respectively. It is anticipated there will be further funding for additional Mental Health resource of £261k and Recurrent funding for Pre Ed Triage of £225k. This gives a total financial envelope of £2,277k.

This paper sets out options for reinvestment of this funding to support the GM Urgent Care pathways and commission a Pre Ed Triage and new model for UTC with additional MH capacity.

1.5 Options appraisal – workforce requirements

This paper describes the potential options for the development of the existing staff model to deliver clinically safe treatment for the 30,000 patients described above. Option 4, which will deliver the increased level of demand within the proposed operating model, and which will achieve the standards described in both the national UTC specification and the requirements of Greater Manchester Urgent Care by Appointment, is our preferred option.

1.6 Estates / capital requirements

In order to deliver the increased patient demand through the proposed operating model, the existing estates infrastructure will require some redesign to expand the physical environment and reduce clinical risk associated with infection prevention and control, and the safe treatment of vulnerable patients. This paper gives a summary position in terms of those requirements with outline capital costs. This will be developed into a full business case.

1.7 Summary of capital cost implications

A forecast cost of the capital works have been provided by NCA at £5,384 per m2. The capital build required has estimated Gross Internal Floor Area (GIFA) of approx. **700m2** – subject to space planning /schedule of accommodation checks.

Based on the above an estimated cost applying the 700m2 GIFA x £5,384/m2 = **£3,768,800**

This is based current information available reflects an **estimated cost** at this stage.

2. National context

The NHS Long Term Plan published in January 2019 outlined the NHS's ambitious commitment to continue the transformation of urgent and emergency care services. Over the next 10 years, NHS organisations will work together to ensure that patients get the right care, in the right place, at the time. In the short term, translating this vision into reality means:

- Promoting a 24/7 urgent care service, accessible via NHS 111, which can refer directly to more appointments in Urgent Treatment Centres (UTCs), general practice (in and out of core hours), and other community services (pharmacy etc.);
- Continuing to stream patients to the most appropriate service at the front door of emergency departments to ensure patients are managed by the correct service;
- Working with ambulance and out-of-hospital services to safely reduce the number of patients who call 999 and don't need to be taken to A&E;
- Maximising the number of patients who can be treated without being admitted to hospital overnight via same day emergency care, resulting in a better experience for patients and reducing pressure on inpatient beds;
- Working closely with primary and community care services to ensure an integrated, responsive healthcare service helping people stay well longer and receive preventative or primary treatment before it becomes an emergency;
- Focusing efforts to reduce length of stay for all patients and paying particular attention to why patients are remaining in hospital for longer than 21 days, improving patient flow and reducing the risk of harm by providing care in the most clinically appropriate setting.

Moving into the medium term the NHS vision for transforming care asks that local urgent and emergency care services increasingly operate as an integrated network of community and hospital-based care, hand in hand with primary care services. By working as part of this extended network, services can collectively reduce pressure on emergency departments, ambulance services, and general practice. To do this the NHS nationally and locally will keep working with systems across the country to enhance the Clinical Assessment Service so that it is a central element of the out of hospital approach.

2.1 Urgent Treatment Centres

In July 2017, NHS England published the National Service Specification for the implementation of Urgent Treatment Centres. From the outset of the review of urgent treatment services in the NHS, patients and the public reported a 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. Within and between these services, there is a confusing variation in opening times, in the types of staff present and what diagnostics may be available.

The core standards for Urgent Treatment Centres therefore aimed to establish as much commonality as possible, and the original aim was to have UTCs fully operational by December 2019.

Reduced attendance at, and conveyance to, A&E are expected as a result of this standardisation and simplified access, as well as improved patient convenience as patients will no longer feel the need to travel and queue at A&E. Attendances at urgent treatment centres will count towards the four hour access and waiting times standard.

2.2 Alignment with primary care and other urgent care services

The guidance set out the key functions of the urgent care system:

- guide the patient to the correct level of care and treatment.
- provide clarity as to which services are provided where, along with providing pathways to access these services reliably 24/7.

NHS 111 should be that guiding service for most urgent care needs, in addition to provision of treatment through the clinical assessment service.

Wherever a patient contacts the health care system they will have consistent access to all services and will, if necessary, be referred on to necessary services through a process of direct booking whenever possible. Urgent treatment centres will operate as part of a networked model of urgent care, with referral pathways into emergency departments and specialist services as required. Commissioners should make sure that all services form part of ambulance services referral pathways as an alternative to conveyance to A&E where appropriate.

2.3 Principles and standards for Urgent Treatment Centres

Urgent treatment centres (UTCs) are described as being community and primary care facilities providing access to urgent care for a local population. They encompass current Walk-in Centres, Minor Injuries Units, GP-led Health Centres and all other similar facilities, including the majority of those currently designated as "Type 3 and Type 4 A&E Departments".

Co-location with, and strong links to, other community urgent care services, such as mental health crisis support, community pharmacy, dental, social care and the voluntary sector will be beneficial in providing an effective and integrated service. There are advantages if they can be co-located alongside hospital A&E departments to allow the most efficient flow of patients to the service that best serves their need but this will be determined by geographic distribution of urgent care sites and patient flows.

The full set of standards from the 2017 national specification are detailed in Appendix 1, however it is recognised that the national context has changed significantly since this was published, (particularly due to the COVID-19 pandemic) and thus certain elements have been considered locally and interpreted for a more appropriate level of provision, particularly around meeting infection prevention and control standards.

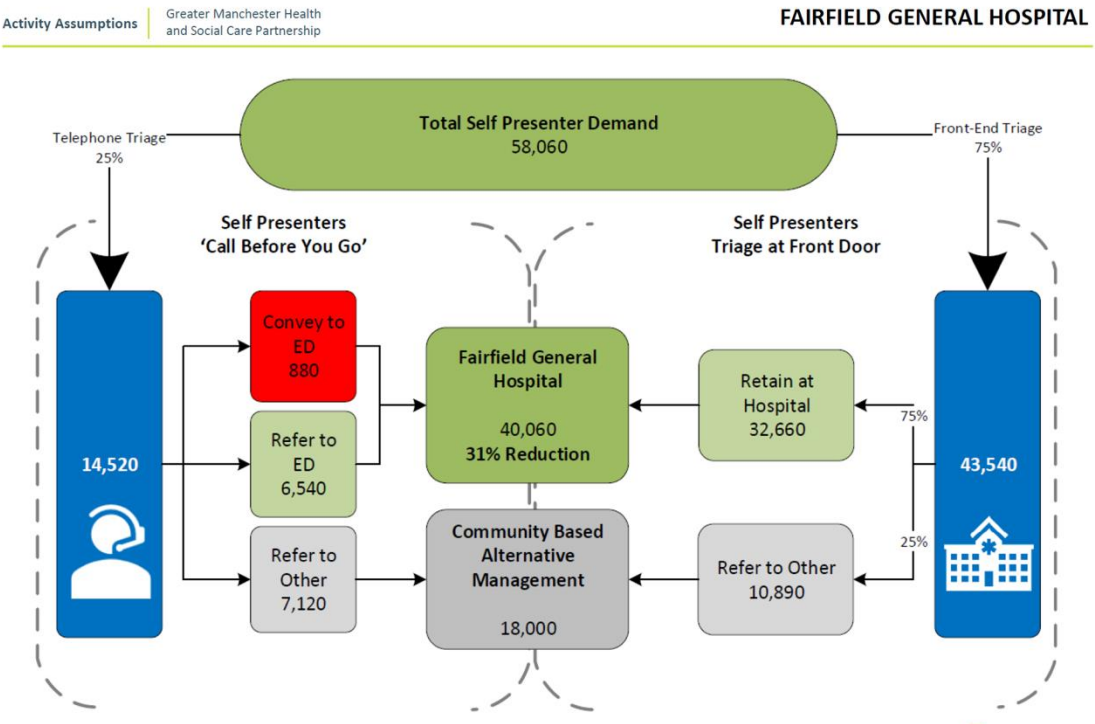
3. Regional Context – Greater Manchester Urgent Care by Appointment

Within the Greater Manchester Urgent Care Strategy there are 5 workstreams to support urgent care as a system. While the proposal is to develop a GM-level model, the emphasis is on locality-developed service models based on the needs of patients, supported and connected by digital solutions where possible. UEC by appointment was further developed in the Spring of 2020, following the COVID-19 escalation, to actively support deflection of patients, where clinically appropriate, away from front door ED/acute sites, to maintain safe social distancing and infection prevention / control.

UEC by appointment assumes a minimum of 25% of self-presenting patients to be deflected to other community based alternative service such as specific specialities, primary care or community services, to be achieved either through "Call before you Go" (NHS 111 First) or pre-ED triage and streaming. This pre-ED based CAS will ensure patients are diverted to the most clinically appropriate setting, connecting patients with local clinicians or services quickly by eliminating non-value adding steps or delays.

The local Bury implementation model for GM UEC by appointment, with anticipated patient volumes, is pictured below:

Figure 1: GM UEC by appointment demand and deflection – Fairfield General Hospital



GM will work with localities to measure and evaluate work programmes to ensure pathways deliver the intended outcomes.

The workstreams will be monitored and evaluated to support commissioning decisions.

4. Local Context – Bury Urgent Care

4.1 The case for change

The local response to Urgent Treatment Centre review and implementation culminated in a system-wide review of urgent care provision in totality in Bury at the beginning of 2020, with a public consultation as to how this should be delivered locally, which included a review of the Walk in Centre provision. A local urgent care strategy was produced with the outputs of the review, along with a Programme Charter (Appendix 2).

There are multiple factors influencing the development of an urgent care system. As a result, the urgent care system in Bury represents a model that has evolved over time rather than one which has been bespoke planned for the locality. Over time services may evolved this way for many reasons including:

- Locally identified need
- Nationally mandated developments
- Ad hoc services rolled over pending wider system change
- System pressures
- National and local drive to integrate services
- Political influences both at a local and national level
- National incidents (i.e. Pandemic)
- Technological advancements
- Finance available
- Changing societal expectations.

Over recent years Bury CCG, with system partners, has been reforming the way urgent care services are delivered across Bury. Many of the changes have been triggered for reasons listed above and include:

- Redesign of Extended Working Hours
- Development of GP Quality Scheme which has increased GP access
- Development of Community Wound Care Services
- Commissioning of NHS111
- Enhancement of Ambulatory Care on acute sites
- Establishment of a Local Care Alliance (LCA) bringing local providers together
- Scaling down of Walk-In Centre Service due to reducing attendances levels
- Expansion of the NWAS Green Car Scheme
- Establishment of NHS Digital
- Increasing use of Pharmacists locally and nationally
- Development of Local Integrated Clinical Hub and GM CAS
- Development of Integrated Neighbourhood Teams
- Emerging Development of Primary Care Networks
- Development of Urgent Treatment Centre at FGH.

This evolutionary approach has left Bury with a range of first-class services however too many of them operate in isolation and do not seamlessly interlink with each other to create a single approach. As a result, the Bury urgent care system could be described as:

- Complicated for patients to navigate
- Complicated for professionals to understand
- Generates high levels of duplication across the system
- Provides too many access points
- Delivers differing responses in differing settings
- Does not recognise the ability of Primary Care influence behaviours
- Does not always ensure patients see the right person, in the right place at the right time
- Does not maximize the potential efficiencies in the system
- Does not lend itself towards an integrated approach
- Does not maximise the opportunities for cross referrals and electronic booking
- Operates using differing IT platforms which do not always talk to each other.

The current urgent treatment centre, based within the ED at Fairfield General Hospital, is small and currently delivers around 17,000 patient episodes / year. The department is often overcrowded. The current issues around infection prevention and control due to the COVID-19 pandemic means that if there are any more than 8 patients awaiting treatment, the waiting area is dangerously overcrowded and unsafe. The children's waiting and treatment area has had to be given over to a 'hot area' to treat COVID-19 positive patients, which means that children have to wait and be treated in the same clinical area as adults. The front door itself consists of a very small foyer which is not fit for purpose.

Additionally, there is limited capacity for assessment and treatment of patients who attend with mental health conditions, and the reduction in community-based capacity in both Bury and Rochdale means that there is now a serious gap in provision for patients with mental health. This is being addressed by means of a separate business case, however assumptions on capacity and demand are being included as part of the overall UTC business case as the staff mix will need to include on site mental health practitioners.

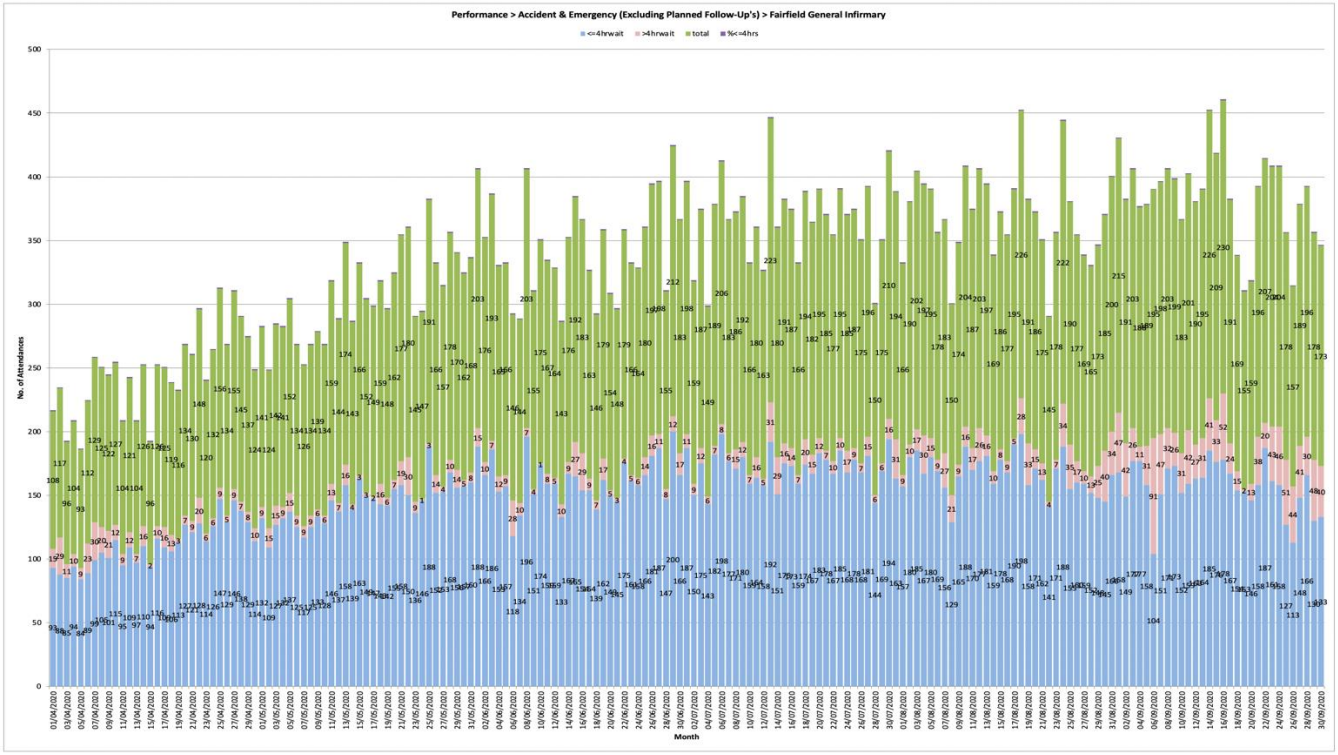
Up until the onset of the COVID-19 pandemic in March this year a Walk in Centre facility had also operated out of the Moorgate site in Bury. To maintain safe social distancing and IPC measures this was closed and the staffing transferred to the UTC. In addition, the provision of a GP within the UTC was also reviewed and ceased.

The IM&T system, Symphony, currently does not allow for direct booking, which means that one of the standards within the national service specification, i.e. the ability to offer patients a booked appointment within a UTC, cannot currently be delivered. IM&T requirements therefore also form part of the business case, and this is part of the wider IM&T strategy for the NCA.

4.2 Activity and demand analysis

Following an initial fall in self presenting activity to ED caused by the COVID-19 pandemic (which was mirrored in all EDs nationally) we have seen a steep rise in attendances throughout Q2, and this has directly impacted on our ability to achieve our 95% 4-hour target. The following chart (Figure 3) shows activity from 1st April 2020 to mid September 2020 clearly shows this, and the worsening position around the 4 hour waits:

Figure 2: Total ED activity and 4 hour performance – 1/4/20 – 30/9/20



5.0 Proposed Operating Model

Transforming hospital urgent care represents one of the critical elements of the new IUCS for Bury.

Workstream 1 describes the redesign and blend of several services into a single Urgent Treatment Centre service offer, based at the Fairfield General Hospital site. This does not mean simply making all current services available 24/7. Within the UTC, we will blend and redesign:

- Moorgate WIC (NCA)
- Bury Out of Hours (BARDOC)
- Bury UTC, currently in the main body of the hospital (NCA and partners)
- ED Minors Service (NCA)
- ED Mental Health Services (PCNHSFT)

A working group consisting of stakeholders from Fairfield Hospital, Bury LCO, Bury OCO, BARDOC, primary care, Pennine Care and community teams have met weekly since late July to fully evaluate the current activity and demand and determine what the future operating model of the new Bury UTC needs to be. This was within the context of delivering the GM UEC by appointment model and having sufficient space to be able to deliver pre-ED triaging/streaming. In addition, we have also considered the requirements of additional capacity to assess and treat patients presenting with mental health conditions.

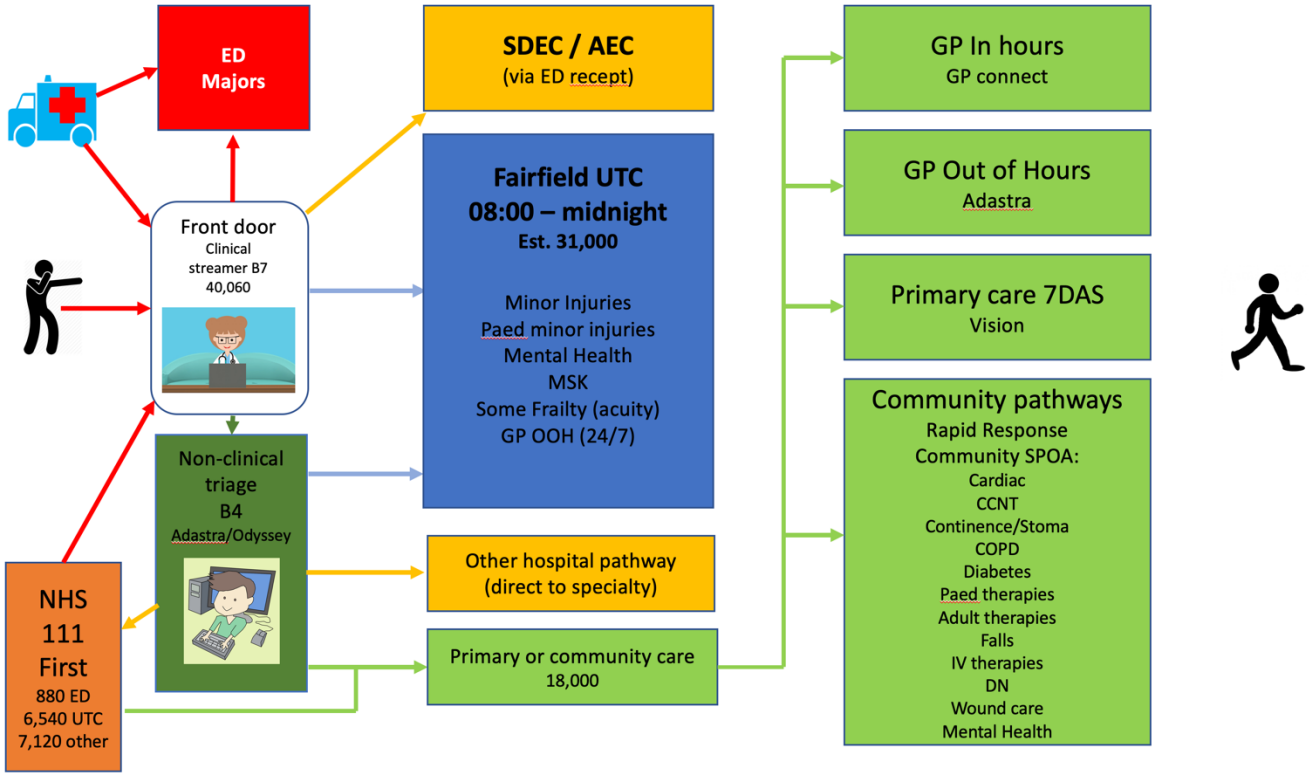
We have had full support from a comms and engagement subgroup which is supporting this workstream, and also from the Bury Urgent Care Clinical Reference Group which is overseeing the clinical governance of this work.

The Bury Urgent Treatment Centre will:

- Operate under a single operational leadership
- Provide a blended staff model across a 24/7 period and will redesign how services are delivered into one place.
- Encompass the services currently delivered by Bury WIC with an assumed reduction in wound care provision as a result of further LCO led work on the wound care service pathway, and the ability to deflect patients back into community-based pathways.
- Deliver GP out of hours service to national required standards. Face to face consultations will be moved from the Folds Suit at FGH to the new build and will be delivered using a blended staffing model as appropriate.
- BARDOC's wider out of hours service offering telephone advice, GM CAS and other support services will be redesigned.
- The current ED minors service will be moved from the main building into the new build and will be delivered using a blended staffing model as appropriate.
- The current Mental Health Service delivered in ED will be further reviewed and redesigned to fit into the new UTC model.
- The new UTC will help to reduce flow into the ED department allowing for it to be redesigned. The ED department and the UTC will be separately staffed and thus operate as two individual units; however we will have the ability to flex staffing arrangements during times of surge;
- The new service will receive electronic appointments from local and national stakeholders as per the current UTC guidance.

The following model (Figure 3) represents the combined operating process of NHS111 First – which will have the ability to offer booked appointments into the UTC – and a pre-ED triaging / streaming function, which will be a combination of both FTF clinical streaming, using a B7 Extended Nurse Practitioner, and the Adastra / Odyssey algorithm, using a Band 4 non-clinical triager. An assumed activity level of 31,000 patients per year has been derived following a 25% reduction in activity away from front door through the pre-ED triaging function, and the ability to transfer patients into alternative pathways such as SDEC/AEC, mental health, or ED majors should this be required.

Figure 3: Proposed operating model – Fairfield Urgent Treatment Centre



5.1 Hours of operation

The UTC will be operational 08:00 – 12 midnight, 7 days / week. In addition, GP OOH will also be present on site, accessible through a booking process, making a 24/7 service offer.

5.2 Pathways to be offered

- Minor injuries (adults and children)
- Mental health
- Musculoskeletal presentations
- Some frailty dependent on acuity
- GP out of hours services

5.3 Demand and case mix

Detailed evaluation of the case-mix of self-presenting patients arriving between 08:00 and 0:00 has shown that around 42% (23,000) of cases are minor injuries (including children) and are thus very suitable for a UTC pathway.

We have also seen a sharp rise (30%) in the number of mental health conditions (3,500) presenting at ED, and thus the operating model for the UTC proposes mental health practitioners being part of that team, with the ability to receive patients who have arrived at the front door with mental health conditions.

We have allowed for a small volume of other presentations (3,000) (e.g. frailty, MSK etc) and thus are estimating therefore we will treat around 29,500 patients / year in the UTC between the hours of 08:00 and 0:00.

Of the remaining 9,000 self presenting patients who are not suitable for UTC, these will be sent directly to same day emergency care (SDEC) / ambulatory care, or diverted into ED majors as appropriate, and as demonstrated in Figure 2 above.

5.4 Deflections from pre-ED triaging and NHS 111 Call Before You Go

We have made an initial assumption, based on work done by GM, that we would be able to deflect around 25% (10,800) of self presenting patients back out into primary or community care. The outputs of the two tests of change held in early October 2020 (see below) have confirmed that this is accurate, however the majority of the deflections were back into primary care, with little community based activity deemed to be appropriate. The average deflection rate across the two days was 26%. Combined with the activity deflected via the NHS 111 "Call before you go" this equates to a total of 18,000 patients who can be seen in an alternative to an acute setting.

We are considering the options for provision of additional capacity in a primary care setting to take the deflected activity, and this will be part of the options appraisal in this business case.

5.5 Tests of change

We have so far held a number of "tests of change" to test our proposals specifically around deflections away from the front door. These have consisted of evaluating the presenting complaint of all self-presenting patients and assessing whether they could have been deflected into community-based pathways, mental health or MSK. We have also tested the concept of "Go Home, we Will See you Later" whereby the patient was offered a booked appointment to return to UTC when it was less pressured.

The outputs of these tests were variable; and demonstrated that it was in a large part due to the skill of the person doing the evaluation as to whether the patient was deemed suitable.

Additionally, we have done two tests of change using an experienced ENP doing face-to-face streaming to actively deflect patients away from the front door. The results of these are as follows:

5.5.5 Outputs of the FTF tests of change held in October:

1st Test of Change – Tuesday 6th October 2020 (face to face clinical streaming)

- 92 self presenting patients assessed
- Total deflections (actual and potential) – 25 (27%)

Actual:

- 14 deflected to Bury primary care (11 in hours to 'duty doctor' and 5 OOH
- 1 patient sent home with advice
- 1 to HMR CMS

Potential:

- 5 would have been suitable for HMR primary care if available
- 2 suitable for MH (no capacity to refer)
- 2 dental patients
- Ambulance arrivals also assessed by the clinical streamer – none suitable for deflection
- Rapid Response took a further two patients from majors.

2nd Test of Change – Monday 12th October (face to face clinical streaming)

- 84 self presenting patients assessed
- Total deflections possible (actual and potential) – 20 (24%).

Actual:

- 1 to Bury primary care duty doctor
- 1 to BARDOC OOH
- 1 to HMR CMS

Potential:

- 7 HMR GP
- 2 Bury MSK
- 1 Bury Wound care
- 1 Bury Mental Health
- 2 Bolton GP
- 1 Middlesborough GP
- 1 Oldham GP
- 1 Bury GP referred to ED without Face to Face appointment from care home, painful hip (could have been referred straight to x-ray or had a FTF assessment as patient was weightbearing).

3rd Test of Change – Saturday 24th October (face to face clinical streaming)

- XX self presenting patients assessed (awaiting figure from FGH)
- Total deflections possible (actual and potential) – 17

Actual:

- 12 in total redirected, including 3 to CMS

Potential:

- 3 requiring wound care had to be seen by ED as no suitable alternative
- 1 x patient rejected due to apparently lack of equipment (speculum) at Rochdale HMR
- 1 x dental pain no access to dentist (booked up)

The outputs of these front door tests of change have confirmed our assumptions around the number of patients who can be deflected safely away into more appropriate pathways, and we are currently in the process of commissioning additional primary care based capacity to be able to accept these patients in both Bury and Rochdale. A total of 30/ day (F-F) additional primary care slots will be available in Rochdale (20 minor illness at Whitehall Street and 10 minor injury at the Rochdale Infirmary UTC) and up to 40 / day (M-F) in Bury in the Moorgate Centre (minor illness). Patients deflected out of core hours or at the weekend will be seen in Extended Working Hours or Out of Hours services.

5.6 Implementation of Pre-ED Streaming / non-clinical triaging

We will be implementing pre-ED streaming, using a clinical nurse streamer, from Friday 6th November 2020. Additional in-hours primary care / GP cover will be provided in Bury on a temporary basis to allow us to further evaluate the potential deflections and also to complete necessary upgrades to the Vision software in General Practice to allow for direct booking. GPs have now agreed to accept 1 patient per site per day from deflections from the front door; and this is in addition to the 1:500 slots ring fenced for referrals from NHS 111/ GM CAS.

Additional primary care cover has also been provided in HMR.

Following the implementation of the Adastra software into the front door, to allow direct booking into ED/UTC and also giving access to the Odyssey clinical triaging system, we will be able to also commence non-clinical triaging. It is envisaged that we will run a hybrid model of non-clinical triaging in less busy times, and clinical streaming at peak times to maximise efficiency and prevent a backlog of patients at the front door.

5.7 Implementation of NHS 111 First "Call before you Go".

This is a nationally mandated initiative and will be rolled out across Greater Manchester localities during November 2020. Following installation of Adastra licences into our ED we will be able to accept patients from the GMCAS, who have called NHS 111 prior to attending ED, and who can be directly booked into slots to manage flow. Having the ability to provide bookable slots into the UTC is one of the requirements of the National UTC Specification, and this will be implemented in Bury no later than 1st December 2020.

6.0 IM&T Requirements

The following paper is an extract from a paper which was written to support the upgrade to IM&T for the Rochdale UTC. It is expected that the IM&T upgrades to Fairfield UTC will mirror that of Rochdale; thus this is presented as an illustration of the likely order of costs and the technical requirements. This has yet to be ratified by the Bury Digital Board and we need to further clarify any additional costs with respect to project management. The annual hosting, licensing and support costs can be shared with HMR @ 50% and this is detailed below.

6.1 Summary

The purpose of the document is to highlight the options and recommendation for a clinical system to be procured and implemented at Rochdale UTC and Fairfield General Hospital UTC to meet NHSE UTC mandated standards (See Appendix 1).

The two systems that have been appraised (via both vendor demo and demo in use clinically) are EMIS and Adastra, these are the only systems that meet the 10 Must have/Critical requirements. However, further evaluation shows that EMIS is the only possible solution, and this is therefore costed in section 6.2 below.

UTC Requirements v1.0.docx

6.2 IM&T Costs

6.2.1 Software, set up and licensing

Year	Item (Excl VAT)	£
1	Database, set up on own instance, deployment, training (one off cost) Annual hosting, licensing and support (no of licences) @ 50% of total **TOTAL**	16,395 36,900 **53,295**
2	Annual hosting, licensing , links to SPINE, Pathology, Manchester triage, ECDS and support for 20 Licences	36,088
3	Annual hosting, licensing , links to SPINE, Pathology, Manchester triage, ECDS and support for 20 Licences	36,088
	Total (3 year cost)	**125,470**

6.2.2 Internal Costs

Project resource (Excl VAT)	Duration	£
Project Manager/ Specialist/Tech Support/ Information	<3 months	36,000
Total		**36,000**
BAU resource		
System Specialist Band 5 PAT	Part Time	20,000

Service desk 1st Line Support PAT	Part Time	10,000
Total		**30,000**

6.2.3 IM&T summary costs:

	Year 1	Year 2	Year 3
Software, setup and licensing/hosting	**53,295**	36,088	36,088
Project management	36,000	-	-
BAU resource (Part time)	30,000	30,000	30,000
TOTAL	**119,295**	**60,088**	**60,088**

6.3 Recommendation

Although both vendors meet the Must have/Critical requirements, reflecting on the cost and additional benefits of the EMIS system the recommendation is EMIS. This has been agreed by the contributors to this document.

6.4 Timescales

The NCA are currently deploying the EMIS tracker in HMR and hence have a PM ready to extend deployment to the Bury site, thus reducing normal time to deploy to circa 3 months, as long as the projects dovetail into each other.

6.5 Site issues

There may be additional networking costs associated with the UTC being situated on a new site; although at this stage until the capital / estates case is made in more detail, this is not quantified – however it needs highlighting as a potential risk to delivery.

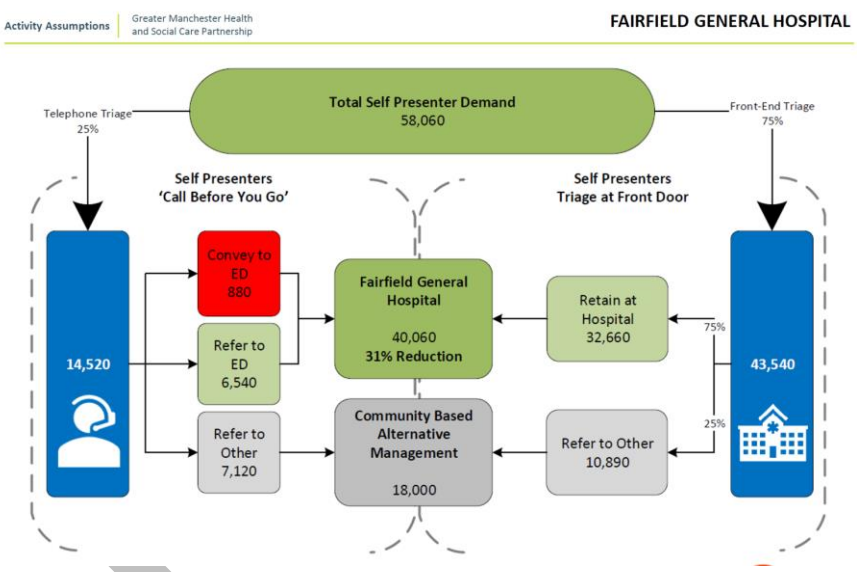
7. Financial context – staffing requirements

7.1 2020-21 Financial Framework

The operational planning process for 2020-21 was suspended in March 2020 to allow the system to prepare for the COVID pandemic. Temporary financial arrangements were put into place. These gave NHS providers a guaranteed a minimum level of income in a block amount. The national block contracts have been in place since 1st April to 30th September. From 1st October budget allocations were awarded to Integrated Care Partnerships (ICPs) and for Greater Manchester ICP there is a reported £120m gap in CCG and providers plans and the current budget available.

7.2 Activity deflections

As provider contracts are fixed, there is no cashable savings in the short term. The focus of this review therefore has been on A&E activity and how this is deflected away from the front door of FGH by using Moorgate and UTC contracted income differently. It is a site based review focusing on activity at FGH rather than activity by CCG. The diagram below shows the activity assumptions for the review.



Within this business case, there are planned forecasted A&E deflections from three sources:

1. Call before you go model
2. Pre Ed Triage
3. Increase activity through UTC

7.3 Current Contracted Activity

The current contracted activity for Moorgate Walk in Centre and Urgent Treatments Centre is as follows:

Service	Provider	Contracted Amount
Moorgate WIC	NCA	£469,190
Urgent Treatment Centre	NCA, BARDOC, GP Fed	£1,322,103
Total		**£1,791,293**

7.4 Current Operating Model

Bury Walk in Centres were stood down at the start of the pandemic. Staff at Moorgate WIC were redeployed to work in A&E and UTC. One Band 7 was redeployed to work as a clinical streamer at the A&E front door at FGH.

The GP element of the UTC was also stood down in April 2020 during the height of the pandemic and resources was prioritised elsewhere in the system. The current operating model is summarised below:

2020-21	RATE	WTE	TOTAL
PRE ED TRIAGE			
Band 7 Clinial Streamer	Redeployed WIC	1	£ 54,230
TOTAL PRE ED TRIAGE		**1**	**£ 54,230**
PAHT			
ANP	B8a	2.64	£ 188,729
ENP	B7	2.64	£ 161,092
Reception	B2	2.76	£ 78,624
Porter	B2	1	£ 26,520
Additional			
ANP/Mid Doctor	B8a	1.63	311,042
HCA	B3	2.13	72,111
Diagnostics			£ 318,240
Consumables [2]			£ 48,000
Drug costs [3]			£ 16,000
Estates			£ 125,623
TOTAL URGENT CARE CENTRE			**£ 1,345,982**
Total			**£ 1,400,212**

Additional costs were incurred by NCA to staff UTC during the pandemic. As the future model and commissioning arrangements of the UTC, staff were employed at agency rates.

7.5 Stranded Costs

Stranded costs are incurred when expenditure cannot be avoided after termination of service contract. In this scenario, all costs have been redeployed to other services areas or reused in the new service model. Therefore, no stranded costs have been included in the future model.

7.6 Financial Options

The summary below shows 4 options for the urgent care pathways with associated deflected activity and costs.

	Option 1 - Current Operating Model		Option 2 - Streaming with no Primary Care & Mental Health		Option 3 - Streaming with Primary Care & Mental Health		Option 4 - Revised UTC Offer Streaming with Primary Care & Mental Health	
	Activity deflected to community	Cost	Activity deflected to community	Cost	Activity deflected to community	Cost	Activity deflected to community	Cost
Pre Ed Triage		£ 54,230		£ 311,298		£ 311,298		£ 311,298
Additional out of hospital capacity		£ -	6,024	£ 75,000	6,024	£ 75,000	6,024	£ 75,000
Additional Primary Care capacity					3,893	£ -	3,893	£ -
Additional Mental Health capacity					973	£ 260,715	973	£ 260,715
UTC Offer	17,000	£ 1,345,982	17,000	£ 1,345,982	17,000	£ 1,345,982	26,000	£ 1,539,281
Total Costs	**17,000**	**£ 1,400,212**	**23,024**	**£ 1,732,279**	**27,890**	**£ 1,992,994**	**36,890**	**£ 2,186,294**

7.6.1 Option 1 – Do Nothing as per Current Operating Model

This assumes no changes to the current operating model and no additional deflections.

7.6.2 Option 2 – Pre Ed streaming with no Primary Care & MH deflections

This model assumes the following staffing mix for the Pre Ed Triage

Hours	B7 Clinical Streamer	B4 Non Clinical streamer
8am-10am	1.00wte	1.00wte
10am – 4pm	2.00wte	
4pm-10pm	1.00wte	1.00wte

The forecasted activity deflected is 6,024 based on the average test of change at FGH. The forecasted split by CCG is:

Bury CCG	4217
HMR CCG	1807

7.6.3 Option 3 – Pre Ed Streaming with Primary Care and MH deflections

Primary care referrals will be deflected to a duty doctor model in the short term until contractual changes can be made to accept deflections from A&E into the Quality in Primary Care contract. The Duty doctor model will run 12-4pm Monday –Friday from Moorgate. The cost of this model is £112,320.

The proposed model for mental health is as follows and is to be considered at SCB on the 6th November:

Urgent and emergency care by appointment (per locality)	WTE	12 months
Team Manager	0.40	20,703
MH Practitioner	4.00	166,878
Admin	1.00	25,007
Non Pay		15,629
Estate Contribution		nil
Corporate clinical delivery support costs and Surplus		32,498
CQUIN		
Total		**260,717**

IT setup costs (Non recurrent)	12,958

The forecasted MH activity from A&E is 3,500 per annum. This includes 973 deferred from Pre Ed Triage. The options on how the delivery of MH activity is to be considered at SCB on 6th November.

7.6.4 Option 4 – Increased UTC offer

The revised UTC model is open from 8am to midnight. There were 3,000 attendances per annum outside of these hours. These attendances will be offered an appointment the following day. Assume 50% will take up these appointments.
The revised forecast UTC activity is as follows

42% minor injury/MSK	23,000	(63 per day)
Mental Health	3500	(9 per day)
Other	3000	(8 per day)
Total	**29,500**	**81 per day**

Current UTC activity is recorded in Symphony as Type 1 activity. By definition UTC activity is recorded as Type 3. Other A&E minor injury activity and it is the intention that all activity in the new model will be recorded as type 3. Therefore, the increased UTC activity has been included in the scope of this business case as it is an increase deflection from Type 1 A&E activity.

UTC activity in 2019-20 was 17,000. The new model forecasts an increase of 9,000 attendances deflected from Type 1 A&E activity per annum with a revised staffing model.

As posts will be permanently recruited to and no agency costs will be incurred, the additional cost of the new model is £133k more than the current operating model.

A further £60k is included recurrently for IM&T costs with the set costs of EMIS included non recurrently.

7.6.5 Preferred Option

The preferred option is option 4. This has a total deflection of 36,890 from Type 1 A&E activity of which 19,890 is new deflections over and above the 17,000 current UTC activity.

The 19,890 additional activity has come from Pre ED Triage 10,890 and 9,000 additional activity flowing through UTC.

The total cost of this option is £2,186,294 with additional contingency of £90,714.
The costs to run this service from November 2020 to March 2021 5 months is £1,060,009 which includes non recurrent expenditure for IT and recruitment and a contingency of £32,953.

Option 4	£	1,060,009	£	2,186,294
Contingency	£	32,953	£	90,714
Total	**£**	**1,092,961**	**£**	**2,277,008**

The preferred option will be funded as follows:

Funding Source	**2020-21 5 months**	**2021-22**
Moorgate WIC	£195,496	£469,190
UTC	£550,876	£1,322,103
GM – CCGs	£225,000	£225,000
GM – Providers	£0	
MH CQUIN/MHIS	£121,589	£260,715
Total	**£1,092,961**	**£2,277,008**

7.7 Assumptions

The following assumptions have been taken into consideration when calculating the funding available:

- £225k made available for Pre ED triage for 6 months in 2020-21 will be made available recurrently.
- Estates charges for Moorgate WIC have been consumed by other services and therefore no VOID costs will be incurred.
- Community capacity made available is sufficient to absorb deflected activity
- Duty Doctor arrangement will not be needed in 2021-22
- Digital costs for Pre Ed streaming has been funded outside the scope of this business case.

8.0 PART TWO: Capital and Estates requirements

This section will be further developed as the case for the capital and estates development is progressed within NCA with detailed costings and an options appraisal, however the purpose of this brief summary is to outline the physical requirements for delivering the enhanced UTC model as described in Part 1 of this paper.

8.1 Current position

The current UTC is delivered from within a shared space with the ED and outpatients department. The waiting area is small, and in line with IPC policies, can seat no more than 8 patients. There is only 1 small area suitable for streaming (either non-clinical or clinical) and, given the need to create a separate area for COVID-positive patients, there is no dedicated area for either paediatric patients, or those presenting with mental health conditions. This creates an element of risk, both from an IPC perspective, and also with respect to vulnerable patients.

8.2 Anticipated requirements

The following table represents the estate requirements for the new UTC, should capital monies be available to develop the estate:

UTC Building

Area	In use	Room Size	No of Rooms
Clinical Streaming Area	08:00 to 22:00	Large sized triage/clinic room	1
Pre ED Triage Non Clinical Area	08:00 to 22:00	Large enough for 4 people	2
Reception	08:00 to 08:00	Room for 3 staff members	1
Waiting Room	08:00 to 08:00	20 people socially distanced	1
Treatment rooms	08:00 to 00:00	Standard size	2
Plaster room	08:00 to 00:00	Standard sized clinic room	1
Clinical Rooms	08:00 to 00:00	Standard sized clinic room	4
Office space	08:00 to 00:00	2 people each office	2
Mental Health	08:00 to 00:00	Rooms need to meet Mental Health Guidelines	2
GP OOH Rooms	18:30 to 08:00 08:00 to 08:00 w/e	Standard sized clinic/GP room	2
Staff Room	08:00 to 08:00	To fit 4 to 5 people socially distanced	1
Staff Kitchen	08:00 to 08:00	Standard - could be incorporated into the staff room above	1
Domestic Room	08:00 to 08:00	Standard size	1
Sluice	08:00 to 08:00	Standard size	1
Toilets	08:00 to 08:00	Patient, staff and disabled	3

8.3 Capital costs

The capital team at PAHT have costed the above in line with a standard algorithm as follows:

The below is based upon a cost /m2 basis for new build accommodation and we have assumed the following

				£/m2	
a	Works Costs			3,000	
b	Contingency	15%		450	
				3,450	
c	Fees	15%		518	
				3,968	
d	VAT @ 20%			794	
e	Reclaimable VAT on Fees		100%	- 104	
f	Reclaimable VAT on Works, say			TBC	
g	Equipment, say	15%		518	
h	VAT on equipment			104	
				5,279	
j	Optimism Bias @ say	2%		106	
				5,384	/m2

8.4 Exclusions and notes

Please note the above excludes

1) Abnormal ground conditions
2) Additional costs arising from contaminated ground
3) De-watering / lowering of the site water table
4) Demolition of existing structures / buildings
5) Land purchase costs
6) Legal fees
7) Diversion of existing services
8) Inflation beyond 4th quarter 2020
9) Framework procurement fees
10) VAT reclaim on the works costs – subject to advice from the Trusts VAT assessor
11) Fixed Furniture and Fittings/ Equipment

Looking at the accommodation listed this may require an estimated Gross Internal Floor Area (GIFA) of approx. **700m2** – subject to space planning /schedule of accommodation checks

8.5 Estimated cost

Based on the above an estimated cost applying the 700m2 GIFA x £5,384/m2 = **£3,768,800**

We can provide more detailed information once we have more firm information available but based on what we have at present the above reflects an **estimated cost** at this stage

APPENDICES:

Appendix 1: - National Standards for Urgent Treatment Centres.

https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf

Saving lives, Improving lives

NHS
Salford Care Organisation
Northern Care Alliance NHS Group

Requirements Document

Rochdale UTC clinical system

Document Properties

Property	Value
Produced by	Sarah Kierans
Document Type	Requirements Specification
Document Version	1.0
Change Request / Project Number	
Date	07/07/20

Contributors

Name	Role
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Approval

This document requires the following approvals:

Name	Title	Date of Issue	Version
Dr Stephen Gerrard	SRO and Divisional Clinical Director, Rochdale UTC	07/07/20	1.0
Tanveer Kausser	Urgent Care Commissioning Manager – HMR CCG	07/07/20	1.0

Glossary of terms

Term/Acronym	Definition
UTC	Urgent Treatment Centre
NCA	Northern Care Alliance
111	NHS 111 Service
HMR	Heywood, Middleton, Rochdale
ECDS	Emergency Care Data Set
PEM	Post Event Messaging
EOL	End of Life
CP-IS	Child Protection – Information Sharing
GM IDCR	Greater Manchester Integrated Digital Care Record

1. Introduction

The purpose of this document is to detail the requirements of a project's software or system requirements so that Digital Technical Services can accurately assess the impact of this system, create any system diagrams, assess impact on other systems, estimate time, and provide costs.

Complete this document in collaboration with the vendor. Provide as much information as possible.

2. Solution Requirements

The solution will need to be able to interface with the following systems:

Microsoft Office	☐
G2 Digital Dictation	☐
Medisec	☐
SCM (EPR)	☐
Patient Flow	☐
Patient Centre	☐
PAS	☐
Windip	☐
TheatreMan	☐
SCR/Spine	☒

Telepath	☐
CRIS	☐
PACS	☐
Integra	☐
Symphony	☐
ERS	☐
Graphnet	☒
Community EMIS SystmOne	☐
EMIS GP systems	☒

Assessment of Requirements

Rochdale UTC clinical system requirements are assessed and given a score using the prioritisation technique MoSCoW, which has been used to reach a common understanding amongst stakeholders on the importance of each of their functional requirements.

Vendors need to meet all the MUST have/Critical Priority requirements.

Acronym		Description	Priority Level
M	MUST have this	Requirements labelled as ***Must have*** are critical to the current delivery time box in order for it to be a success. It is a requirement that has to be satisfied for the final solution to be acceptable.	**Critical**
S	SHOULD have this	Requirements labelled as ***Should have*** are important requirement that should be included if possible within the delivery time frame. Workarounds may be available for such requirements and they are not usually considered as time-critical or must-haves.	**High**
C	COULD have this	Requirements labelled as ***Could have*** are desirable or nice-to-have requirement (time and resources permitting) but the solution will still be accepted if the functionality is not included.	**Medium**
W	Won't have this	Requirements labelled as ***Won't have*** represent a requirements that stakeholders want to have, but seen as less critical as such, will not be implemented in the current delivery time box or not appropriate at that time. However, they can be considered for inclusion in the future	**Low**

Ref	Requirement Description	MoSCoW Level	Priority Level
UTC1	Enable 111 service to directly book appointments into the UTC system	Must	Critical
UTC2	Ability to extract and submit all the mandated ECDS	Must	Critical
UTC3	Allows electronic prescribing	Must	Critical
UTC4	Allows UTC to view HMR GP clinical record	Must	Critical
UTC5	Ability to send a PEM or electronic discharge summary to GP	Must	Critical
UTC6	Allows UTC to access EOL information	Must	Critical
UTC7	Allows UTC to access Mental Health information	Must	Critical
UTC8	Allows UTC to access CP-IS	Must	Critical
UTC9	Enable UTC service to directly book appointments into HMR GP clinical systems	Must	Critical
UTC10	Able to interface with and send data to the GM IDCR (Graphnet)	Must	Critical
UTC11	Electronic prescribing allows patients to collect prescription from any pharmacy (not just nominated one)	Could	Medium
UTC12	Order comms – ability to request pathology and radiology from the system	Could	Medium
UTC13	Ability to receive pathology and radiology results into the system	Could	Medium
UTC14	Tasks/flags sent to GP with actions required from the discharge summary	Could	Medium
UTC15	Ability to host system on existing NCA or HMR infrastructure/platform with vendor	Could	Medium

H. Timescales

Timescales	
What are the proposed timescales?	UTC mandated standards from NHSE are that the above critical digital requirements are met by 31/08/20.