Lancashire and South Cumbria Integrated Care Board

NHS Lancashire and South Cumbria Integrated Care Board

Integrated Urgent Care Redesign Programme

Case for Change July 2026

Contents

Executive Summary

Integrated Urgent Care (IUC) services across Lancashire and South Cumbria (LSC) are fragmented, inequitable and no longer fit for purpose. Twelve legacy contracts delivered by eight providers have resulted in significant variation in access, quality, digital maturity, workforce models and cost. These arrangements reflect historic commissioning decisions made prior to the Covid-19 pandemic and do not align with current or future national policy, population need, or system pressures.

Demand for urgent and emergency care continues to rise faster than capacity, with LSC experiencing higher growth in ED attendances and emergency admissions than the national average. A significant proportion of this demand is low acuity and could be managed safely in community settings if a consistent, modern IUC offer were in place. Current variation, data gaps and lack of integration contribute to failure demand, poor patient experience and avoidable pressure on EDs and general practice.

National policy direction is clear: urgent care must be digital first, clinically integrated, neighbourhood based and operate 24/7, with ED as a destination rather than the default. Achieving this requires a systemwide redesign of IUC, not a like-for-like re-procurement of outdated services.

This case for change sets out the strategic, clinical, population and financial rationale for redesigning IUC across LSC. It demonstrates why maintaining the status quo is not viable, identifies the risks and benefits of change, and provides a strong foundation for progressing to option development, engagement and procurement of a modern, standardised IUC system that meets the needs of the population over the next decade.

Purpose

This document is the case for change for the redesign of Integrated Urgent Care (IUC) services in Lancashire and South Cumbria (LSC). A case for change sets out a clear, evidence-based, and strategically aligned rationale for changing services. This case for change also explains why a like-for-like re-procurement is not viable, why current service variation and performance pressures cannot be sustained, and why system-wide transformation is required to meet national, regional, and population needs over the next decade.

Introduction

IUC is a collective term that brings together all same-day, unplanned urgent care services outside Emergency Departments (EDs), including Urgent Treatment Centres (UTCs), GP Out-of-Hours (OOH), Clinical Assessment Services (CAS), and walk-in centres/minor injuries units.

Across Lancashire and South Cumbria (LSC) there is substantial variation in delivered IUC services, with twelve different commissioned contracts being delivered by eight different providers. This has led to different scopes, quality and cost, creating inequity and inefficiency across places.

The current services were primarily designed and commissioned prior to the Covid-19 pandemic and reflect the historic commissioning priorities of the former Clinical Commissioning Groups (CCGs). Healthcare activity/demand and the use of digital technology have significantly changed over recent years. A simple re-procurement would result in the continuation of services that were designed to meet the needs of the population six or more years ago, which may no longer meet the needs of today or those in ten years' time.

The case for change looks across all parts of the LSC system, whilst being mindful of commitments already made to the West Lancashire place as part of the Shaping Care Together Programme. Similarly, the case for change recognises the limitations of the redesign programme and the fact no part of the health and social care system can be designed in isolation.

This programme redesigns the commissioning and delivery of IUC services. It does not redesign neighbourhood teams, general practice contracts or mental health crisis services, but will align with and enable these programmes

“When I needed help, I didn’t care which service was which — I just needed someone to guide me to the right care quickly. The new Integrated Urgent Care approach means people like me won’t be left worrying or waiting; no matter where you live, you’ll get clear advice, the right support first time, and a smoother journey through care when it matters most.”- a quote from a member of the population.

Vision and objectives

Approaching this redesign programme, we have a clear vision and set of objectives that have been developed through feedback from current providers and engagement with our population.

We aim to commission an IUC system to meet the needs of individuals within our population(s) of LSC for the next ten years.

To do this effectively we will need to fully understand the current activities, challenges and opportunities of the current commissioning and provider landscapes, building on the redesign work already undertaken.

Our framework will ensure that patients have equitable access to high quality IUC.

Our strategically commissioned proposal will ensure that successful providers will continue to evolve and flex care delivery to meet the needs of their respective populations according to need, throughout the life of the contract.

At the heart of this will be a balanced approach between advancing robust, safe and effective integrated digital first clinical pathways and building mature collaborative relationships between all stakeholders within a local footprint.

Through the work we aim to deliver the following objectives:

- Develop a 24/7 integrated urgent care services model
- To maximise the use of digital first solutions
- To maximise the use of all primary care providers, providing more care in a community setting
- To support the population to access the right care, in the right place, at the right time
- To achieve efficiencies in services by reducing the failure demand associated with patients not getting the right care first time
- Improve patient experience through simpler access, fewer hand-offs and faster resolution

Strategic context

This section looks at national and local strategic context in relation to IUC services. It is shaped by key policy documents influencing both UEC and primary care. An effective IUC model can contribute to addressing pressures with in UEC settings and also supports proactive preventative neighbourhood and multi-neighbourhood based care, both of which are key components in a highly-functioning health and social care system.

When developing the national strategic context policy and guidance has been considered from the following: NHS Fit for the Future:10 Year Health Plan for England[1] ambitions, including the National Neighbourhood Health Implementation Programme, the Urgent & Emergency Care Plan 2025/26[2], the Medium Term Planning Framework 2026/27–2028/29[3], The Model Emergency Department blueprint[4], the National General Practice Improvement Programme[5] and the Modern General Practice model[6].

Together these set clear expectations for whole-system flow, neighbourhood health, digital-first access, and consistent urgent care alternatives to ED.

Across the country and in LSC we are seeing demand outstripping capacity resulting in ambulance handover delays, overcrowding in ED, corridor care, and overall challenges with in-hospital patient flow. Guidance emphasises that high-performing UEC pathways depend on the whole system working 24/7 with ED as a destination rather than a default. A key system component to achieve this is strong upstream IUC capacity and navigation.

Nationally tangible system priorities for winter and beyond have been set (e.g., 45-minute maximum ambulance handover, reducing 12-hour waits, accelerating UTC/SDEC, expanding community-based urgent response and mental health crisis alternatives), alongside stating that all EDs should be supported by co-located UTCs. These expectations are likely to remain, which will continue to require ICBs to develop ambitious plans that increase urgent care provided

[1] Fit for the future: 10 Year Health Plan for England
[2] Urgent and emergency care plan 2025/26
[3] Medium term planning framework - delivering change together 2026/27 to 2028/29
[4] NHS England » The Model Emergency Department: high performing urgent and emergency care pathways
[5] NHS England » National General Practice Improvement Programme
[6] NHS England » Modern general practice model

outside hospital. These requirements directly reinforce the need to standardise and scale IUC to reduce avoidable ED attendances and admissions.

NHS England has set out clear priorities for the ICB to shift from sickness to prevention, moving urgent care to a more structured, digital-first model, and accelerating neighbourhood health so that more care is delivered closer to home. It requires urgent care to move towards a structured, digital first model with clear performance trajectories for ED four hour waits and category 2 ambulance response times. The guidance reinforces the need for consistent access, stronger integration with neighbourhood urgent care capacity and a systemwide shift from reactive hospital-based care to proactive, community-based support. These expectations cannot be met without a modernised, standardised IUC service.

The national IUC service specification was written prior to the Covid-19 pandemic and prior to recent digital advancements and increased trust and acceptance of digital health models. It does however establish the ‘consult-and-complete’ operating model (integrated NHS 111/CAS with direct booking, prescribing, and warm transfer, underpinned by interoperable DoS and post-event messaging). This provides the baseline for standardising clinical assessment, navigation and digitally enabled booking across places.

Within primary care, there is a national approach for inclusive, structured access, single care navigation across channels, and better allocation of capacity to demand. For IUC, this matters because same-day episodic demand, that does not require continuity of care, can be safely managed in a coordinated IUC offer, protecting GP time for continuity-based care of people with increasing clinical complexity. Without a reliable and consistent IUC offer, same day capacity pressures default back into general practice and ED, exacerbating flow issues and reducing the availability of continuity-based care for those with complex needs.

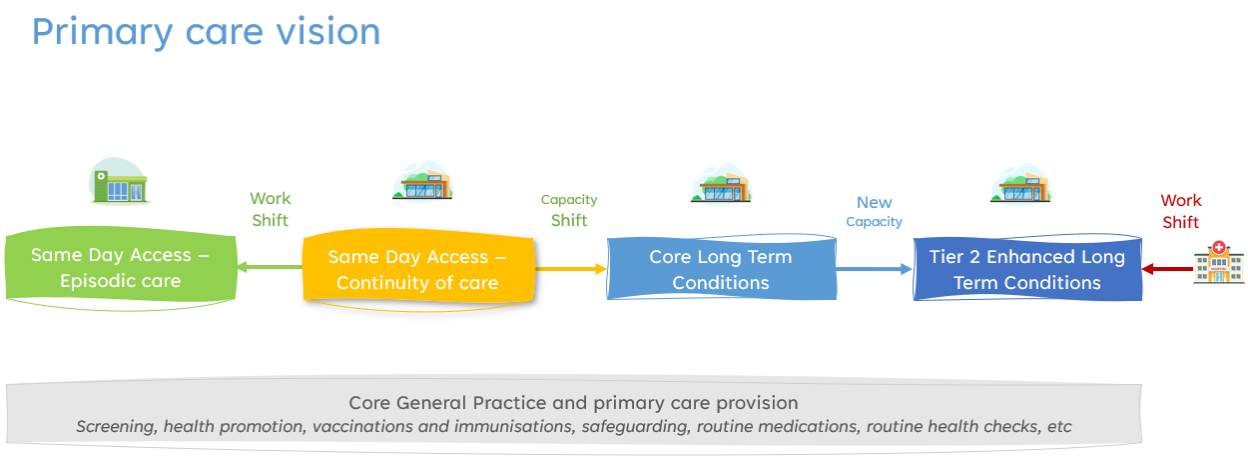
This approach for General Practice needs to be balanced with their contractual obligations that have a renewed focus on urgent same day care from April 2026.

Neighbourhood health models add a further foundation for IUC through the development of integrated neighbourhood teams, urgent neighbourhood services and population health management. IUC should work with care co-ordination/single point of access as the same-day urgent care ‘front door’ that connects neighbourhood capacity with ED avoidance pathways.

These national policies have influenced the local strategies and visions of the ICB.

As reflected in the LSC UEC 5-year strategy 2024 – 2029, urgent and emergency care in LSC is under intense pressure, with rising demand, worsening flow, and significant inequalities. The current integrated urgent care model is identified as contributing factor to these pressures, citing multiple providers, inconsistent models, differing pathways and access challenges creating confusion for patients and staff. The strategy identifies integrated urgent care redesign as a key component to address this and calls for a more standardised, joined up IUC model.

With regards to primary care, the graphic below shows the vision for general practice. As the bedrock of the neighbourhood health model, general practice plays a key role in the left shift of care from secondary care settings and supporting people with a complexity of care where continuity has been showed to produce better patient outcomes.



Achieving this vision relies on the capacity to support individuals with a same day episodic health need. The role of pharmacy, optometry and dental have also expanded over recent years, providing more funded same day episodic care. However, these services have not been fully integrated into the urgent care system, and they are not being fully utilised, despite often being available in locations closer to people's homes and over a wider range of hours.

Taken together, national and local policies demonstrate a clear need for redesign of the IUC system: reduce avoidable ED and hospital demand, create reliable, standardised clinical assessment/treatment and direct booking, integration with care co-ordination, enable digital-first navigation with inclusive access, and support primary care to focus on complex continuity, thereby improving outcomes, experience, equity and system resilience.

The current strategic context provides the opportunity to review the various IUC models within LSC to ensure that they meet the articulated ambitions and remain fit for purpose as new models of care develop. We need to move away from looking at the current structures we have in place and how we develop an integrated model to meet the un-met needs of those with an urgent, not routine or emergency, need.

Population health needs

This section looks at the local population needs and how these contribute to the need to redesign the current IUC model. The information in this section is built from the ICB's Population Health Needs Assessment.

LSC is home to 1.74 million residents, with an older age profile than England overall. 25% of the population is aged 65 or over, rising to over 35% in Fylde Coast and Morecambe Bay. Deprivation is a major driver of health need: 31% of lower super output areas are within the most deprived 20% nationally, with Blackpool and Pennine Lancashire containing some of the worst deprivation clusters in England.

Health need is significantly shaped by multimorbidity. Over 150,000 residents currently live with three or more long-term conditions, projected to rise by over 30% by 2047. Long-term conditions such as cardiovascular disease, COPD, diabetes, cancer, and dementia all show higher prevalence than the England average. Mental health need is also high, with depression prevalence at 16.7%, which is amongst the highest nationally.

Urgent care use reflects these inequalities. ED attendance rates are nearly two-and-a-half times higher in the most deprived communities than the least deprived, and children in more deprived areas are almost twice as likely to attend ED. Emergency admission rates are also significantly higher in deprived groups.

Inequalities in digital access, transport, language and health literacy further contribute to variation in urgent care use. Areas with high digital exclusion rely more heavily on walk-in urgent care and ED, while many communities with actual or perceived limited access to same day primary care routinely bypass general practice for urgent needs. Strengthening IUC is therefore essential to ensure a fair, consistent and accessible route into urgent care that works for all communities, regardless of socioeconomic status or digital capability.

Current outcomes

This section aims to look at the current outcomes and activity taking place within the IUC system. However, a challenge with the IUC redesign programme is that the ICB does not currently hold clear outcomes data for the services being commissioned. Due to data collection requirements negotiated by different CCGs, there is also a huge variance in the quality and quantity of data available, including significant gaps, meaning we do not have a universal picture of the current activity and acuity of IUC services across LSC.

To gain an agreed understanding of current activity and acuity, a number of assumptions have been applied to the available data. These assumptions have been tested with current IUC providers and commissioning colleagues at a workshop held in February 2026.

The data modelling provided an imperfect view of detailed activity, but it was possible to draw some system level conclusions of activity and acuity. Within Lancashire & South Cumbria in the past twelve months there are probably about 500,000 attendances to ED, UTC or other urgent care facilities (excluding Primary Care and Out of Hours GP) of low acuity that could be managed in a community setting.

This is approximately one in three attendances.

The redesign provides an opportunity to standardise activity and acuity definitions.

System performance data across UEC pathways shows significant and persistent pressure. The LSC UEC 5-year strategy 2024–2029 highlighted that ED attendances increased by 19% between 2018/19 and 2023/24, significantly outpacing the 6% growth seen nationally. More recent analysis shows that in 2024/25, emergency and non-elective admissions per weighted capita reached 20% higher than national average – equating to over 30,000 admissions. These sustained demand pressures are characterised by severe and persistent system stress, resulting in patient safety risks. Patients are waiting too long for ambulance handover (20% waited over 45 minutes in January 2026) and experiencing prolonged delays in ED (19.4% waited over 12 hours in January 2026). As a consequence, corridor care has increasingly become routine rather than exceptional, further compounding risks to patient safety, dignity and quality of care.

These challenges come about due to demand within hospital settings that could potentially be managed earlier in the system.

Across LSC, IUC demand is compounded by the pressures facing general practice. Within LSC, the number of monthly consultations undertaken by practices has increased from a pre-pandemic baseline of 750,000 per month to a new 880,000 per month in the past two years.

Alongside this there has been a significant increase in patients accessing care via online consultations, with monthly activity increasing from 50,000 per month in April 2024 to 130,000 per month in winter 2025/26.This indicates an increase in demand, with an increase in efficiency and capacity within General Practice to meet this.

If we do not look at redesigning the current IUC model, it is likely that we will continue to see ED growth and ambulance delays, worsening inequalities and pressures on general practice with growing financial inefficiency and an inability to meet national expectations.

Current service model

This section looks at the current IUC service availability and variation across LSC.

The current IUC offer across LSC comprises a mixture of UTCs, GP OOH services, CAS, walk-in centres/minor injury units. These services have developed through historic commissioning arrangements, resulting in wide variation in scope, operating hours, workforce models, diagnostics availability, digital maturity and pathways between places.

For patients, this fragmentation contributes to inconsistency in the offer, inequity in access and differences in quality and experience across the system.

For the strategic commissioning and provider partners this fragmentation creates multiple layers of complexity that prevent accurate analysis and assessment of system services. This applies equally to contractual assurance, financial performance and quality of care delivered.

The range and variation of services can be seen in the table below:

Place	OOH	CAS	MIU	UTC	WIC
Central Lancs					
Fylde Coast					
Blackburn with Darwen					
East Lancs					
MBay (N.Lancs)					
Mbay (S.Cumbria)					
West Lancs					

KEY	
Service in place	
Service in place – no recurrent funding / part funded	
No service in place	

Across the system, some UTCs provide extended hours, point-of-care diagnostics and streaming from ED, while others operate with limited diagnostics and narrower case mix. In addition, University of Morecambe Bay Hospital Trusts do not currently have an UTC co-located with their ED departments. GP OOH models range from those integrated within other IUC services and those that function completely separately.

The CAS is similarly variable in its integration with NHS 111, primary care and community services, and in some areas is not fully aligned with the national 'consult and complete' expectations set out in the IUC Service Specification (including prescribing, warm transfer and direct booking).

Digital capability also varies significantly across providers, with differing clinical systems, connectivity to the Directory of Services (DoS), and inconsistency in the quality and completeness of post event messaging back to primary care. This variability limits the system's ability to operate as a single, IUC front door, and contributes to duplication, repeat contacts and handover delays. These digital gaps are particularly critical given national direction for a structured, digital first urgent care model.

Pathway alignment between IUC, primary care, neighbourhood urgent community response (UCR), virtual wards, mental health crisis pathways and ED streaming also differs between places, resulting in inconsistent patient journeys and variation in how demand is managed upstream of ED. The care co-ordination programme is developing connections between these pathways for health and care professionals managing those with more complex needs, and there are clear benefits to wiring a highly functioning CAS into this model.

Overall, the current service model functions, however, there is inconsistency in service provision, failure demand and integration opportunities.

Patient engagement

During a series of public roadshows held during September-November 2024 and an online questionnaire from October-November 2024, residents across LSC were asked what urgent care services they were aware of, which they use, why they choose them and what their experience has been. A list of clear recommendations came out of this engagement:

- **Establish 24/7 urgent care**: Create urgent care pathways that are person-centred and operate around the clock to provide accessible services for non-emergency cases outside of traditional GP hours and reduce pressure on ED departments.
- **Improve public awareness**: Develop simple, easy-to-understand messaging about and consistent naming for urgent care services to help the public navigate their options effectively. Launch campaigns to educate the public on the types of urgent care available, how to access them, and

clarify the differences between ED, UTCs, and walk-in facilities. Provide education campaigns focused on urgent care pathways, including the role of services like 111 and pharmacies, to build public confidence and understanding.

- **Launch community-based health hubs**: Create centralised community hubs that combine multiple health services, including urgent care, primary care (including dentistry), and mental health support.
- **Utilise virtual care options**: Explore and implement virtual urgent care to improve accessibility and to allow patients to consult healthcare professionals remotely, thereby reducing travel and wait times for non-emergency issues.
- **Implement a single point of access**: Create a single, clear point of access for urgent care services, such as one telephone number that integrates various healthcare services, making it easier for patients to navigate their options.
- **Enhance IT systems**: Implement joined-up IT solutions for accessing patient records and service navigation to ensure healthcare providers have immediate access to accurate patient information.
- **Utilise community resources**: Leverage existing community spaces, such as leisure centres, to provide health services, wellness programmes, and urgent care options directly within neighbourhoods.
- **Reduce inequalities**: Focus on rural and underserved areas by ensuring that urgent care services are geographically accessible (in collaboration with wider partners to address issues around transport) and consider mobile/virtual healthcare options in those regions. Include ways for people who are digitally excluded to access services. Make urgent care services available at the same opening times across all of Lancashire and South Cumbria.
- **Expand workforce roles**: Introduce care navigator roles in community settings who can assist patients in understanding their options and accessing appropriate services. Expand on which healthcare professionals can prescribe medications and handle minor ailments, which could reduce patient load on GPs and streamline the urgent care process.

Current financial spend

Current spend on IUC across LSC varies significantly between places, reflecting historic commissioning decisions, legacy contractual arrangements and differences in service scope, hours, diagnostics availability and workforce models.

Footprint	Cost per Footprint	Population size	Spend per weighted pop
Blackpool, Fylde & Wyre	£14,103,632	408,908	£34.49
Central & West Lancs	£16,803,925	560,844	£29.96
East & Pennine	£35,671,251	628,093	£56.79
S Cumbria & Morecambe Bay	£11,665,860	381,780	£30.56
	£78,244,668	**1,979,625**	**£39.52**

The table summarises 2025/26 financial budgets across ICB locality footprints. Service delivery is shared by both Hospital Trusts and Independent Sector providers, with the latter's contracts originally commissioned by the legacy CCGs. Contracts have been extended on a rolling annual basis, uplifted in-line with national guidance. Our objective is to achieve both financial and service parity across the whole ICB footprint.

Costs have been calculated from a mixture of where services are commissioned by standalone contracts, others are provider estimates on what the costs of the IUC services are as they are delivered as part of wider contracts. Currently, there is not a clear financial understanding of the exact spend on IUC services.

The fragmentation of the current delivery model, with multiple providers, variable service specifications and differing digital maturity, leads to duplication, inefficiency and higher system costs. These include repeated clinical contacts, variable staffing models, inconsistent triage processes and limited economies of scale. A standardised IUC model provides an opportunity to rationalise these system cost pressures and deliver a more efficient and financially sustainable IUC service.

The Medium Term Planning Framework 2026–2029 introduces expectations for digital first urgent care, improved population health management and better alignment of financial mechanisms to incentivise left shift. Systems that fail to

modernise IUC will face ongoing financial pressure from increasing ED activity, flow constraints and rising acute costs associated with avoidable admissions and long stays.

The current provider market also creates financial complexity. Multiple contracts, different organisational forms and inconsistent incentives make it difficult to optimise cost, performance and service integration. A more coherent commissioning approach will support clearer accountability, enable economies of scale, and allow investment to be directed toward modernisation, integration, digital transformation and enhanced clinical capability.

Further work is required to gain a better understanding of the financial spend, if variation is warranted based on population needs and investment in other services, and what outcomes are achieved.

Risks, challenges and benefits

The redesign is not without risk. It is likely to result in a complex procurement, built on data limitations, with ambitious timelines, during a period of significant organisational change, and closely linked service transformations. It will also require providers to be ready to work in different ways. However, these risks must be balanced against the strategic benefits: equity, consistency, improved performance, reduced failure demand, alignment with national direction, and a sustainable system for the next decade.

Key risks

- **Delivery and implementation:** Transitioning from multiple legacy IUC contracts to a standardised, modernised model requires significant change management, including redesign of pathways, workforce roles, digital systems, contractual arrangements, plus carries the risk of procurement challenge. This needs to be managed to minimise any disruption to operational services.
- **Workforce cultural changes:** To successfully deliver an integrated service, cultural changes are required within the workforce to ensure different providers talk to each other and work seamlessly together within the available workforce skill mix, and adopt a trusted assessor model. Achieving these cultural changes requires active wider work to take place as part of the neighbourhood/multi-neighbourhood programme.

- **Digital interoperability:** Variation in clinical systems, Directory of Services (DoS) integration and post-event messaging processes poses risks to clinical safety, continuity of care and the ability to meet national expectations for ‘consult and complete’. Without unified digital infrastructure, redesign benefits could be constrained.
- **UEC system flow:** If IUC redesign is not aligned fully with ED streaming, care co-ordination and mental health crisis pathways, there is a risk that urgent care growing demand continues to default to ED.
- **Financial and contractual:** Reform of the provider landscape and commissioning model may introduce financial uncertainty in the short term. Complex contracting arrangements, historic cost variation and differing organisational capabilities could create risks during transition to a unified model.
- **Public understanding and behaviours:** Changes to the IUC model require clear communication to ensure people understand how to access urgent care consistently. Without robust public engagement (and potentially, consultation) over any proposed changes, there is a risk of confusion, increased representation, and continued reliance on ED as a default.

Key challenges

- **Achieving system-wide consistency:** Current variation across UTCs, OOH, CAS, walk-in centres and digital services mean that establishing a single, coherent IUC model requires substantial alignment of clinical pathways, digital processes, workforce arrangements and governance structures within existing financial resources.
- **Balancing consistency with local nuances:** A fragmented, varied service is causing confusion for the population and providers and therefore consistency is required. However, this needs to be balanced with local flexibility to ensure that the unique needs of the different populations in LSC can continue to be met.
- **Integration across multiple programmes:** IUC modernisation is dependent on progress across general practice, neighbourhood teams, care co-ordination, mental health crisis models and ED transformation. Coordination across programmes is challenging but essential.

- **Addressing health inequalities:** Significant deprivation gradients and higher urgent care utilisation in certain communities require targeted, inclusive access models. Ensuring digital inclusion and equitable access across all places is a persistent and complex challenge.
- **Data quality and insight:** Inconsistent activity definitions, reporting processes and clinical coding across providers limit financial transparency, demand forecasting and performance evaluation. Overcoming these limitations is essential for effective future commissioning.

Key benefits

- **Improved access and equity:** A single, consistent IUC model will reduce unwarranted variation and ensure all residents across LSC receive a fair and predictable urgent care offer, regardless of location or socioeconomic status.
- **Reduced ED demand and improved flow:** Enhanced clinical assessment and treatment, digital navigation, direct booking and integration with community alternatives will reduce avoidable ED attendance and generate capacity for general practice to support left shift and those members of the population with more complex needs.
- **Better patient experience:** Simplified access routes, increased clinical assurance at first contact and smoother transitions between services will reduce repeated navigation, duplication and delays, improving safety, timeliness and overall patient confidence in urgent care pathways.
- **Stronger workforce sustainability:** A unified, multidisciplinary workforce model supports better resilience, allows for a trusted assessor model and improves recruitment and retention.
- **Increased financial efficiency:** Standardisation, reduced duplication, improved digital integration and more effective upstream demand management will support a more sustainable financial model.
- **Alignment with national policy and future models of care:** A modernised IUC model ensures full alignment with local and national policy and strategies positioning the system for future contractual, financial and regulatory expectations.

The risks and challenges associated with IUC redesign are significant but manageable with strong system oversight, coordinated programme delivery and clear communication. The benefits, particularly improved flow, equity, experience

and long-term financial sustainability, create a compelling case for change and justify proceeding to the next phase of detailed option development.

Timelines

The programme is currently working to the following timescales:

Timeline should public consultation not be required

- Case for Change: July 2026
- Pre-consultation engagement: October 2026
- Options Appraisal: January 2027
- Decision Making Business Case: March 2027
- Procurement commences: April 2027
- Contract go-live: June 2028

Timeline should public consultation be required

- Case for Change: July 2026
- Pre-consultation engagement: October 2026
- Options Appraisal: December 2026
- Pre-consultation Business Case: March 2027
- Consultation concludes: September 2027
- Decision Making Business Case: December 2027
- Procurement commences: January 2028
- Contract go-live: September 2029

Resource requirements

			WTE required							
Area	**Role**	**Status**	**CFC**	**PCE**	**OA**	**PCBC**	**PC**	**DMBC**	**Procurement**	**Mobilisation**
Programme Team	Executive Sponsorship	In place	0.05	0.05	0.05	0.1	0.2	0.1	0.1	0.05
	SRO- Director Level	In place	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
	Programme Director	In place	0.4	0.4	0.4	0.5	0.5	0.5	0.4	0.3
	Programme Management	In place	0.4	0.4	0.4	0.5	0.4	0.5	0.4	0.4
	Clinical Leadership	0.2 in place	0.4	0.4	0.4	0.5	0.4	0.5	0.4	0.4
	PC Data Lead	In place	0.3	0.3	0.3	0.3	0.3	0.3	0	0
	Data Lead	Required	0.3	0.3	0.3	0.3	0.3	0.3	0	0
	PC Commissioning Lead	In place	0.5	0.5	0.5	0.5	0.5	0.5	0.6	0.6
	UEC Commissioning Lead	In place	0.5	0.5	0.5	0.5	0.5	0.5	0.6	0.6
	Place Leadership (total across all places)	Required	0.2	0.4	0.4	0.4	0.4	0.4	0.6	0.8
	Admin Support	Required- not critical	0.2	0.4	0.4	0.4	0.4	0.4	0.4	0.4
Subject Matter Experts	Digital	In place	0.1	0.1	0.3	0.3	0	0.3	0.2	0.2
	Finance	In place/will be provided	0.1	0	0.2	0.5	0.5	0.5	0.6	0.4
	Comms and engagement*	In place	0.5	0.5	0.5	0.5	2	0.5	0.2	0.2
	Contracting and procurement**	In place	0.1	0	0.1	0.1	0	0.1	1	0.6
	Quality	In place	0.1	0.1	0.1	0.2	0	0.2	0.2	0.2
	Additional SME at procurement stage	Required							0.4	
Total			**4.35**	**4.55**	**5.05**	**5.8**	**6.6**	**5.8**	**6.3**	**5.35**
Recommendation for 6 month review of staffing structure	* plus external support and consultation budget will be required									
	* plus external procurement support at an additional cost									

Conclusion

This Case for Change provides a compelling rationale to progress to the next stage of redesign. Further work will refine outcomes, model options, financial scenarios, and detailed service specifications, supported by enhanced data and engagement.

One of the key principles underlying this case for change is that for the potential to be realised it will require both intelligent procurement and the cultivation of strong and functional integration between multiple providers and partner organisations. This will require active system planning and coordination to achieve this over the next few years. Change will require more than a simple re-procurement and relying on the content of a contract. Maintaining the current model is not a neutral option: it represents an active risk to equity, quality and system sustainability.

Glossary

IUC service	
AVS (Acute Visiting Service) *also delivered as Call b4 Convey*	**AVS -** is offered to patients registered with GP surgeries. Only GPs and their clinical teams can refer patients who require urgent primary care into to AVS for a home visit or advice consultation from a clinician, that might otherwise result in the patient being referred or conveyed to hospital. **Call b4 Convey** – some areas have developed this into a call b4 convey service using the NWAS pathfinder service. Using the Pathfinder Tool developed by NWAS, the service identifies patients that are safe to be left at home, subject to their being another service available, to continue appropriate assessment and care of patients in a timely manner.
CAS (Clinical Assessment Service)	A clinical assessment service (CAS) is an intermediate service that allows for a greater level of clinical expertise in assessing a patient than would normally be expected of a referring clinician (such as a GP), staffed by clinicians incl. senior nurses, pharmacists and GPs. This expertise should be used to ensure that patients are directed efficiently and effectively into the most appropriate onward care pathway. Patients are referred by NHS 111 or health professionals.
DVT (Deep Vein Thrombosis)	The DVT service is an emergency clinic which sees patients with suspected blood clots in their leg. The patients are referred by GPs, A&E and hospital outpatient clinics.

IUC service	
MIU (Minor Injuries Unit)	A nurse-led unit run by Emergency Nurse Practitioners and Emergency Care Practitioners (ENP and ECPs), that can treat injuries that are not critical or life-threatening.
OOH (Out of Hours)	OOH services are arrangements to provide access to healthcare at times when GP surgeries are closed; in the United Kingdom this is normally between 6.30pm and 8am, at weekends, Bank Holidays and sometimes if the practice is closed for educational sessions.
UTC (Urgent Treatment Centre)	Are GP-led, open at least 12 hours a day, everyday, offer appointments that can be booked through NHS111 or through a GP referral, and are equipped to diagnose and deal with many of the most common ailments people attend A&E for.
WIC (Walk-in Centre)	WiC services are available if you feel unwell or suffer from a minor injury when you're away from home, if you aren't registered with a local GP or your GP is unavailable. They're open early till late, and most are open 365 days a year and offer advice and treatment without an appointment.