AGENDA

1. Apologies for Absence

2. Declaration of Members' Interests
   In accordance with the Council’s Constitution, Members are asked to declare any interest they may have in any matter which is to be considered at this meeting.

3. Minutes (Pages 1 - 6)
   To confirm as correct the minutes of the meeting held on 06 March 2013

4. Introducing Healthwatch Barking and Dagenham (Pages 7 - 11)

5. Walk-in Centres in Barking & Dagenham: Consultation on Proposals to Close the Broad Street Walk-in Centre (Pages 13 - 89)

6. Review on Type 2 Diabetes Services across the London Borough of Barking and Dagenham (Final Version) (Pages 91 - 179)

7. Ideas for Scrutiny Reviews in 2013/14 (Pages 181 - 186)

8. Updated Terms of Reference for the HASSC (Pages 187 - 193)

9. Work Programme going into 2013/14 (Pages 195 - 196)
10. **Date of Next Meeting**
   - 6pm, Monday, 10 June 2013 – Barking Town Hall

11. **Any other public items which the Chair decides are urgent**

12. **To consider whether it would be appropriate to pass a resolution to exclude the public and press from the remainder of the meeting due to the nature of the business to be transacted.**

   **Private Business**

   The public and press have a legal right to attend Council meetings such as the Health and Adult Services Select Committee, except where business is confidential or certain other sensitive information is to be discussed. The list below shows why items are in the private part of the agenda, with reference to the relevant legislation (the relevant paragraph of Part 1 of Schedule 12A of the Local Government Act 1972 as amended). **There are no such items at the time of preparing this agenda.**

13. **Any other confidential or exempt items which the Chair decides are urgent**
HEALTH AND ADULT SERVICES SELECT COMMITTEE

Wednesday, 6 March 2013
(6:00 - 7:30 pm)

Present: Councillor S Alasia (Chair), Councillor A Gafoor Aziz, Councillor M McKenzie MBE, Councillor C Rice, Councillor A Salam and Councillor J Wade

Also Present: Cllr M Worby

Apologies: Councillor E Keller and Councillor L Butt

43. Declaration of Members' Interests

There were no declarations of interest.

44. Minutes

The minutes of the meeting held on 13 February 2013 were confirmed as correct.

45. Diabetes Scrutiny: Update

The HASSC noted the report and welcomed Cllr Worby and Dr Mohi to the meeting to receive and discuss the findings of the diabetes scrutiny undertaken by the HASSC.

Cllr Worby thanked the HASSC for giving diabetes profile and moving it up the list of priorities for commissioners and strategists in the health and social care economy. Cllr Worby stated that through the Health and Wellbeing Board it will be possible to establish accurate baseline data for diabetes prevalence. This will inform commissioning and result in better provision and access to services. The Board also has a role in spreading awareness and understanding the wider impacts of diabetes across the health economy. The Board hopes to commission the BAD Youth Forum to engage in public health campaigns and educate at peer level. Cllr Worby assured the HASSC that their findings will influence the next iteration of the Health and Wellbeing Strategy.

The HASSC asked if there was enough diabetes literature and whether it was being given out to those in need of information. Dr Kalkat explained that diabetes literature is under review by the CCG having reached the end of an old print run. The CCG will investigate whether GPs are giving out the information packs in light of the HASSC’s concern.

The HASSC asked if people with mental health services would be targeted for diabetes intervention as prevalence is higher in this group. Furthermore, diabetes tend to be more likely to suffer from mental health issues such as depression so it is important services are appropriate for those with mental health conditions. David Horne confirmed that physical check-ups for diabetics with mental health conditions were being monitored to ensure that they receive the right level of care and support.
Dr Mohi shared with the HASSC several areas for improvement, including:

- Extending the reach of diabetes services to find all groups within the community, targeting services accordingly (especially screening)
- Improving the usage of the DESMOND programme
- Developing services at Porters Avenue
- Learning from national and local best practice examples
- Developing expertise among GPs

To drive these improvements the CCG has established a diabetes forum. Once the forum has completed preparatory work stakeholders will be invited to add value and contribute.

Matthew Cole and Elaine Clark commented that commissioners need to concentrate on managing diabetics within the community setting because there are too many hospital admissions from Barking and Dagenham diabetics. Elaine added that out of hours services were not suitable for diabetics and diabetics struggle to access the out of hours service.

Dr Kalkat accepted the HASSC’s findings in relation to weaknesses within GP care for diabetes and especially the standard and adherence to the 9 NICE health checks. He admitted that standards of care across the borough are not consistent but these will be addressed through a programme of peer review. Dr Kalkat and Dr Mohi were in agreement that GPs are in need of further training about diabetes and welcomed the comment about GPs needing to spend more time with newly diagnosed diabetics.

The final report of the HASSC will be presented to the next meeting before being passed to the Health and Wellbeing Board for formal response and implementation of recommendations.

46. **CQC inspection report of A&E: Holding BHRUT to account**

Stephen Burgess (Deputy Medical Director, BHRUT) delivered a presentation to the HASSC which:

- Described the background to the CQC reports. Highlighting issues with staffing and quality of care in the maternity and emergency departments. Referencing previous CQC reports, shortcomings identified by commissioners, and the most recent round of CQC inspections.

- Summarised the findings of CQC citing long waiting times, staff shortages, lack of privacy and dignity in care, and patients being nursed in inappropriate environments. The HASSC noted that in December 2012 80.88% of patients completed their care within 4 hours. (against target of 95%)

- Explained capacity issues and increasing demand on A&E services.
  - Queen’s Hospital was designed to deal with 90,000 attendances per year but now responds to 132,000
  - 22% rise in attendances from 2011 to 2012
  - In 2012 Queen’s saw 73 patients a day more than in 2011
  - In 2012 there were 23 days where there were more than 470 A&E
attendances. In 2011 there were only three.
- The average number of attendances a day in 2012 was 404 (highest 518), in 2011 it was 331.
- Queen’s hospital receives more blue light ambulances than any other hospital in London.

- Outlined the Trust’s action plan
  - Opening new surgical assessment unit
  - Introducing direct access for GP admissions
  - Improving staff cover and overhauling rotas
  - Introducing clinical fellows into A&E
  - Working to improve discharge and hospital flow
  - Redesigning and rebuilding the emergency department
  - Increasing urgent care centre utilisation
  - Introducing care of the elderly input into front end of A&E
  - Closely monitoring patient experience
  - Strengthening performance management

- Outlined what partners can do to support improvement programme, including:
  - Reducing ambulance flows
  - Increasing primary care access and use of GP appointments
  - Improving availability of rehab beds
  - Improving stroke pathway

- Highlighted the Trust’s success in turning around the maternity department which is now compliant with all CQC standards that were inspected. The transformation has seen:
  - The opening of the Birth Centre which has 50% use of birthing pools, 80% of women breastfeeding, and low levels of transfers to the main labour ward.
  - 100% of women receiving one-to-one care in labour
  - The department operate with a full complement of staff
  - Improved patient feedback. 96% of women would recommend Queen’s to friends and family

- Updated on the situation at King George Hospital confirming that subject to final checks there will be no more deliveries from March 2013. A&E services will remain until such time that the regulators, commissioners, and the Trust judge Queen’s A&E to be well performing.

Following the presentation the HASSC asked the following questions of Stephen Burgess and Dorothy Hosein (Chief Operating Officer, BHRUT):

- What was the reaction of the Trust’s Board? What responsibility does the Board take for the findings? How will the Trust ensure that any improvements that are made to A&E sustained?

  Dorothy Hosein, as a Board Member, responded stating that she and the Board take the findings very seriously indeed. The Board is aware that the standard of care is unacceptable and has approved a robust action plan to address CQC’s findings. Patient care is the number one priority for the Trust and is at the heart of all of the actions put forward in the plan. Board members are receiving daily
performance updates and visiting the front line to get first-hand experience of care. The HASSC was pointed to the recent success of the Trust in turning around the situation with maternity as proof that the Trust is capable of responding and improving.

Elaine Clark, who represents patients on the Trust Board, confirmed that the atmosphere of the Board is uncomfortable and all Board Members very serious about the challenges and they are working hard to address them.

- How will the Trust respond to the staffing issues raised? When can the Committee expect to see a fully staffed emergency department?

It is essential that staffing levels are raised and that the Trust becomes less reliant on bank or agency staff. Recruitment is very difficult for the Trust as because of its reputation and business it is not an attractive organisation to work for. Another problem is that the Trust has a high turnover of nurses and finds it difficult to retain staff. The Trust is trying to be creative in its recruitment to overcome these problems, for example it is exploring joint appointments with teaching hospitals as a way to bring in high calibre staff. It was noted that recruiting doctors and nurses is a national problem. The Trust asserted that recruiting to vacant posts was not linked to cost savings for the Trust. Recruitment and retention is a top priority. The HASSC was assured that the Trust’s staffing levels are safe despite the shortage of middle grade doctors, nurses, and consultants. Moreover, the rota is being overhauled so that the hospital has appropriate medical cover at all times.

- Is the Trust capable of managing and responding to more than one crisis at any given time?

Cllr Worby echoed the concerns of the HASSC and pressed the Trust over their history and failure to get on top of problems. Dorothy Hosein assured all present that the governance of the Trust is being strengthened, key personnel and Board Members who were not performing to the require standard have been replaced, and the Trust is looking across the piece rather than just focussing on individual areas. Furthermore, a Director of Governance has been appointed to ensure that governance and performance management is robust.

- What can be done to improve the patient’s experience?

Re-designing the department physically will help to improve the patient experience. The Trust will also need to direct more activity to the Urgent Care Centre at Queen’s and more nurses will need to be recruited. In the last two months the Trust has introduced ward rounds and privacy checks in response to the criticisms of CQC.

- Why has it been proposed that the Broad Street Walk-in Centre is closed at a time when A&E services cannot cope?

Cllr Worby (Chair, Health and Wellbeing Board) was equally concerned by the proposal to close Broad Street Walk-in Centre. Cllr Worby advised the HASSC that the Health and Wellbeing Board will be considering the proposal at its next meeting on 12 March 2013 and reporting the views of the Board back to the
Dr Mohi (Chair, B&D CCG) stated the Walk-in Centres are part of a bigger agenda for primary and urgent care. When patients visit the Walk-in Centres they are denied the holistic care that they would receive from their GP. It is important GP capacity is being properly utilised, currently the system is inefficient and not conducive to good care. The HASSC was assured that residents will get a better service under the new model. Furthermore, the changes to urgent and primary care will result in better value for money. Dr Mohi reminded the HASSC that the proposal was still under consultation and no firm decisions have been taken about the future of Broad Street Walk-in Centre.

- In light of with Lewisham's Hospital Trust, is there a possibility that BHRUT will be judged financially unviable and thus broken up? Will the Trust achieve Foundation Trust status?

No, the Trust is confident that it will recover its financial position. The Trust is meeting its deficit targets and is due to clear its £40 million deficit in 2 years’ time; this is part of a longer term 5 year financial plan. BHRUT believes that because of the strong levels of activity that pass through the Trust it will be able to achieve savings. Similarly the Trust is confident that it will achieve Foundation Trust Status. Although the Trust was not able to explain to members the implications of not doing so by the 2014 deadline set out in the Health and Social Care Act 2012.

- What does the CQC’s report mean for A&E services at King George Hospita?

The HASSC was advised that the A&E department of KGH will only be closed once there have been adequate assurances that Queen’s is safe. There is no timeframe associated with the closure of KGH A&E at this time; the closure is a gateway process whereby milestones must be achieved.
HEALTH AND ADULT SERVICES SELECT COMMITTEE
17 APRIL 2013

Title: Introducing Healthwatch Barking and Dagenham

Report of the Corporate Director of Adult and Community Service

Open For Information

Wards Affected: All Key Decision: No

Report Authors: Contact Details:
Ben Campbell, Adult Commissioning
Glen Oldfield, Democratic Services

Telephone: 020 8227 5796
E-mail: glen.oldfield@lbld.gov.uk

Accountable Divisional Director:
Glynis Rogers, Community Safety and Public Protection

Accountable Director:
Anne Bristow, Adult and Community Services

Summary:
The major thrust of the NHS reforms, along with clinically-led commissioning, is to make the NHS patient centered and to give citizens greater input into how the NHS is run. Healthwatch England and local Healthwatch organisations have been created as a consumer champion to represent the views of local residents. Healthwatch has specific functions to advocate and influence the delivery and commissioning of health and social care services on behalf of residents and its activities will drive improvements in health and social care services. Further to the establishment of Healthwatch Barking and Dagenham on 1\textsuperscript{st} April 2013, the report overleaf seeks to:

Part 1
- remind the HASSC of the functions of Healthwatch
- update the HASSC on the development of Healthwatch locally

Part 2
- suggest practical ways in which HASSC and Healthwatch might interact, or work collaboratively, taking account of the role and functions of both parties

Marie Kearns (Healthwatch Lead, Harmony House) has been invited to the meeting to give a short presentation introducing Healthwatch to the Select Committee. This paper serves as background information to the presentation.

Recommendation(s)
The HASSC is asked to:

- note the establishment of Healthwatch locally
- Give consideration to how the HASSC and Healthwatch might work together to fulfill those aspects of their remits which overlap
- Note that HASSC will not co-opt a representative from Healthwatch as it is a member of the Health and Wellbeing Board

### Background papers

- Healthwatch: New Ways of Involving the Public in Health and Social Care Services (LBBD, Cabinet, 26 June 2012)
- Local Healthwatch: A strong voice for people – the policy explained (Department of Health, March 2012)
- Local Healthwatch, health and wellbeing boards and health scrutiny: Roles, relationships and adding value (Centre for Public Scrutiny, October 2012)
- Establishing Local Healthwatch: Introduction and the Local Authority Role (Local Government Association)

#### 1. What is Healthwatch?

1.0.1 Healthwatch will be the voice of local people on health and social care issues reporting concerns and patient feedback to commissioners to influence the planning and delivery of health and social care. Healthwatch will act as a consumer champion and provide advice to help people to access and make choices about services and generally promote better health and wellbeing across the community.

#### 1.1 What are the functions of Healthwatch?

1.1.1 The functions\(^1\) of Barking and Dagenham’s local Healthwatch are as follows:

- Gather views and understand the experiences of people who use services, carers and the wider community
- Make people’s views known
- Promote and support the involvement of people in the commissioning and provision of local care services and how they are scrutinized
- recommend investigation or special review of services via Healthwatch England or directly to the Care Quality Commission (CQC)
- Conduct independent investigations, including Enter and View of health and social care premises
- Provide advice and information for local people about access to services and support for making informed choices
- Make the views and experiences of people known to Healthwatch England and providing a steer to help it carry out its role as national champion

---

\(^1\) as determined by the Health and Social Care Act 2012 and The NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012
• Make the views and experience of people known to the Health and Wellbeing Board and provide a steer in terms of local strategy and commissioning priorities
• Provide an independent expert voice on locally determined priorities and concerns
• Feed back to service users on changes or improvements that have come about through their engagement

1.2 Developing a local Healthwatch

1.2.1 Since being awarded the contract, Harmony House, the local provider for Healthwatch, has been preparing for launch. The preparatory work has included ensuring there are staff in place and resolving TUPE issues, setting up office facilities, developing a website, raising awareness with key stakeholders, recruiting a board and chair for Healthwatch and early stages of planning a launch event on 1 May 2013.

1.2.3 Marie Kearns, Chief Executive of Harmony House and lead for Healthwatch, will be attending the meeting to update further on the development of Healthwatch and its launch.

2. Crossovers with Health Scrutiny

2.0.1 Naturally the relationship between HASSC and Healthwatch Barking and Dagenham will develop and become defined over time as structures bed-in and Healthwatch grows into its role. However, recognising the synergies with Healthwatch, the HASSC might wish to be pro-active and take steps to ensure that its relationship with Healthwatch gets off to a good start, building on the legacy of LINks and seizing opportunities with regard to the new status, functions and responsibilities of Healthwatch.

2.0.2 The table below attempts to highlight where HASSC and Healthwatch crossover and the particular functions of Healthwatch that are relevant to the HASSC’s health scrutiny remit:

<table>
<thead>
<tr>
<th>Topic</th>
<th>HASSC Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work programming</td>
<td>To achieve alignment it might be in the interest of the Chair of the HASSC to meet the Healthwatch lead quarterly to share work programmes and horizon scan</td>
</tr>
<tr>
<td>Topic selection</td>
<td>In future years the HASSC may wish to invite recommendations from Healthwatch about areas for member-led scrutiny reviews and include provision for this in its topic selection process.</td>
</tr>
<tr>
<td>Referrals from Healthwatch</td>
<td>The HASSC should be prepared to accommodate referrals from Healthwatch, adjusting its work programme and agendas accordingly to respond in a timely fashion.</td>
</tr>
<tr>
<td>Enter and View</td>
<td>The HASSC may wish to keep oversight of Healthwatch’s programme of Enter and View inspections and receive findings of, and discuss, Enter and View visits at Select Committee meetings</td>
</tr>
<tr>
<td>Topic</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>-------------</td>
</tr>
<tr>
<td>Citizen involvement and engagement</td>
<td>The HASSC will want to be kept up-to-date with Healthwatch’s public engagement work as a means for the Committee to gather intelligence/local views about health/social care services. Also, where the NHS launches a consultation, the HASSC and Healthwatch may wish to work in partnership to collect views to inform their responses, targeting different groups to maximise coverage/reach.</td>
</tr>
<tr>
<td>Requesting information from NHS funded providers</td>
<td>The HASSC may wish to offer to use, on Healthwatch’s behalf, its enhanced powers to request information or attendance of relevant persons to answer questions.</td>
</tr>
<tr>
<td>Escalating matters</td>
<td>In a situation where HASSC felt obliged to escalate a matter to a higher authority (such as the National Commissioning Board, Care Quality Commission, Monitor, or the Secretary of State) it is recommended, in advance of doing so, that it shares its intentions with Healthwatch and allows sufficient time for Healthwatch to inform any submission from the HASSC. Where the HASSC and Healthwatch are seen to be on the same wavelength it is more likely that any concerns raised will be given more weight. Also, in some instances, through a co-ordinated approach the HASSC and Healthwatch may be able to broker necessary action to allay concerns at a local level by influencing the Health and Wellbeing Board and CCG.</td>
</tr>
<tr>
<td>Holding Healthwatch to account</td>
<td>Naturally the HASSC will have an interest in ensuring that the arrangements for local Healthwatch are effective and represent good value for money. The HASSC may wish to receive Healthwatch’s Annual Reports and use them as a tool by which to evaluate the effectiveness of Healthwatch’s activities for that time period passing any comments about the performance of Healthwatch to commissioners or through the portfolio holder for Health.</td>
</tr>
<tr>
<td>Receiving referrals</td>
<td>The power LINks had to make referrals to Overview and Scrutiny Committees is maintained and therefore the HASSC should be prepared to accommodate referrals from Healthwatch, adjusting its work programme and agendas accordingly to respond in a timely fashion.</td>
</tr>
</tbody>
</table>

2.1 Role on the Health and Wellbeing Board

2.1.1 Since May 2010 the HASSC has formally co-opted a LINk member onto the Select Committee as a measure to ensure good communication and the timely sharing of

---

2 Because of limitations of regulations, Healthwatch will be reliant on the Freedom of Information Act 2000 to get information from private providers that are in receipt of public funds. This could result in requests getting caught up in bureaucracy and unsatisfactory information being returned.
information between the LINk and HASSC. The co-option also served as a means of giving the LINk an additional platform from which it could bring local concerns to the attention of decision-makers and service providers. However, with the emergence of the Health and Wellbeing Board and Healthwatch’s full member status on that Board, formal co-option of a Healthwatch member to the HASSC will no longer be necessary.

2.1.2 The HASSC will still wish to invite representatives from Healthwatch as observers to participate in discussions but the HASSC will need to recognise Healthwatch’s position on the Health and Wellbeing Board and the impact this affiliation/alignment might have when discussing certain issues or when holding Healthwatch or the H&WBB to account.
This page is intentionally left blank
## Walk-in Centres in Barking & Dagenham: Consultation on Proposals to Close the Broad Street Walk-in Centre

### Report of the Corporate Director of Adult and Community Services

<table>
<thead>
<tr>
<th>Open</th>
<th>For Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wards Affected:</td>
<td>All</td>
</tr>
<tr>
<td>Key Decision:</td>
<td>No</td>
</tr>
</tbody>
</table>

**Report Author:**
Mark Tyson, Group Manager, Service Support and Improvement

**Contact:**
- Tel: 020 8227 2875
- E-mail: mark.tyson@lbld.ogv.uk

**Accountable Divisional Director:**
Glynis Rogers, Divisional Director, Community Safety & Public Protection

**Accountable Director:**
Anne Bristow, Adult and Community Services

### Summary:

Two reports concerning this subject precede this one:

- For the meeting of 12 December 2012, Members received a presentation on the Clinical Commissioning Group's (CCG’s) plans to make improvements to urgent care services;
- On 13 February 2013, Members received a pre-consultation draft of the business case for proposals to close Broad Street Walk-in Centre and to look at a new model for the delivery of out-of-hours primary care. Members discussed the consultation process, and requested that 12 weeks be provided in which to consider responses.

The consultation process began on 27 February 2013, and HASSC are now provided with the opportunity to discuss the proposals and raise questions with the Clinical Commissioning Group. Consultation closes on 21 May 2013.

HASSC asked that the Health & Wellbeing Board consider the proposals and provide a view for HASSC to take into account alongside its own review of the proposals; discussion took place at the Health & Wellbeing Board on 12 March 2013, and a summary of the views expressed is included in this report.
**Recommendation(s)**

1. That Members review the report, note the points of concern raised, including those raised at the Health & Wellbeing Board;

2. That Members review the questions raised in section 6 of the report, and take the opportunity to explore them with colleagues at the CCG, as well as raising any further queries that they may have with respect to the proposals and which they feel should shape their response;

3. Through the discussion, provide direction to officers in the preparation of a formal view on behalf of the Select Committee for submission to the CCG’s consultation process; and

4. Delegate to the Chair and Vice-Chair to jointly approve the submission to the formal consultation on behalf of the London Borough of Barking & Dagenham in time to meet the deadline of 21 May 2013.

---

1. **What are Walk-in Centres?**

1.1. Walk-in Centres operate in the middle-ground between GPs and A&E departments providing rapid access for patients to obtain advice, diagnosis and a limited range of treatments for minor ailments. Walk-in Centres feed into the wider complement of urgent care services by treating injuries and sickness that are not severe enough to warrant medical attention at A&E. They were introduced nationally in 2000, as part of measures to expand the range of access options for primary care.

1.2. The borough has two Walk-in Centres located at Broad Street (Dagenham) and Upney Lane (Barking). Both are co-located with other services and both are nurse-led services which are open 7 days a week. Broad Street is co-located with a GP practice. Upney Lane is part of the Barking Community Hospital site.

2. **Proposals that are under consideration**

2.1. The Clinical Commissioning Group, having reviewed options for retaining, remodelling or ceasing Walk-in Centre services, favours an option to retain and remodel Upney Lane whilst closing the Walk-in Centre at Broad Street.

2.2. In favour of that option, the consultation document notes four major points in the ‘case for change’:

   - Walk-in services do not encourage better health, since they discourage residents from visiting (or registering) with GPs who can provide continuous care over the longer term.
   - They do not provide the best care for many conditions, or the sort of preventive health services that a GP can provide.
   - They are part of an unnecessarily complex system of different options, including GPs, GP out-of-hours, urgent care centres and A&E.
They are expensive to run, and anything that leads to a risk that patients will turn up at multiple points in the system (because they haven’t got the right treatment in the first place) can lead to high costs per case for health services.

2.3. In addition, there are contractual issues which require a decision either way on the future of Broad Street. The contract expires in May 2013, and has been extended to October 2013 in order to accommodate, in part, the longer consultation period requested by the Select Committee in its February discussion. It is understood that no further extension is possible, and so re-procurement or alternative provision must be made by October.

2.4. Savings expected are of the order of £530,000 per annum. No reinvestment proposals with respect to this sum are made in the business case at this stage.

3. Response of the Health & Wellbeing Board

3.1. As requested by the Select Committee at its February meeting, the Health & Wellbeing Board, at its last meeting in ‘shadow’ form, considered the CCG’s proposals. The summary of those discussions is reproduced here. Further detail will be in the minutes of the Board when published. In summary, it is important to note that the Board were supportive overall to the direction of travel described in the business case; their concerns focused on the process and timescale, which did not satisfy all members of the Board as a robust plan to achieve satisfactory replacement services for Broad Street Walk-in Centre in time for its closure.

_Barking & Dagenham Shadow Health & Wellbeing Board, at their meeting of 12 March 2013, considered the CCG’s proposals for review of urgent care services and the closure of Broad Street Walk-in Centre._

_The Board noted the principles that underpinned the review, in particular the move towards GPs providing extended access to care. The Board recognised the benefits that this potentially brought, in terms of continuity of care, access to full medical records and more local access to services. As a direction of travel, the Board were broadly supportive of this approach._

_However, the specific proposals before the Board raised a number of significant concerns. Overall, it was felt that the timing of the closure of Broad Street Walk-in Centre did not provide sufficient time to establish the alternative model described above, particularly given that local residents regularly report difficulties in accessing GP services. The CCG acknowledged this, and stated that work was underway to address the issues. Nevertheless, some members of the Board considered that the necessary steps to be taken to get all GPs to deliver improved primary care access, as well as a consistent clustered extended care model were insufficiently detailed to assure some members of the Board._

_Without firm adoption of the new model, not only by GPs but in fact by the population at large, the loss of Walk-in Centre capacity (particularly in the_
east of the Borough) risks diverting people to A&E for minor urgent and out-of-hours care.

These risks appeared to be inadequately modelled, and this is compounded by the absence of geographical modelling of the current users of the Broad Street Walk-in Centre. Furthermore, analysis of the particular characteristics of users of the Walk-in Centres remained incomplete, with further details being required on the population immediately around Broad Street in terms of young children (under 5), older people, those with long-term conditions, as well as the working patterns of those using the centre, for whom out-of-hours provision may be essential to match their working lives. The proposals should also recognise the changing demography of the borough, particularly in respect of the rapidly rising numbers of young children. Understanding more clearly the potential gaps in service for groups such as these is essential, in the event that the transition to the new arrangements does not occur smoothly.

In summary, the Health & Wellbeing Board accepted, for the most part, the case for change and vision described. The Board remained unconvinced, however, that the plans (as described in business care) were credible and deliverable, and were therefore concerned that the closure of Broad Street Walk-in Centre would leave a gap in service provision for the east of the Borough, with the potential to add further pressure in the Accident & Emergency Department at Queen’s Hospital.

4. Analysis of the Business Case

4.1. The proposals are detailed in full in the CCG’s business case attached at Appendix 1, as well as the overview provided in the consultation document provided at Appendix 2. Both are essential reading to understand the proposals and their basis.

4.2. There are also two further reports on which the business case draws: a ‘patient audit’ by the CCG and a patient consultation survey by the Local Involvement Network, and these were included with the report to HASSC on 13 February 2013.

Profile of users of the service by demographic group

4.3. Patient Audit

The business case document relies on the patient audit undertaken by the CCG to describe the demography of the users of the Walk-in Centres, rather than drawing on any known or recorded characteristics of the users of the service from within their own management information. This audit used data for 640 patients, 242 at Broad Street and 398 at Barking Hospital. Different times of day were used for sampling, and the report suggests that there was no significant difference between the age profile of attendees at different times of day.
4.4. **Working-age attendances; during GP opening hours**

However, the demography is heavily skewed towards the working-age population, with around 70% of the survey sample in the age range 16-65, approximately 20% at ages 0-16 and then 5% over 65. Attendance times are, however, predominantly during the day (61% attending during GP core hours, and 59% for the cohort known to be ‘employed’), which is taken to suggest that Walk-in Centres are not necessarily catering for those needing an appointment outside of their own working hours. This appears to be based on a premise that working hours are Monday to Friday, 9am-5pm, and not the plethora of working patterns that we know exist in the borough. By simply being more flexible, Walk-in Centres help workers to deal with medical needs at relatively short notice and at the patient’s convenience, without having to balance time off work with the availability of a GP appointment.

**Throughput and use of the Walk-in Centres**

4.5. There were 62,000 attendances at Walk-in Centres during 2011/12. This is in excess of the 50,000 attendances at A&E during the period, and well in excess of Urgent Care Centre (12,000) or GP out-of-hours (15,650) use. These attendance figures divide roughly equally between Broad Street and Upney Lane.

4.6. **Residence of attendees**

In terms of residence, the audit/survey reported that 66% of the Broad Street attendees lived in Barking & Dagenham, 10% in Havering, 7% elsewhere ‘out of borough’, and 12% unknown. The highest numbers were in GP cluster ‘Locality 4’ (approximately 41% of Barking & Dagenham attenders), followed by GP cluster ‘Locality 2’ (approximately 22%). These figures would equate to an annual demand for around 8,400 GP appointments in Locality 4 and 4,500 in Locality 2.

4.7. **Blood sugar testing service**

Of the Walk-in Centre attendances, the business case notes that 8% were for blood sugar testing which is provided under the contract with Broad Street. These could, the business case suggests, be transferred to primary care, and this analysis assumes, though it is not clear from the document, that all of those blood sugar tests take place at Broad Street only.

4.8. **Referrals to A&E and potential for management in primary care**

Of the remaining 28,520 appointments at Broad Street, 8% required referral to A&E and 92% “could be managed appropriately within a primary care setting, or at home with self-care, or with advice from a community pharmacy.” This therefore confirms the view that there is no activity at Broad Street Walk-in Centre that could not be managed elsewhere, in particular predominantly in primary care. The 92% figure equates to 26,238 visits (based on 31,000 overall use of the Centre), and the analysis estimates two-thirds to be minor ailments (~17,490), with one-third being minor injuries (~8,745).

**Access to primary care services**
4.9. **Problems of access to primary care**
The business case emphasises the importance of primary care in better managing the demand that currently presents at the Walk-in Centre. However, it also notes that “it is clear from the survey/audit and from the GP patient survey that patients do not feel that they can always easily access their GP” and that this perception is driven by patients' “experience in trying to access their GP”. This would be backed up by the prevailing concerns expressed by Members, drawing on their contact with constituents. Local MPs have also reported to Members having this issue raised with them by constituents. It is an impression that is confirmed by a third of respondents to the LINks survey of Walk-in Centre users, who reported that they were at Broad Street Walk-in Centre because there were no appointments available at the GP.

4.10. **Lack of proposals to improve access to primary care**
However, the business case does not propose alternative actions to address these problems. The NHS Outer North East London Primary Care Strategy has been “recommended but not adopted by the CCG”, and the business case makes reference to the CCG “developing its own Primary Care Strategy”. It is therefore difficult at this stage to understand how the requisite improvement in the perception of access to primary care will be made in the period to October, when Walk-in Centre services would cease.

4.11. **‘Under-doctored’**
The business case repeats previously presented information confirming that the borough has lower than the average (and insufficient) numbers of GPs for the population. However, the analysis does not detail how this plays out for the area around Broad Street Walk-in Centre specifically, or provide any account of how this issue will impact on the proposals to transfer activity out of the Walk-in Centre. The Primary Care Strategy presented by NHS Outer North East London in January 2012 refers to this issue but is similarly unclear about solutions. The Walk-in Centre business case says that this Primary Care Strategy has been “recommended but not formally adopted” by the CCG and that they are developing their own primary care strategy. Given the reliance of the Walk-in Centre proposals on the enhancement of local primary care services, it may seem surprising that the local Primary Care Strategy is still awaited.

4.12. **Extended hours ceased**
It is understood that the National Commissioning Board has ceased the Locally Enhanced Service contract for extended hours for GPs across the borough. This service, which was the subject of Elected Member campaigning during 2011/12, was seen as a critical response to the issue of ‘under-doctoring’, as well as the flexibility needed in a low-wage economy where time off for a GP appointment can be costly for residents to arrange. Its loss, at a time when a Walk-in Centre is being considered for closure, is a further concern, and there appears to be no analysis of the impact of this on the capacity that would be needed to absorb patients no longer attending the Walk-in Centre.
4.13. **Analysis of local GP practice capacity to absorb redirected ‘business’**

It would be helpful to understand more fully the capacity available in the ‘GP cluster’ localities whose patients are most heavily using Broad Street. These are to be the principal recipients of the ca. 13,000 appointments identified in 4.6, above, that will divert from Broad Street. Factors which will affect this include:

- Proportions of single-handed vs. more ‘flexible’ group practices;
- Opening hours and services provided by practices;
- Patterns of patient requirements (employment, children in the household, caring responsibilities and other factors that drive desire for walk-in convenience);
- Geographical locations of practices, relative to transport routes and patient addresses, with relative ease of getting to Queen’s Hospital, King George Hospital or Barking Community Hospital compared to local GP.

Given that this analysis is not provided in the business case, information is being collated by officers and will be shared with Members to inform the final response to the consultation. Should Members have further questions or concerns relating to this which they would like to have investigated, feedback is welcomed by officers.

4.14. **The ‘111’ non-emergency NHS phone line**

The business case refers on a number of occasions to the development of the ‘111’ non-emergency number for health service information, including (as below) for patients not currently registered with their GP. However, there has been considerable national press coverage recently about problems with the reliability and capacity of 111. A representative of the British Medical Association went so far as to refer to “the ‘chaotic mess’ of the 111 service” that “was straining parts of the NHS that were already stretched, potentially putting patients at risk”. [Guardian, 28 March 2013]

4.15. **Unregistered patients**

Unregistered patients, based on the audit/survey data, form around 4% of the attendances at Broad Street Walk-in Centre. However, this is contrasted with previous data on unregistered patients attending Walk-in Centres that suggests a figure of 10%. Of the ca. 31,000 attendances at the Broad Street centre, this puts the number of unregistered patients in the range 1,240 - 3,100. There is no discussion about the likely behaviour of these patients in the absence of a Walk-in Centre option, and Members may wish to reflect on the likelihood that these patients, needing healthcare but not having immediate access to a GP, would choose A&E or Urgent Care Centres over the process of calling 111 and arranging registration with a local GP.

**East Dagenham Health Centre**

4.16. Sanofi-Aventis and their consultants have been in lengthy discussions over the past year with NHS North East London & City, on behalf of the Clinical Commissioning Group, regarding a health facility as part of the masterplan for their site. With Sanofi-Aventis leaving the site by the end of the year, they have indicated that NHS commitment will be required by June this year. The CCG have given approval to
develop an Outline Business Case and we are awaiting a timetable for this. At the
time of writing the developer for the site has been working with potential providers
on the design of the health centre. How the Centre will be funded is unresolved a
funding proposal is due to be considered by the CCG soon. A meeting of the East
Dagenham regeneration group took place on 9th April; the HASSC may wish to ask
the CCG for an update on the latest position.

However, with question marks still hanging over the East Dagenham Health Centre
and a lack of clarity about how primary care services will be developed at Broad
Street (see paragraph 4.27), provision of health services in the east of the Borough
remains a concern.

Patients’ preference

4.17. The suggestion that all activity could be managed elsewhere, particularly in primary
care rather than urgent care settings, would appear to overlook the patient’s view of
the provision, which they may see as simply more convenient than their GP.
Indeed, in the LINks survey, people being at Broad Street Walk-in Centre due to it
‘being more convenient’ were the largest single cohort of respondents (at just over
40%, closely followed by the 32% who reported that they couldn’t get a GP
appointment).

4.18. Walk-in Centres not intended to reduce demand on A&E
The business case reports that there is little evidence that Walk-in Centres reduce
demand in A&E, and indeed that that demand is rising. However, returning to the
original policy driver for the creation of Walk-in Centres it was not their intention to
reduce A&E demand. The original announcement by the then-Prime Minister cited
the need to create “a modern NHS that fits in with modern patterns of living and
working”, with the intention that Walk-in Centres did not “replace the highly valued
traditional family doctor services, but [added] to them, providing the convenient
access that some people need.” Without a clear model for the delivery of an
alternative - and the plan by which that will be achieved - this flexibility for local
residents would appear to be at risk.

Relationship to A&E

4.19. Overall increases in urgent care activity in line with population increases
The business case notes an overall increase in urgent care activity for the borough
over the period 2008-2012, drawn from the analysis that supports the CCG’s Urgent
Care Case for Change. This notes a 9.17% increase in all urgent care activity (A&E,
Walk-in Centres, Urgent Care Centres and GP out-of-hours) for the period from
2008 to 2012. However, this is not out of step with population increases for the
period, which are estimated by the GLA to be of the order of 10% (173,500 in 2008
rising to 191,400 in 2012).

4.20. Walk-in Centre clinicians’ views of appropriateness of A&E attendance
Of the (approximately) 8,745 attendances at Broad Street Walk-in Centre classed
as ‘minor injuries’ (see point 4.7), clinicians are reported as estimating that 29%
should have gone to A&E, although only 10% were actually referred there. The
4.21. **Conflicted view of potential unmanageable demand in primary care and A&E**

The business case rejects option 4 (closing Upney Lane Walk-in Centre as well as not re-procuring Broad Street) on the basis that “this option would be too disruptive a service change and would potentially cause a surge of additional pressure on primary care and other urgent care services”. However, the modelling included in the business case (page 36) seems to suggest that, from next year, not only will all of the activity at Broad Street be accommodated, but the activity at Upney Lane will drop to 24% of its former levels. Taken together, this would be the same as reducing activity at both Walk-in Centres to about 13% of current levels. It seems difficult to reconcile these two statements: redirection of 87% of all Walk-in Centre activity is not so far away from the cutting of both facilities, and raises the likelihood of a similar “surge in additional pressure” to that which, quite rightly, concerns the CCG.

4.22. **No provision at all made for diversion of attendees to A&E or Urgent Care**

On the basis of clinical assessment, the modelling assumes that, after removal of those numbers already being sent back to their GPs and those taking up blood sugar testing, only 7% of current activity at the Walk-in Centres would “continue to go to A&E” and only 2% to an Urgent Care Centre. That the business case contains no provision whatsoever for current attendees of the Walk-in Centre to choose A&E as an alternative, however inappropriate it might be deemed clinically, seems to stretch credibility. It is the case that A&E at Queen’s is expecting to see more patients in an Urgent Care Centre attached to the unit, in an attempt to minimise the pressure on the department, which also renders the 2% figure as difficult to accept. The analysis does not seem to recognise the reality of individuals’ decision-making, that there is a very real likelihood that A&E or an Urgent Care Centre would be a favoured option for many.

**Financial modelling**

4.23. **Savings planned**

The full-year effect savings for this proposal as given as £537,886 in year 1, £580,678 in year 2 and £626,182 in year 3, out of a total budget for Broad Street Walk-in Centre of £870,970. This implies an assumed cost in the region of...
£300,000 for activity that goes elsewhere in the system. It should be borne in mind that some of the costs of running the Centre will transfer to other services, for example the premises costs for those services occupying the space currently used by the Walk-in, so all of the difference is not strictly a cash saving back to commissioners.

4.24. Only limited financial modelling undertaken; risk of escalating costs from relatively small activity shifts to A&E/Urgent Care

The financial modelling undertaken does not include any alternative costs for those that transfer from Walk-in Centre to primary care, as they are already effectively ‘paid for’ in the contracting of GPs based on list size. However, the modelling (as noted above) does not make provision for significant diversions to other parts of the urgent care system. Some basic alternative costs for different scenarios are presented below. Given that no additional costs or savings result from variances in the attendance at GPs, these proportions (48% to an LBBD GP and 20% to an out-of-borough GP in the business case) have been omitted. All estimates are based on the removal of 24% of activity currently referred back to GPs, and 17% of blood test activity, from a baseline of 31,000 cases per year (basis of calculations is therefore 18,290 attendances assumed to divert).

### Scenario 1: The Business Case current estimation

<table>
<thead>
<tr>
<th></th>
<th>Percentage</th>
<th>Number</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendances at Upney Lane (£29 per case)</td>
<td>18%</td>
<td>3,292</td>
<td>£95,474</td>
</tr>
<tr>
<td>Other walk-in centres (£29 per case)</td>
<td>5%</td>
<td>915</td>
<td>£26,521</td>
</tr>
<tr>
<td>Urgent Care Centre (£75 per case)</td>
<td>2%</td>
<td>366</td>
<td>£27,435</td>
</tr>
<tr>
<td>A&amp;E (£100 per case)</td>
<td>7%</td>
<td>1,280</td>
<td>£128,030</td>
</tr>
<tr>
<td><strong>TOTAL COST</strong></td>
<td></td>
<td></td>
<td><strong>£277,459</strong></td>
</tr>
</tbody>
</table>

### Scenario 2: All unregistered patients (ca. 2,000 at midpoint of estimates) divert to A&E & UCC

<table>
<thead>
<tr>
<th></th>
<th>Percentage</th>
<th>Number</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendances at Upney Lane (£29 per case)</td>
<td>18%</td>
<td>3,292</td>
<td>£95,474</td>
</tr>
<tr>
<td>Other walk-in centres (£29 per case)</td>
<td>5%</td>
<td>915</td>
<td>£26,521</td>
</tr>
<tr>
<td>Urgent Care Centre (£75 per case)</td>
<td>7%</td>
<td>1,366</td>
<td>£102,435</td>
</tr>
<tr>
<td>A&amp;E (£100 per case)</td>
<td>12%</td>
<td>2,280</td>
<td>£228,030</td>
</tr>
<tr>
<td><strong>TOTAL COST</strong></td>
<td></td>
<td></td>
<td><strong>£452,459</strong></td>
</tr>
</tbody>
</table>

### Scenario 3: All unregistered patients (ca. 2,000) PLUS all those deemed clinically appropriate (29% of caseload) divert to A&E & UCC, with assumed 20% overlap

<table>
<thead>
<tr>
<th></th>
<th>Percentage</th>
<th>Number</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E (£100 per case)</td>
<td>12%</td>
<td>2,280</td>
<td>£228,030</td>
</tr>
<tr>
<td>Attendances at Upney Lane (£29 per case)</td>
<td>18%</td>
<td>3,292</td>
<td>£95,474</td>
</tr>
<tr>
<td>Other walk-in centres (£29 per case)</td>
<td>5%</td>
<td>915</td>
<td>£26,521</td>
</tr>
<tr>
<td>Urgent Care Centre (£75 per case)</td>
<td>10%</td>
<td>1,831</td>
<td>£137,295</td>
</tr>
<tr>
<td>A&amp;E (£100 per case)</td>
<td>15%</td>
<td>2,745</td>
<td>£274,510</td>
</tr>
<tr>
<td><strong>TOTAL COST</strong></td>
<td></td>
<td></td>
<td><strong>£533,799</strong></td>
</tr>
</tbody>
</table>

This approach to modelling highlights how financially fragile the business case is, with relatively small shifts in activity towards urgent care and A&E generating significant costs and eating into the proposed savings. Even on the basis of this relatively crude modelling, scenario 3 suggests that the total cost of the alternative activity represents around two thirds of the cost of running Broad Street Walk-in Centre.

**Premises considerations**

4.25. **Building history**
The building that houses Broad Street Walk-in Centre opened in May 2005 and was a flagship project of the Barking & Dagenham ‘Local Improvement Finance Trust’ (LIFT) programme, essentially a public-private partnership for the construction or refurbishment of health facilities. It was in an ‘early wave’ of LIFT development, and was built at a cost of £3.5m.

4.26. **Assessment of the site**
The site itself, according the analysis in the business case, is considered to be a poor contender for any further consolidation of services compared to, for example, Upney Lane. Problems are cited around parking, the opportunity for primary care expansion and value for money (on a cost-per-square-metre basis).

4.27. **Mixed uses; no alternative proposals for premises**
The site overall is just under 2,000m$^2$. The full facility contains the Walk-in Centre, alongside a GP practice and the Older Persons Community Mental Health Team operated by North East London Foundation NHS Trust (which includes the memory clinic, older person’s day hospital and young onset dementia clinic). There are no proposals to reduce or close those other services, only the Walk-in Centre. The business case suggests (but doesn’t explicitly confirm) that the move of the Walk-in Centre would provide opportunity to expand the GP practice, which currently stands at a list size of 4,795 (Oct 2012) against an initial planned size of 8,000.

5. **Progress on the Consultation**

5.1. Barking & Dagenham CCG have provided an update on progress on the consultation, which is attached at Appendix 3. This provides an overview of the process, and Members may wish to note in particular a further consultative event taking place on 23 April 2013, from 3-7pm at Dagenham Library.
6. Conclusion and questions Members may wish to consider

6.1. The sense from the discussion at the Health & Wellbeing Board, and from the analysis presented in this report is that this is one half of a proposal. Whilst the alternative proposed is deemed to be a sensible aim to work towards, i.e. that GPs cluster and urgent appointments are provided at whichever practice has the capacity at the time. However, the overriding concern remains that this will take a lot longer to develop and implement than is allowed for in the extension of the Walk-in Centre contract to October. In October, it is feared that the Walk-in Centre will close, problems of access (and/or the perception of problems of access) to a GP will remain, and that activity will divert instead to urgent care centres or A&E at Queen’s Hospital. This would not be clinically appropriate, but would fit with the current expectations of Walk-in Centres that they provide flexibility and responsiveness, as an open-access service.

6.2. Undoubtedly, the analysis presented here is based on only that information that is readily accessible, through the Business Case and related documents published by the CCG. Nevertheless, it raises a number of questions which Members may wish to explore with the CCG as a way of allaying some of the concerns that the proposal appears to raise. These include:

- What analysis has the CCG done of the capacity in the specific GP practices likely to be affected (cluster 2 and 4), and where do they anticipate there being initial teething problems?
- What are the specific steps that the CCG will take between now and October to ensure that:
  - Current perceptions of the problems of getting a GP appointment are addressed; and
  - Specific issues with on-the-day appointments and timely in-advance appointments, where known about by the CCG, are addressed to ensure that provision meets public expectations in the absence of a Walk-in Centre?
- If there is ‘spare’ capacity in GP surgeries to accept the redirection of Walk-in Centre activity:
  - Why are there perceptions of problems with access to services in a timely fashion; and
  - Why are reports indicating that the borough is ‘under-doctored’, when there is alleged to be spare capacity that should be utilised?
- Given the national problems with the rollout of 111, how are the CCG going to ensure that people phoning for a GP appointment get clear and timely information about the urgent care options available to them through the new cluster model that will replace the Walk-in Centre?
- What is the impact in the removal of extended hours provision on these proposals, and are the CCG confident that the ‘double-whammy’ of extended hours and Walk-in Centre closure can be absorbed into core GP capacity?
- If there is to be additional capacity created through any special additional services (akin to the extended hours service that used to be funded over and above the national GP contract), what are the likely levels of investment?
○ If such investment is planned, it will be to the benefit of local primary care services, and in which case, have the issues of pecuniary interest on the part of GPs making the decisions been considered?
• Accident & Emergency services at Queen’s Hospital are already under considerable pressure. The business case makes incredible claims that no additional diversion of activity to A&E will occur, which is in conflict with Walk-in Centre clinicians’ assessment. What is the CCG putting in place to mitigate the flows through to Urgent Care and A&E?
  ○ What is the financial impact of these assumptions being incorrect and what modelling and prediction is being done? Is this being managed through the CCG’s risk register, and are the risks therefore quantified?
  ○ Has this been raised with BHRUT and other interested parties, including formally through such mechanisms as the Integrated Care Coalition, and what is their response?

7. Appendices

Appendix 1: Business Case for closure of Broad Street Walk-in Centre

Appendix 2: Consultation document for the closure of Broad Street Walk-in Centre

Appendix 3: Update from Barking & Dagenham CCG on the consultation process for the closure of Broad Street Walk-in Centre
This page is intentionally left blank
Walk-in Centres in Barking and Dagenham
A pre-consultation business case

January 2013

Version 1.0 final
## Contents

<table>
<thead>
<tr>
<th>A</th>
<th>Introduction</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Executive Summary</td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td>Introduction and overview</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>National and local context</td>
<td>8</td>
</tr>
<tr>
<td>4</td>
<td>Summary and recommendations from studies</td>
<td>12</td>
</tr>
<tr>
<td>5</td>
<td>Engagement feedback</td>
<td>16</td>
</tr>
<tr>
<td>6</td>
<td>Decision to consult</td>
<td>17</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B</th>
<th>The case for review of the walk in centres</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Current provision (Market analysis)</td>
<td>19</td>
</tr>
<tr>
<td>2</td>
<td>Assessment of benefits</td>
<td>26</td>
</tr>
<tr>
<td>3</td>
<td>Cost / benefits analysis</td>
<td>27</td>
</tr>
<tr>
<td>4</td>
<td>Options appraisal</td>
<td>29</td>
</tr>
<tr>
<td>5</td>
<td>Key assumptions and dependencies</td>
<td>35</td>
</tr>
<tr>
<td>6</td>
<td>Resource Requirements and Cost</td>
<td>38</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C</th>
<th>Recommendations and next steps</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Recommendations</td>
<td>39</td>
</tr>
<tr>
<td>2</td>
<td>Timescales</td>
<td>39</td>
</tr>
</tbody>
</table>

### Appendices

<table>
<thead>
<tr>
<th>A</th>
<th>Walk in centre audit report</th>
<th>Attached</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>Walk in Centre patient survey report</td>
<td>Attached</td>
</tr>
<tr>
<td>C</td>
<td>Stakeholder summary</td>
<td>Attached</td>
</tr>
<tr>
<td>D</td>
<td>Risks and sensitivity analysis, comments and issues</td>
<td>To be tabled</td>
</tr>
<tr>
<td>E</td>
<td>Case for change detailed report</td>
<td>Not attached</td>
</tr>
<tr>
<td>F</td>
<td>Equalities impact assessment</td>
<td>Not attached</td>
</tr>
<tr>
<td>G</td>
<td>Commercially confidential information</td>
<td>Attached in CCG version only</td>
</tr>
</tbody>
</table>
A. Introduction

1. Executive summary

In its Commissioning Strategic Plan for 2012-15, Barking and Dagenham Clinical Commissioning Group (The CCG) committed to developing an Urgent Care strategy as well as “a wider review of the Polyclinics and Walk in Centres to ensure that the development of the cluster wide model for urgent care is reflected in the future provision of these services.”

The CCG has been leading a review of options for walk in services at Broad Street in Dagenham and Upney Lane at Barking Community Hospital in Barking. The CCG believes the current services could better meet the health needs of local people and is considering a number of alternatives.

A number of studies of the walk centres have been undertaken to understand their use better. Results, together with financial and cost benefit analysis, are set out in this pre-consultation business case:

a. A patient survey to ascertain patients’ reasons for using the walk in centres
b. An audit led by clinicians to identify the clinical reasons for use and follow up
c. Stakeholder engagement meetings to understand patients’ views on all proposals for improving urgent care services
d. Future activity modelling.

The audit and survey of the walk in centres has provided evidence of the reasons why people use them. The results show that clinically, most people attend for conditions which require primary care/self care/community pharmacy support only. In terms of patients’ motivations, many attending the walk in centres are not satisfied with access to their GP or primary care and some feel it is easier to access the walk in centres than their GP. There is a significant proportion of activity which takes place when GPs are not open for face to face appointments but have arrangements for a GP out of hours service in place.

The CCG is seeking to maximise the chances of all Barking and Dagenham residents registering with and accessing health services through their GP practice as a first point of contact, including for urgent primary care. This would mean that patients receive the associated benefits from GP registration including preventative care and health promotion, health check services and continuity of care. Patients who are unregistered or unsure about their registration would be able to access the new telephone number 111, going live in February 2013 and be supported to register with their local GP.

The CCG is also seeking to improve value for money for its urgent care and assessment of the cost and benefits of the walk in centres and alternative services is included.

This walk in centre review is part of this ambition and a wider Urgent Care Strategy is in development, through which the CCG will also consider how patients access other urgent services in hours, out-of-hours and extended hours primary care, community pharmacies, community services and integrated care. The Strategy will also include, in due course, integration with the 111 telephone number, urgent care centres, accident and emergency departments (A&Es) and the ambulance service.

The CCG is also developing and piloting ways of delivering a number of health services through a Localities Model, where GP practices come together to provide services in their area. A pilot in 2013 will explore collaborative ways of working to deliver primary urgent care.
Combined, these proposals are expected to improve the health benefits of the population of Barking and Dagenham and improve equity of access by increasing consistency of the health service offer from more locations in the community.

Proposals meet ‘the four tests’ of reconfiguration as they: are fully supported by the CCG and GP practices; have involved meaningful engagement in the planning stages; are supported by a clear evidence base and are in line with national guidance regarding patient choice.

Depending upon the preferred option(s) to be further explored, there may be a period of public engagement/consultation. This would commence in February 2013 for a period of 6 weeks. This business case summarises the detailed findings of a number of supporting documents which act as appendices and can be accessed at: http://www.barkingdagenhamccg.nhs.uk/

2. Introduction and overview

The evidence from the studies of the walk centres set out in this business case suggests that:

Clinical demand for walk in services is driven by primary care need - most people attending the walk in centres require primary care, self-care or community pharmacy support

Clinical urgency of need: patients attending the walk in centres considered they had an urgent need to be seen that day - urgency defined by the fact they are motivated to go to the centres. Clinical views on urgency of attendance indicates that a fair proportion of attendances were not considered urgent /requiring same day treatment

Access to primary care: people who use the walk in centres are not satisfied with access to their GP or primary care for various reasons (opening hours, attitudes of staff, etc). Some people feel that walk in services are easier to access than their GP. There is a significant proportion of activity that is during the period that GPs are not routinely available (although other services such as out of hours GPs are).

Demand for urgent services: the walk in data and other information about activity and cost indicates that urgent care activity continues to increase and therefore expenditure is increasing. This increased expenditure on urgent care services is not linked to improvement in patients’ health outcomes.

The CCG response

The CCG believes that it is better for people to receive primary care services from the GP practice that they are registered with, or to be supported to register if they are unregistered. The CCG strategy is to increase capacity in general practice and to ensure need is met for:

- Improvement to access to primary care
- Reduction in duplication of services
- Improvement in value for money for our urgent care

A new service model for primary care, the localities model, is proposed to deliver these improvements. This model will need to provide urgent care services and will incorporate primary care urgent care activity that is currently provided by the walk in centres. Options to deliver the model are set out in this business case with the rationale for how all urgent
unplanned care will be provided by and within existing general practice providers/locations wherever possible, with proposals to retain one walk in centre and redefine its service.

There are four options for the walk in services at Broad Street in Dagenham and Upney Lane in Barking. The case for all options is set out below including:

- The service location considerations and implications for the different sites
- The service model options and their impact on patient activity indicating alternative services to respond to patient need
- The financial implications including additional investment required or financial savings achieved to March 2016.
- The commissioning implications for the CCG and the National Commissioning Board.

The CCG has taken delegated responsibility for commissioning urgent care, including commissioning of the walk in centre contracts. The proposals are clinically led and support the delivery of the vision and objectives of three key programmes for Barking and Dagenham:

- The Urgent Care Strategy
- Primary Care Strategy
- The development of a Localities Model

A summary of these strategies is set out in the National and local context in Section 3 below.

2.1. Primary urgent care

The focus of this business case is the walk in centres in the context of the following primary urgent care services in Barking and Dagenham:

- In hours, out-of-hours and extended hours primary care
- Community pharmacies
- Community services
- Integrated care
- Walk-in centres
- Integration with:
  - The 111 telephone number
  - Urgent care centres (community and attached to A&Es)
  - Accident and Emergency departments (A&Es)
  - The Ambulance service.

2.2. The walk in centres

National context

A defining characteristic of a walk in centre is that it treats at least minor injuries and illnesses (sprains for example) and can be routinely accessed without appointment\(^1\).

\(^1\) [http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh_129783.doc](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh_129783.doc)
They act "as a complementary service to traditional GP and A&E services and some walk in centres offer access to doctors as well as nurses. However, they are not designed for treating long-term conditions or immediately life-threatening problems."

There are around 92 centres nationally dealing with minor illnesses and injuries, treating around 3 million patients a year.

Walk in centres are not, however, a "nationally mandated" policy by the Department of Health. They are rapidly closing across the country, with figures recently suggesting a quarter have closed in the past year.

Walk in centres were established under two national programmes:

In 1999 the Department of Health authorised funding for a pilot scheme of 40 NHS walk-in centres in 30 towns and cities across England. The overall aim of walk-in centres was to improve access to high quality health care in a manner that is both efficient and supportive of other local NHS providers. It was hoped that the centres will complement other primary care initiatives such as NHS Direct, playing a major part in the government's commitment to modernise the NHS.

Equitable Access to Primary Medical Services established centres which met the criteria of GP Lead Health Centres, defined as opening hours of 8am to 8pm, 365 days per year; accessible for registered and unregistered patients; offering bookable and walk-in appointments and operating as a GP-lead service.

Local context

There are two walk in centres in Barking and Dagenham: Broad Street Medical Practice and Walk-in Centre and Upney Lane Walk in Centre at Barking Community Hospital. These walk in centres are three miles apart or 11 and 20 minutes travel by car and public transport respectively. Both are nurse led services which are open 7 days a week. Each walk in centre sees patients living in Barking and Dagenham and some who live outside the area.

Broad Street Walk in Centre, set up at its current location in May 2006, as a GP led Health Centre integrated with a Medical Practice. It provides a minor ailments and injuries service in Dagenham. Upney Lane Walk in Centre, co-located at the Barking Community Hospital in February 2012 having moved from the former Upney Lane Clinic building, provides a minor ailments and minor injuries service in Barking.

A snapshot of the current walk in service provision is set out in Table 1 below:

---

2 [http://www.nhs.uk/NHSEngland/AboutNHSservices/Emergencyandurgentcareservices/Pages/Walk-incentresSummary.aspx](http://www.nhs.uk/NHSEngland/AboutNHSservices/Emergencyandurgentcareservices/Pages/Walk-incentresSummary.aspx)
3 As above
5 [http://www.ncbi.nlm.nih.gov/pmc/articles/PMC65536/#B1](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC65536/#B1)
6 All travel times provided by googlemaps.co.uk
7 [http://broadstreetwalkincentre.co.uk/](http://broadstreetwalkincentre.co.uk/)
2.3. Walk in usage

The two walk in centres in Barking and Dagenham had approximately 62,000 attendances in total last year (2011-12). An analysis of patient activity over four years to (2011-12) showed that activity increased across all points of urgent care access increased by an average of 9%. Walk in centre increases in use over that period were lower as in the graph below:

### Table 1: Summary of current walk in services

<table>
<thead>
<tr>
<th></th>
<th>Broad Street Medical Practice and Walk-in Centre</th>
<th>Upney Lane Walk in Centre</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Opening times</strong></td>
<td>Mon-Fri 7am-10pm Sat-Sun 10am-6pm</td>
<td>Mon-Fri 7am-10pm Sat-Sun 9am-10pm</td>
</tr>
<tr>
<td><strong>Location</strong></td>
<td>Morland Road, Dagenham, RM10 9HU</td>
<td>Barking Community Hospital Upney Lane, Barking IG11 9 LX</td>
</tr>
<tr>
<td><strong>Provider</strong></td>
<td>Care UK</td>
<td>NELFT</td>
</tr>
<tr>
<td><strong>Contract</strong></td>
<td>An APMS contract</td>
<td>Part of the Community Service Contract</td>
</tr>
<tr>
<td><strong>Activity</strong></td>
<td>Approximately 80 patients a day or 560 patients a week</td>
<td>Approximately 80 patients a day or 560 patients a week</td>
</tr>
<tr>
<td><strong>Service type</strong></td>
<td>Minor ailments and minor injuries Nurse led with health care assistants and a doctor available at co-located health centre.</td>
<td>Minor ailments and minor injuries Nurse led with emergency care practitioners and a doctor available</td>
</tr>
<tr>
<td><strong>Service inter-dependencies</strong></td>
<td>Co-located with a GP practice and provides complex care to Park View Care Home residents</td>
<td>Co-located at Barking Community Hospital</td>
</tr>
<tr>
<td><strong>Diagnostic Equipment</strong></td>
<td>No diagnostic equipment</td>
<td>X-ray equipment</td>
</tr>
<tr>
<td><strong>Age Exclusions</strong></td>
<td>Children under 2 years</td>
<td>None</td>
</tr>
</tbody>
</table>
More detailed information on the walk in centres is set out in Section B2 below.

3. National and local context

A summary of the national and local policy context is set out in this section.

3.1. National context

a. Department of Health Urgent Care
b. The Royal College of GPs Urgent care
c. PC Foundation re urgent care: “Breaking the mould”
d. RCGP Federated Primary Care

a. Department of Health: Urgent Care

The Department of Health defines Urgent Care as “The range of responses that health and social care services provide to people who require (or perceive the need for) urgent advice, care, treatment or diagnosis” - Direction of Travel for Urgent Care, Department of Health.

b. The Royal College of GPs Urgent care

The CCG wishes to develop its strategy in line with guidance for commissioning integrated urgent and emergency care a whole system approach (Dr Agnelo Fernandes, August 2011) to commission coherent 24/7 urgent care services with greater consistency, improved quality and safety, improved patient experience, greater integration and better value. The system needs to support easy and appropriate access to the right level of service and provide responsive services for children, frail older people and those with mental health needs that integrate effectively with primary, community and other services designed to keep people well and out of hospital.

Current patterns of service for 999 ambulance, A&E and specialist care for emergencies/more complex cases would remain – the focus is on making sure this level of care is targeted for patients in need.

c. Primary Care Foundation re urgent care

Breaking the mould without breaking the system provides new ideas and resources for clinical commissioners on the journey towards integrated 24/7 urgent care. It provides six central themes to consider:

- Build care around the patient not the existing services
- Simplify an often complicated and fragmented system
- Ensure the urgent care system works together rather than pulling apart
- Acknowledge prompt care is good care
- Focus on all the stages for effective commissioning
- Offer clear leadership across the system, while acknowledging its complexity

d. RCGP Federated Primary Care

The Royal College of GPs has developed a toolkit\(^{10}\) for the development of **federated Primary care**. This provides a useful checklist for the piloting and future development of GP localities.

3.2. Local context

Providing better access to and quality of primary care means that people will be able to access the services of their GP as their first port of call. If people do, the need for other urgent care including A&E visits could decrease.

As described in the Case for Change, the need to review urgent care services has been recognised by the CCG and others locally:

**Agreed strategies**

a. Health for north east London  
b. Barking and Dagenham Health and Wellbeing Strategy 2012-15  
c. Barking and Dagenham Commissioning strategy plan 2012-15, underpinned by the Joint strategic needs assessment  
d. The Draft Primary Care Strategy 2012-17\(^ {11}\)

**Emerging strategies**

  e. The Urgent Care Strategy  
  f. The Primary Care Localities Model  
  g. Extended hours

a. **Health for north east London**

The joint committees of the seven PCTs, including Barking and Dagenham, approved the Health for north east London clinician endorsed vision and recommendations.\(^ {12}\)

Decisions were made:

- To reduce the number of hospitals in north east London providing traditional A&E and acute medical surgical and paediatric care from six to five
- To reduce the number of hospitals in north east London providing maternity birthing services from five
- To provide a 24/7 urgent care centre at King George Hospital.

b. **Barking and Dagenham Health and Wellbeing Strategy 2012-15**\(^ {13}\)

The Strategy sets out how the council, the NHS and other organisations aim to prevent, protect, improve and personalise services to:

- increase the life expectancy of people living in Barking and Dagenham

\(^{10}\) [http://www.rcgp.org.uk/pdf/Toolkit_Content_Final.pdf](http://www.rcgp.org.uk/pdf/Toolkit_Content_Final.pdf)  
\(^{11}\) See status in Section d below  
• close the gap between the life expectancy in Barking and Dagenham and the London average
• improve health and social care outcomes through integrated services

Our plans aim to deliver the ambition of the Health and Wellbeing Strategy: “More children and families have access to urgent care community services which meet their needs.”

c. Commissioning Strategy Plan 2012-15

In this Plan, Barking and Dagenham CCG identified urgent care as a priority area for improvement and particularly highlighted the requirement to:

• increase productivity and move care and services closer to people’s homes
• reduce variation in performance across providers
• reduce inappropriate use of A&E
• deliver high quality, equitable and value for money care from fit for purpose estate

d. The DRAFT ONEL Primary Care Strategy

NHS Outer North East London (ONEL) produced a strategy and development plan for primary care services in outer north east London from 2012 to 2017: “Achieving excellence in our primary care”. This has been recommended to but not formally adopted by the CCG. The CCG will take the ONEL strategy into account as well as the proposals for the localities model when developing its own primary care strategy.

Its aim was to ensure that primary care services are:

• High quality and equitable primary care improving outcomes
• Provided from fit for purpose estate
• Representing value for money to our residents.

Primary care premises development principles are also set out in Section B1 1.5.

e. The draft Urgent Care Strategy

A Case for Change sets out the CCG’s reasons for considering changes to the current Urgent Care system. It is intended as a discussion document with which to engage stakeholders in developing a local urgent care strategy which transforms the quality of services in the borough. The Urgent Care Case for Change can be read in full at: http://www.barkingdagenhamccg.nhs.uk/BarkingAndDagenhamNews/urgent_care.htm (Appendix E)

The aim is: “to ensure patients and the public have access to convenient, high quality, timely and cost effective urgent and emergency care services and know how to access these services effectively”.

The principles for an urgent care service are:

- No confusion of what to do, who to call or where to go
- A joined up and co-ordinated urgent and emergency care system
- Consistent, responsive and high quality service
- A consistent, standard offer throughout Barking and Dagenham.

f. The draft Primary Care Localities Model

The aim is “A new delivery model to ensure that urgent care is integrated into primary care and alongside the local integrated care model, making general practice the first port of call for all patients with urgent care needs.”

This means localities of GP practices working together more effectively to best meet the needs of their patients and local population. This includes more effective local co-ordination of community and specialist services.

Key objectives:

- Improved urgent care
- Improved management of planned care including referrals to secondary care
- Greater integrated care, supporting the integrated care service model

End state principles: services which are:

- Designed around the needs of the patient
- Designed around a locality of GP practices with primary care at the heart of service delivery
- Integrated within the health economy.

Design principles:

To achieve the above:

- Develop a consistent, standard offer throughout Barking and Dagenham and within each of the six clusters/localities
- Deliver a primary care network: initially working through the existing six clusters to develop a localities-based urgent primary care model
- Consider options for provision for urgent general practice in: a) core hours, b) extended hours c) walk in centre opening times on weekdays and weekends
- Consider (the baseline of activity and) provision for the CCG as a whole in the first instance, then at cluster level, with the starting point for options for localities options observing the integrated case management (ICM) approach of site and provider neutrality.

A pilot will be delivered early in 2013 in one of Barking and Dagenham’s six localities. This will be evaluated in Spring 2013.

g. The draft Primary Care Localities Model and Extended hours – a case study

Extended Hours in general practice run in the week and at weekends. They were introduced to:

- Improve patient satisfaction with opening hours
- Increase primary care workforce and access
- Potentially reduce A&E and walk in centre attendances.
Due to changes in commissioning arrangements in 2013, the CCG has to consider the options for re-commissioning certain local services provided by General Practice. This could be used as an opportunity for improvement. Services commissioned to meet the PCT’s requirements could be redesigned to meet the needs of the local population in line with the CCG’s key priorities.

The table below shows how the extended hours service could be modelled to ensure better patient access to primary care, regardless of where they are registered:

<table>
<thead>
<tr>
<th>Current State</th>
<th>Desired State</th>
</tr>
</thead>
<tbody>
<tr>
<td>No relation between extended hours and primary care access, variance in appointment price.</td>
<td>Agreed baseline for access, and standard costs for additional appointments.</td>
</tr>
<tr>
<td>Practices work in silos to meet the needs of their population.</td>
<td>Practices to use locality working to maximise primary care provision to patients</td>
</tr>
</tbody>
</table>

4. Summary and recommendations from studies

A summary of the findings and recommendations from recent local studies in relation to the walk in centres is set out in this section.

In 2011, a study of urgent care activity for Barking and Dagenham residents was carried out at:

- The Out of Hours service
- Walk in centres at Broad Street and Upney Lane as well as for B&D patients attending the neighbouring Loxford polyclinic
- The urgent care centres at King George and Queen’s Hospitals
- Accident & Emergency at King George and Queen’s Hospitals

The results are summarized in Table 2 and Section B1.1.1 below

4.1. The patient survey

Barking and Dagenham LINk was commissioned by the CCG to do a patient survey to understand patients’ views in November 2012, at the same time as a patient audit. The following is a summary of “points to note” in the survey report at Appendix D. Patients who use the walk in centres tend to have lower than Borough average satisfaction with Primary Care.

Key findings

Convenience and proximity to the centres played the largest part in patients’ reasons for attending, with lack of access to their GP the second most common reason. In addition,
approximately 40% of people had stated they, or a member of their family, had attended the walk in centre more than once in the 6 months prior to the audit.

- In deciding to use the Walk in Centres, a significant number of patients said that:
  - They were not able to get an appointment with their GP
  - They went because the services are convenient and close to where they live.

- Patients who were not satisfied with booking appointments to see their GP gave the reasons such as they were not able to get an appointment outside of normal working hours and at weekends; long waiting times for appointments, considered front line staff impolite and felt that their GP was not interested in them or their health problem

- Most patients did not need an interpreter, however for those who might there are no notices or information that interpreting services could be made available at either walk in centre. LINk advises that this be addressed and pro-actively promoted.

- Half (50%) of people who used the walk in centres were either in employment or self-employed. The LINk suggested their use by employed people could be linked to accessing GP services and the walk in centres being open for longer hours, enabling the individuals to access health services around their working hours, however nearly two thirds used them during GP core or extended hours:

  **Walk in centre attendees in employment**
  - 59% of the employed people who used the WIC used the service during GP core hours, being 08.00 – 18.30 Monday to Friday
  - 12% of the employed people who used the service during GP extended hours
  - 29% used the service when neither of the above were open.

**Telephone follow up interviews**

The majority of patients interviewed by phone after their consultation:

- Felt that their health issue was correctly diagnosed (irrespective of whether it was advice only, active treatment or referral). In addition, the majority felt they had received enough information about their health condition.
- Were happy with the treatment and information they were given regarding their health condition, however some patients intended to go elsewhere for a second opinion, including to A&E.
- Would use the same Walk in Centre again for a different health problem.
- Thought that they did not have to wait too long to be seen.

**4.2 The audit**

The CCG and walk-in centres' carried out an audit to understand patients' health needs at the same time as the patient survey above, to seek information on:

- Patterns of walk in centre use including seeking help before using the centres
- The medical reasons why people use the walk in centres
- The clinicians’ diagnosis, active management and referrals
- Permission to use their NHS number to do further research. This will be used in further analysis and modelling to inform final commissioning decisions.
Who patients are (demographics)

The services are mostly used by working age adults and people in their late teens, and therefore, users are not representative of the local population in terms of age. With regard to ethnicity, there is no disproportionately represented ethnic group and patients attending reflect the general population.

Patient use

61% of patients attend the walk in centres during core GP opening hours and 13% during extended GP hours. 30% of patients attended outside these hours when general practices were not open – either in core or extended hours.

Clinical evidence

A large proportion of the patients could be managed in primary care (GP and pharmacy) and a small proportion (8%) needed A&E care. As much of the usage was within core GP hours it indicates there is an issue about duplication of services and parallel provision where the patient may choose the nearest service.

The majority of cases were appropriate to be managed by patients themselves through self care, using community pharmacy or in a primary care setting. The majority of attendances were for minor injuries and ailments, with the most common diagnoses for both walk in centres being:

1. Injuries (including cuts, fractures and dressings) 31%
2. Respiratory conditions 22%
3. Skin related ailments (including infections) 13%
4. Reproductive and urinary 10%
5. Ear & eye related ailments 7%

Active management and referral

Approximately one third of patients that attended the walk in centres received advice only and were not actively managed or referred elsewhere. A greater percentage of patients who attended Broad Street were actively managed or referred compared to those attending Upney Lane:

A breakdown of the clinical services to which patients were referred is set out in Appendix A. This has informed the clinical modelling and consideration of duplication of services in the options appraisal in Section B4.
This means 33% of patients attended and received advice only, in other words, no active treatment at the walk in centre or any referral to another service. This may reflect the capacity of the professional available and pathways for common ailments within the walk in centres. It also suggests that with no active input, a walk in centre may not be the best use of resources and alternative sites for advice could be sought.

**Second opinions**

Another factor considered in considering duplication of services was whether patients were seeking a second opinion. 75% of patients did not seek previous advice, and of the 12% (74 patients) that did, the majority had sought advice from a GP.

**Best place to manage patients**

Clinicians were asked their subjective but professional opinion about the best way to manage the patient’s problem at the time they were attending. As this is a key question, the results have been shown in some detail in the Walk in centre report, including by total; by condition type and by clinician seen.

Although the opinions seem fairly consistent across the two walk in centres, there is quite a notable difference between the two as to when patients should have been self-managed or attended A&E.

Unsurprisingly, for patients attending with minor ailments, most clinicians’ opinion was that the patient’s condition could have been managed in primary care (non-urgent) or at the walk in centre. Additionally a much larger percentage of patients attending Upney Lane could have been self-managed compared to those that attended Broad Street.

Opinions differed between the two walk in centres when it came to patients attending with minor injuries. In the clinicians’ response to this question, 29% of patients who attended Broad Street for minor injuries should have attended A&E, while only 2% of Upney Lane patients should have been according to their clinicians. Interestingly, this does not compare to the diagnoses made by the clinicians in the audit – 10% of patients seen at Broad Street and 8% of Upney Lane patients were actually referred to A&E.

**Where patients live**

61% of all patients were registered in Barking and Dagenham, with 11% registered in Havering and Redbridge, 9% Out of area other locations and 16% who did not say.

The data shows that the highest proportion of people attending Broad Street and Upney Lane are those that live the nearest to the centres. There is also an allowance for 2% of Broad Street registered patients to attend in any month.

**Where patients are registered**

Only 3% or 22 patients said they were not registered with a GP (unregistered) in the audit, compared to previous estimates that up to 10% of patients who use walk in centres are not registered with a GP. Out of area patients, however, who are unregistered numbered 8 people.

Looking at patients’ practices by the six GP localities in Barking and Dagenham, patients who lived closest tended to use the walk in centres more, with the highest number of:
• **Broad Street** patients were registered with practices in Locality 4, which had the highest walk in attendances of all the localities. Broad Street walk in centre is geographically closest to localities 2 and 4.

• **Upney Lane** patients were registered with practices in Locality 6. Upney Lane walk in centre is closest to Localities 5 and 6.

The survey and audit questionnaires, methodology and findings are in the audit report at Appendix A.

5. Engagement feedback

A summary of the feedback from local informal engagement is set out in this section.

5.1. Aim of engagement

The CCG identified in its Commissioning Strategy Plan (CSP) in 2011-12 a need to focus on engaging stakeholders from across the health and social care system in developing integrated approaches to commissioning coherent 24/7 urgent care services. The aim is to understand patients’ views on achieving greater consistency, improved quality and safety, improved patient experience, greater integration and better value, with services developed around the needs of the patients that use them.

5.2. Engagement

In addition to the work with the LINk to survey patients, the CCG has looked at local engagement and patient feedback in Barking and Dagenham from a number of recent activities. Past local engagement included:

- Health for north east London consultation held from November 2009-March 2010 with engagement in Summer 2010
- Primary care strategy consultation held from November 2011 – February 2012
- GP patient survey 2011/12 referenced in the case for change

Recently, engagement meetings were held with the following patient and patient and health representatives:

- The CCG Patient Engagement Forum (on 3 occasions)
- A CCG Stakeholder event for its strategic plan in January
- The Diabetes Forum
- The Health and Adult Services Select Committee (The HASSC or OSC)
- The Nursing Home Provider Forum
- The Shadow Health and Wellbeing Board.

A summary of what stakeholders said and the CCG responses is set out in Appendix C.

---

15 Ipsos MORI GP patient survey 2011/12
5.3. Equality impact assessment

An equalities impact assessment (stage one) has been developed as part of the evidence base underpinning this pre-consultation business case.

It has been informed by a review by a CCG management team which looked at equality considerations and feedback from stakeholder engagement. It will also inform the consultation plan).

The effects on all groups were considered. Initial key findings were that:

- Patients who do not currently use the walk in centres are currently disadvantaged and would benefit from the proposals in this business case
- Patients who are unregistered – and in particular vulnerable unregistered patients – would be encouraged and supported to register with a GP.
- Patients who do attend the walk in centres are primarily registered patients who can go to their GP. Through the survey and audit, however, 25% of patients who access the walk in centres say they do so as they cannot get an appointment. Improved access to general practice needs to be fully addressed
- There are patients attending across borough boundaries – both coming into Barking and Dagenham and well as B&D patients attending walk in centres in Redbridge (Loxford Polyclinic) and Havering (Harold Wood Polyclinic and Orchard Village walk in centre).

An equalities impact assessment is available on request and forms Appendix F.

(Underlined text will be revised in the public document.)

6. Decision to consult

Below is a summary of the national context and local proposal for engagement and consultation for the walk in centres.

Service change and engagement

In 2012, NHS NELC published an “NELC CCG Service change and engagement guide” which offers an overview of good practice in relation to:

- Current policy on service change in the NHS;
- Local scrutiny groups that have a key role in service change;
- The different levels of service change and the expected level of consultation and engagement required.

NHS NELC’s CCG service change and engagement guide sets out the three legal duties to involve and consult and requirements of ‘the four tests’ of reconfiguration published by the Secretary of State in 2010, summarised below:
The process of consultation and engagement is governed by Sections 242 and 244 of the National Health Service Act, 2006 and includes duties to:

- Promote public involvement and consultation under section 242, NHS Act 2006.
- Consult with local authority overview and scrutiny committees (OSCs) under section 244, NHS Act 2006.

The four tests’ of reconfiguration, to demonstrate:

- The level of support from commissioners’
- Robust and meaningful patient and public engagement in planning service change.
- A clear evidence base including an understanding of the views of relevant experts and the views of clinicians directly affected by the proposed change.
- Changes are in line with national guidance regarding patient choice; consider impact on competition.

Local proposal

Following discussions with local community groups, clinicians and the Health and Adults Services Select Committee, the CCG is proposing a six week period of public engagement and consultation, starting in February 2013, including a variety of activities described in this document. This approach is subject to CCG Board, the NELC Board and the Health and Adult Services Select Committee consideration in late January 2013.

After an assessment of the responses received, consideration of any amendments to the proposals and of any other information (e.g. the equalities impact assessment) it is expected that a decision on the future of the services would be taken in late March or April. The proposal is to implement changes from 1 November 2013.

Underlined text will be revised in the final public document.
B. The case for review of the walk in centres

1. Current provision (Market analysis)

In this section is a more detailed analysis of how many primary care same day appointments are currently offered in GP practices and in walk in centres in the wider context of urgent care. This informs proposals about future access to services and the impact and cost to the health economy. This is informed by current contractual arrangements and clinical and infrastructure considerations such as estates and information technology.

1.1. Local urgent care access

As illustrated in the diagram below, urgent care can be accessed in a variety of ways by residents of Barking and Dagenham, through:

- Self-care and/or a visit to a community pharmacy
- A same day (urgent) or pre-booked appointment at their GP during core opening times and in extended hours
- Walk in centres at Broad Street and Upney Lane as well as for B&D patients attending the neighbouring Loxford polyclinic
- The Out of Hours service
- The urgent care centres at King George and Queen’s Hospitals
- Accident & Emergency at King George and Queen’s Hospitals

Urgent care activity

As set out in the case for change at Appendix E, a study of urgent care activity for Barking and Dagenham residents showed that, between 2008 and 2012 there was a steady
increase of 9.17% across urgent care services (the activity counts each visit or call to these service so includes for example multiple visits from the same person).

Looking at the trends in further, however, activity decreased in:

- The out of hours service – activity decreased by 9.3% in that time, much of it caused by a steep drop in activity in 2009-10. The reasons need to be understood further.
- The urgent care centre at King George Hospital.

In addition, there was no significant activity shift between A&E and the urgent care centres at either King George Hospital or Queen’s. Primary care type activity is estimated to make up 50% of all A&E activity at King George and Queen’s Hospitals – yet it is not seeing the shift to more appropriate services expected. A process called a ‘redirection order’ has recently been put in place to divert these types of patients away from A&E and back to primary care.

The study also showed that walk in centre activity for Barking and Dagenham made up a combined total of 39% of urgent activity. The summary is in Table 2 below:

<table>
<thead>
<tr>
<th>Barking &amp; Dagenham</th>
<th>4 Year Total</th>
<th>% Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident &amp; Emergency</td>
<td>244,700</td>
<td>40%</td>
</tr>
<tr>
<td>KGH UCC</td>
<td>27,420</td>
<td>4%</td>
</tr>
<tr>
<td>Queen’s UCC</td>
<td>39,340</td>
<td>6%</td>
</tr>
<tr>
<td>Loxford WIC</td>
<td>5,060</td>
<td>1%</td>
</tr>
<tr>
<td>Upney Lane WIC</td>
<td>116,630</td>
<td>19%</td>
</tr>
<tr>
<td>Broad Street WIC</td>
<td>117,280</td>
<td>19%</td>
</tr>
<tr>
<td>Out of Hours</td>
<td>65,740</td>
<td>11%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>616,170</td>
<td>100%</td>
</tr>
</tbody>
</table>

1.2. Primary urgent care baseline

The above study did not include rapid response, the ambulance service, pharmacies or appointments provided by GPs.

A breakdown of urgent care activity for 2011-12 is in Table 3 below which includes actual attendances for a wider range of urgent services but still excludes urgent appointments with a GP:
Table 3: Urgent care activity in B&D 2011-12

<table>
<thead>
<tr>
<th>Service</th>
<th>Daily</th>
<th>Weekly</th>
<th>Annual</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walk in centres (WICs)</td>
<td>170</td>
<td>1,192</td>
<td>62,000</td>
<td>34%</td>
</tr>
<tr>
<td>GP out of hours service</td>
<td>43</td>
<td>301</td>
<td>15,650</td>
<td>9%</td>
</tr>
<tr>
<td>Urgent Care Centres (UCCs)</td>
<td>33</td>
<td>231</td>
<td>12,000</td>
<td>7%</td>
</tr>
<tr>
<td>Rapid response(^{16})</td>
<td>5</td>
<td>38</td>
<td>1,950</td>
<td>1%</td>
</tr>
<tr>
<td>London Ambulance Service (LAS)(^{17})</td>
<td>73</td>
<td>510</td>
<td>26,500</td>
<td>15%</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>137</td>
<td>962</td>
<td>50,000</td>
<td>28%</td>
</tr>
<tr>
<td>Acute (non elective) admissions</td>
<td>33</td>
<td>231</td>
<td>12,000</td>
<td>7%</td>
</tr>
<tr>
<td><strong>Sub-total</strong></td>
<td><strong>494</strong></td>
<td><strong>3,465</strong></td>
<td><strong>180,100</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Primary care (GP) attendances are in both core (weekdays 8.30 – 18.30) and extended hours (8.00 – 8.30 and 18.30-to 20.00 midweek and weekends (times vary).

To estimate the total number of appointments offered, a national target of 67 appointments per 1,000 patients or 4 appointments per patient per year is used.

Were all GP practices in Barking and Dagenham to meet this national target, this would give the “baseline” number of appointments for all patients (both urgent and non urgent) as in Table 4 below.

It is also estimated nationally about a third of the overall visits to practices in a year are same day or urgent appointments\(^{16}\).

Table 4: Estimated equivalent primary care activity in B&D

<table>
<thead>
<tr>
<th>Estimate for service</th>
<th>Appointments</th>
<th>Registered Popn</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP urgent appointments(^{18})</td>
<td>1.33</td>
<td>-</td>
<td>279,000</td>
<td>33%</td>
</tr>
<tr>
<td>GP non urgent appointments</td>
<td>2.67</td>
<td>-</td>
<td>557,000</td>
<td>67%</td>
</tr>
<tr>
<td><strong>TOTAL baseline</strong></td>
<td><strong>4.00</strong></td>
<td><strong>209,000</strong></td>
<td><strong>836,000</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

1.3. Primary care capacity

It is clear from the walk in centre survey/audit and from the GP patient survey that patients do not feel that they can always easily access their GP. It seems that this perception is driving a significant proportion of the walk in centre activity. This perception seems to be caused by people’s experience in trying to access their GP. In order to understand what needs to happen to improve access and to ascertain what additional capacity might be required in primary care to facilitate better access, work is underway to map out current

\(^{16}\) Activity is no of patients who averaged 3 episodes, or a total of 6,100 attendances  
\(^{17}\) Activity is a full year but from Jan 11- Dec 12  
\(^{18}\) Primary Care Foundation Trust [http://www.primarycarefoundation.co.uk/urgent-care-in-general-practice.html](http://www.primarycarefoundation.co.uk/urgent-care-in-general-practice.html)  
\(^{19}\) As above
capacity and provision of primary care including understanding variation across the borough.

There are 40 GP practices in Barking and Dagenham, none of which have closed lists, meaning all have capacity to register patients.

There is evidence to suggest, however, that Barking and Dagenham is “under doctored” – or that it does not have sufficient GPs for its population. Figure 9 below is taken from NHS Outer North East London (ONEL)’s draft Primary Care Strategy, which indicated that, while the borough has a greater proportion of GPs than its neighbours, Redbridge and Havering, it is below the London average per 100,000 population:

**Figure 9: Number of GPs in each PCT**

![Bar chart showing GPs per 100,000 population for Redbridge, Havering, Barking & Dagenham, and Waltham Forest.](chart)

**GP appointments**

A baseline is being collected of appointments types available in 2011-12:

- By clinician: GP, nurse practitioner, nurse or health care assistant
- By type: Telephone, face-to-face consultation and home visits
- By opening hours – including by practice arrangements for half day closing.

Significant work is also in hand to improve understanding of demand for primary and secondary services as well as intermediate care by practice and locality. Data is being analysed by locality by understand disease prevalence, primary care capacity and urgent care use.

**1.4. Clinical use of the walk in centres**

Based on the audit undertaken, the clinical view is that:

**Planned care:**
- 8% attended for a blood sugar testing service which is also provided under the walk in centre contract at Broad Street.
Of the remaining total walk in activity:
- 8% of attendances were referred to A&E
- 92% of attendances could be managed appropriately within a primary care setting, or at home with self-care, or with advice from a community pharmacy.

**Approximately two-thirds** of the walk in centre attendances was for **minor ailments**. A clinical review of these identified these as being appropriate for General Practice and part of their core service capabilities, for example, respiratory conditions, skin infections and urinary tract infections were advised as being better placed in a GP setting as there would be a proportion of patients who may require follow up and review.

**One third was for minor injuries** of which a high proportion would be suitable for General Practice management but a small proportion would not. For example, fracture care and more complex injuries may require further training in core general practice.

1.5. **Financial position**

Any new service model will need to provide high quality care for service users within an increasingly strained financial environment. Health budgets across the boroughs of Barking & Dagenham, Havering and Redbridge total £1.2bn. If current ways of working remain unchanged, overall healthcare costs for the three boroughs may exceed budget by around £177m in five years’ time. Approximately half of this challenge will need to be met by hospital providers, with the remainder found from other parts of the health budget:

**Forecast position of the BHR health economy, 2011/12 to 2017/18**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue limit (recurrent)</td>
<td>1,122.2</td>
<td>1,153.6</td>
<td>1,185.9</td>
<td>1,219.1</td>
<td>1,253.2</td>
<td>1,288.3</td>
<td>1,324.4</td>
</tr>
<tr>
<td>Revenue limit (non recurrent)</td>
<td>77.5</td>
<td>57.6</td>
<td>59.2</td>
<td>60.9</td>
<td>62.6</td>
<td>64.3</td>
<td>66.1</td>
</tr>
<tr>
<td>Acute hospital care</td>
<td>(583.9)</td>
<td>(607.3)</td>
<td>(638.0)</td>
<td>(670.1)</td>
<td>(703.2)</td>
<td>(738.3)</td>
<td>(774.8)</td>
</tr>
<tr>
<td>Specialist hospital</td>
<td>(39.9)</td>
<td>(41.5)</td>
<td>(43.7)</td>
<td>(45.9)</td>
<td>(48.1)</td>
<td>(50.6)</td>
<td>(53.1)</td>
</tr>
<tr>
<td>Learning disabilities and mental health</td>
<td>(99.5)</td>
<td>(103.5)</td>
<td>(108.8)</td>
<td>(114.3)</td>
<td>(120.0)</td>
<td>(126.0)</td>
<td>(132.2)</td>
</tr>
<tr>
<td>Prescribing</td>
<td>(100.4)</td>
<td>(104.4)</td>
<td>(109.7)</td>
<td>(115.2)</td>
<td>(120.9)</td>
<td>(126.9)</td>
<td>(133.2)</td>
</tr>
<tr>
<td>Community health services</td>
<td>(140.2)</td>
<td>(145.8)</td>
<td>(153.2)</td>
<td>(160.9)</td>
<td>(168.9)</td>
<td>(177.4)</td>
<td>(186.2)</td>
</tr>
<tr>
<td>Primary medical services</td>
<td>(155.0)</td>
<td>(161.2)</td>
<td>(169.4)</td>
<td>(177.9)</td>
<td>(186.7)</td>
<td>(196.1)</td>
<td>(205.8)</td>
</tr>
<tr>
<td>Corporate and other</td>
<td>(69.7)</td>
<td>(72.5)</td>
<td>(74.5)</td>
<td>(76.6)</td>
<td>(78.8)</td>
<td>(81.0)</td>
<td>(83.2)</td>
</tr>
<tr>
<td>Surplus/(deficit)</td>
<td>11.0</td>
<td>(25.0)</td>
<td>(52.1)</td>
<td>(81.0)</td>
<td>(110.8)</td>
<td>(143.6)</td>
<td>(177.9)</td>
</tr>
</tbody>
</table>

Barking, Havering, Redbridge University Hospital Trust (BHRUT) are forecast to report a £40m deficit in 2012-13 and will need to make CIP savings of c.£125m over the next 5 years. This will need to be achieved through a combination of productivity and efficiency gains.

**Urgent care expenditure**

Spending on urgent health care services in Barking and Dagenham cost nearly £50 million in 2011-12, or an average of £266 a year for each of its 187,000 residents, set out in **Table 5** below. This also shows the relative unit cost of different services: ranging from £29 to £2,240, considerably higher than estimates of the cost of a GP appointment:
### Table 5: Urgent care cost in B&D 2011-12

<table>
<thead>
<tr>
<th>Service</th>
<th>Unit £</th>
<th>Activity</th>
<th>£m Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walk in centres (WICs)</td>
<td>£29</td>
<td>62,000</td>
<td>1.8m</td>
</tr>
<tr>
<td>GP out of hours service</td>
<td>£70</td>
<td>15,650</td>
<td>1.1m</td>
</tr>
<tr>
<td>Urgent Care Centres</td>
<td>£75</td>
<td>12,000</td>
<td>0.9m</td>
</tr>
<tr>
<td>Rapid response</td>
<td>£462</td>
<td>1,950</td>
<td>0.9m</td>
</tr>
<tr>
<td>London Ambulance Service</td>
<td>£253</td>
<td>26,500</td>
<td>6.7m</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>£100</td>
<td>50,000</td>
<td>5.0m</td>
</tr>
<tr>
<td>Acute (non elective) admissions</td>
<td>£2,240</td>
<td>12,000</td>
<td>26.9m</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td><strong>484,100</strong></td>
<td><strong>49.8m</strong></td>
</tr>
</tbody>
</table>

### Barking and Dagenham walk in centre costs

<table>
<thead>
<tr>
<th>Year</th>
<th>Broad Street</th>
<th>Upney Lane</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010-11</td>
<td>754,798</td>
<td>1,018,850</td>
<td>1,773,648</td>
</tr>
<tr>
<td>2011-12</td>
<td>842,152</td>
<td>1,060,121</td>
<td>1,902,273</td>
</tr>
<tr>
<td>2012-13</td>
<td>870,970</td>
<td>1,049,537</td>
<td>1,920,507</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>2,467,920</strong></td>
<td><strong>3,128,508</strong></td>
<td><strong>5,596,428</strong></td>
</tr>
</tbody>
</table>

**Notes**

*Includes a forecast for Dec- March 2012-13

### 1.6. Cross border and out of borough area patients

As well as cost of its local walk in services, and the effect of out of area patient use, the CCG needs to consider the additional cost pressure of its patients using other walk in services outside the borough, in particular, at:

- The Loxford Polyclinic, Ilford (Redbridge CCG)
- The Harold Wood Polyclinic, Romford (Havering CCG)
- Orchard Village walk in centre, Rainham (Havering CCG)

---

20 Costs to the PCT excluding costs of cross border recharging
21 Includes a forecast for Dec- March 2012-13
22 [http://www.onel.nhs.uk/health-services](http://www.onel.nhs.uk/health-services)
- The Loxford Polyclinic in particular has seen steep increases in Barking and Dagenham patients attending. Over a six month period from April to September 2012, Barking and Dagenham patients made up 16% of attendances (1,757 out of 11,190).

- Conversely, from the audit evidence, 22% of patients attended Upney Lane walk in centre and 17% attended Broad Street walk in centre were out of borough.

Recharging arrangements have been in place since 2011-12 but recharging represents a future cost pressure which has been identified as a risk.

1.7. Contractual position

**Broad Street:** The APMS contract was due to expire in May 2013 and extended to 31 October 2013 to enable a timely review. Other services are currently part of the contract and there are a number of service interdependencies particularly in relation to the Broad Street contract which are set out in Table 16 in Section B5.5.2. Any new service will require a procurement process.

**Upney Lane:** Part of Community Services Contract with NELFT, due to expire March 2013 currently in negotiation. The lease for the walk in centre at Upney Lane was agreed to March 2013. The CCG will need to agree a new lease for the service.

The contracts relating to the walk in centres are commercially confidential and details are set out in a confidential Appendix G.

1.8. Infrastructure:

**Estates**

To deliver the draft Primary Care Strategy, a set of premises development principles were developed with prioritization criteria to guide any developments and business cases. The latter are set out below:

<table>
<thead>
<tr>
<th>Table 12: Estate business case priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Factors</strong></td>
</tr>
<tr>
<td>Condition / flexibility of current premises</td>
</tr>
<tr>
<td>Demonstrable best value and improvement in service areas</td>
</tr>
<tr>
<td>Addressing health inequalities and population health need</td>
</tr>
<tr>
<td>Addressing shortfall in current primary medical services (GP) capacity</td>
</tr>
<tr>
<td>Spread across ONEL</td>
</tr>
</tbody>
</table>

A summary of how the current locations meet these criteria for the current walk in service is set out in Table 12 in Section B2.4.2 below.
IT and information sharing

A summary of current information technology for walk in centres is set out in Table 7:

<table>
<thead>
<tr>
<th>Table 7: IT and interoperability for walk in centres – a summary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>System</strong></td>
</tr>
<tr>
<td><strong>Interoperability issues</strong></td>
</tr>
<tr>
<td><strong>Future proof?</strong></td>
</tr>
<tr>
<td><strong>Other systems available</strong></td>
</tr>
</tbody>
</table>

2. Assessment of benefits

A summary of the potential patient, health, financial benefits of proposals to deliver more primary urgent care through the localities model is set out in this section.

The following patient, health, financial and system benefits in Table 8 have been identified by increasing patients’ access a GP service for their urgent care primary care needs. These have been developed through clinically lead meetings:

---

23 Note that it is not currently possible to share patient records between practices. This is due to information governance rather than IT systems.
Table 8: Benefits of proposed changes to primary urgent care

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Patient</th>
<th>Health</th>
<th>Financial</th>
<th>System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s health management and clinical outcomes are improved</td>
<td>Patient’s health management and clinical outcomes improve including management of chronic disease</td>
<td>Reduction in unnecessary duplication of interventions</td>
<td>A clearer pathway which patients understand and use</td>
<td></td>
</tr>
<tr>
<td>Patients are seen promptly at the right place, first time</td>
<td>Reduction in unnecessary attendances and waiting at other urgent care services</td>
<td>Associated reduction in cost of avoidable hospital admissions</td>
<td>A clearer pathway which is easier for providers to deliver and follow; better sharing of information</td>
<td></td>
</tr>
<tr>
<td>Patient experience improves</td>
<td>Clinical quality, safety and efficiency improves</td>
<td>Investment of savings in health economy service improvement and prevention</td>
<td>The health system enjoys greater efficiency</td>
<td></td>
</tr>
</tbody>
</table>

Measure through

| Performance against baseline; QOF targets; Other points of delivery activity reduction; Patient satisfaction survey | Peer review in practices and localities through the pilot and borough roll out Improved clinical outcomes, patient access and experience | Evaluation and monitoring | Integration with 111 and Urgent care metrics |

3. Cost / benefits analysis

Below is an assessment of the benefits of the walk in centres and alternative provision:

3.1. Walk in centres

Are accessible: The biggest benefit of walk in centres to those patients who use them is their convenience and ease of access. They can be used without an appointment and are open 7 days a week with hours extending from early morning to late evening as per Table 9 below. This makes the service very attractive to some patients. The survey and audit work has focused on understanding the current use of the WICs. The views of those patients who do not access the WIC have not been assessed in the same way.

Table 9: Scope – walk in hours of service

<table>
<thead>
<tr>
<th>Weekdays during:</th>
<th>Weekends</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP Extended hours</td>
<td>GP Core hours</td>
</tr>
<tr>
<td>06.30 – 08.00</td>
<td>08.00 – 18.30</td>
</tr>
</tbody>
</table>
Encourage frequent, local use: Their accessibility can mean that the service encourages people to use them frequently and potentially inappropriately, in that they would receive more appropriate care with greater continuity of care at their own GP. Around half of patients or their families reported to have used the walk in centres 2-5 times in the last six months. Trends indicate that people living closer are more likely to use a walk in centre.

Drive additional cost to the commissioner: As the walk in centres is a fee for service contract, there is an additional cost every time a patient uses them to the cost of their GP registration. This additional cost is an opportunity cost lost to the health economy. As in the clinical findings above:

- 60% of demand is during the week when local GP practices are open
- 12% of patients were seeking a second opinion for the presenting problem
- Up to 18% of use was by out of area residents, the majority of which were registered with a GP.

Extend pathways: The audit suggests that there is a potential for duplication and additionality from walk in attendances, and if follow up advice is needed, it could extend the patient journey further. On the whole, it is clear that with innovative access in primary care, these conditions could be treated in a GP practice, or in a locality.

Demand management: do not help reduce A&E attendances: There is little evidence to suggest walk in centres being opened reduces demand for other urgent care services and locally demand for all services is increasing.

3.2. Primary care provision

Patients can have many appointments in a year with their GP with no additional financial cost to the health service, since GPs contract values include a significant payment based on their list size. Overall, an appointment with a GP costs the health service less than any other urgent care appointment.

National benchmarks for access to a registered GP advise that practices should aim to provide 67 appointments per 1,000 registered patients per week. Table 10 below utilizes this benchmark to illustrate the approximate potential additional capacity for registered patients if the funding used for walk in centre services were instead made available for registered patients, to a maximum of 15,694 additional patients being registered:

<table>
<thead>
<tr>
<th></th>
<th>Approximate Activity per week</th>
<th>WIC activity divided by 72</th>
<th>x 1,000 = additional patient registrations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broad Street</td>
<td>560</td>
<td>7.8</td>
<td>7,778</td>
</tr>
<tr>
<td>Upney Lane</td>
<td>560</td>
<td>7.8</td>
<td>7,778</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1,120</td>
<td>15.7</td>
<td>15,556</td>
</tr>
</tbody>
</table>

The NHS in effect pays twice for patients who are both registered with a GP and seek primary care services elsewhere (e.g. at walk in centres or A&E). This is both through the list fee through the GMS or APMS contract plus the activity cost of the additional service. It is this duplication that the CCG is seeking to reduce, while maintaining and improving health outcomes.

---

24 This is in line with guidance from the Royal College of General Practitioners (RCGP).
3.3. Primary care capacity

In order to reduce this double funding effect, however, the CCG needs to be assured that primary care capacity and skill mix is sufficient to manage and “absorb” current walk in centre activity. If not, patients currently attending could experience a reduction in health outcomes and attend other more costly services resulting in a higher overall cost.

Any additional investment in primary care therefore needs to be included in any financial forecast of the proposal.

3.4. Primary care benefits

Patients who register receive the associated benefits from GP registration including prevention, health check services and continuity of care:

- A full range of enhanced services
- A range of additional services
- A pro-active system of health promotion and prevention through immunisations and screening programmes
- Active and on-going management of long term conditions
- Continuity of care

Patients who are unregistered or unsure of their registration status would be able to access the new telephone number 111, going live in February 2013 and be supported to register with their local GP.

3.5. Health benefits

- so that Enable more patient to register. This would ensure a greater focus on the prevention of ill-health, and the management of long-term conditions and social care needs;
- Make it easier for patients to register with a GP;
- Make it easier for people to access advice from healthcare professionals so that they could avoid having to travel if it is unnecessary;
- Provide a less confusing service to patients and clinicians.

4. Options appraisal

4.1. Proposed future models

A summary of the options is in Table 11 which is then further explored below:

<table>
<thead>
<tr>
<th>Option 1</th>
<th>Do nothing – retain both walk in centres</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 2</td>
<td>Reprocure a service at Broad Street walk in centre, close Upney Lane</td>
</tr>
<tr>
<td>Option 3</td>
<td>Retain and remodel a service at Upney Lane walk in centre</td>
</tr>
<tr>
<td>Option 4</td>
<td>Do not reprocure a walk in service at Broad Street and close Upney Lane walk in centre</td>
</tr>
</tbody>
</table>
### Table 11: summary of options for future models

<table>
<thead>
<tr>
<th></th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
<th>Option 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service locations</strong></td>
<td>Retain two services (do nothing option)</td>
<td>Consolidate on one site: Broad Street</td>
<td>Consolidate on one site: Upney Lane</td>
<td>Reconfigure primary care</td>
</tr>
<tr>
<td><strong>Option 2</strong></td>
<td>2 sites</td>
<td>1 site: Broad Street</td>
<td>1 site: Broad Street</td>
<td>No sites</td>
</tr>
<tr>
<td><strong>Status quo</strong></td>
<td>Broad Street</td>
<td>Upney Lane</td>
<td>No other suitable sites in the borough</td>
<td></td>
</tr>
<tr>
<td><strong>Commissions consideration</strong></td>
<td>Status quo</td>
<td>Service changes</td>
<td>Service changes</td>
<td>Service change – GP led service</td>
</tr>
<tr>
<td><strong>Any Qualified Provider procurement of a new service at Broad Street (contract expires in 2013)</strong></td>
<td>Negotiate variation of existing service with NELFT as part of current contract. If there is a significant change the CCG may decide to re-procure</td>
<td>Decommission both services /process to establish GP localities model</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Estate</strong></td>
<td>Extend lease at Upney Lane</td>
<td>Extend lease at Upney Lane</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Impact / implications</strong></td>
<td>Engagement req’d Increase investment Introduce protocol or caps</td>
<td>Engagement req’d Agree investment Patient choice Competition</td>
<td>Engagement req’d Agree investment Patient choice Competition</td>
<td>Engagement red’q Agree investment Patient choice Competition</td>
</tr>
</tbody>
</table>

A description of the process used to generate options, including criteria and rationale for discarding options is set out in this section:

- Appropriate number of service locations
- Clinical viability and the appropriate service model
- Financial and affordability
- Activity analysis and modelling assumptions

### 4.2. Determining the appropriate number of service locations

A summary of how the current locations meet the Primary Care Strategy prioritization criteria for the walk in service is set out in Table 12 below:
### Table 12: Estate business case priorities and the walk in centres

<table>
<thead>
<tr>
<th>Building type</th>
<th>Broad Street</th>
<th>Upney Lane</th>
</tr>
</thead>
<tbody>
<tr>
<td>Building type</td>
<td>LIFT Building</td>
<td>Owned by B&amp;D PCT</td>
</tr>
</tbody>
</table>

#### Condition of the building

**Broad Street**
- **Status:** B (of A-C): Satisfactory, minor change needed. Space is well designed and fit for purpose.

- Location/layout = C in 3 out of 4 criteria (not satisfactory, major change needed):
  1. Adequacy of car parking (biggest problem)
  2. Access to public transport
  3. Public access to stairs

  **Source:** CIAMS assessment

**Upney Lane**
- **Status:** Green (of Green, amber red): Good condition: unlikely major works required within the next 5 years.

- Much of the work is still under warranty. The building is purpose designed and 'as new'.

  **Source:** inspection Sept 2012

#### Flexibility of the building

- **Broad Street:** Fully utilised though some treatment rooms under-utilised (Less than 4% of total building)
  
  **Score:** 7

- **Upney Lane:** Opportunity to expand further clinical services into an area which currently un-utilised at the hospital although it is not directly linked to the existing Walk in Centre.
  
  **Score:** 10

#### Demonstrable best value and improvement in service areas

- **Broad Street:** Does not provide best value in terms of cost per metre (Cost in confidential Appendix G)
  
  **Score:** 3

- **Upney Lane:** Provides good value at a lower than previous cost (Cost in confidential Appendix G)
  
  **Score:** 9

#### Addressing health inequalities and population health need

- **Broad Street:** Area of health need
  
  **Score:** 4

- **Upney Lane:** Area of health need
  
  **Score:** 4

#### Addressing shortfall in current primary (GP) services capacity

- **Broad Street:** Currently at the site is a GP lead health service with a list size of 4,795 (as at October 2012).

  The opportunity cost is that the GP provision could not be expanded if other services are not located elsewhere.
  
  **Score:** 3

- **Upney Lane:** Currently at the site are other boroughwide community and diagnostic services: maternity, mental health and sexual health services, Moorfields eye clinic, blood-testing clinic and haematology and a café.

  The opportunity cost is the GP health centre planned but not commissioned could not go ahead. Vacating Broad Street clinical space provides an opportunity to address primary care premises shortfall.
  
  **Score:** 8
Table 12: (cont) Estate business case priorities and the walk in centres

<table>
<thead>
<tr>
<th>Spread across ONEL (weighting = 4)</th>
<th>Broad Street</th>
<th>Upney Lane</th>
</tr>
</thead>
<tbody>
<tr>
<td>In terms of transport links, the nearest station is Dagenham Heathway station a 10-minute walk away. 3.8 miles from Queens Hospital (13 and 28 minutes travel by car and public transport respectively).</td>
<td>Score: 3</td>
<td>This is considered the most suitable site for a borough-wide service such as a walk in centre. The nearest station is Upney Station - a 2-minute walk away. 3.6 miles from King Georges Hospital (which 12 and 29 minutes travel by car and public transport respectively).</td>
</tr>
</tbody>
</table>

Estate summary view

<table>
<thead>
<tr>
<th>Estates summary view</th>
<th>Broad Street</th>
<th>Upney Lane</th>
</tr>
</thead>
<tbody>
<tr>
<td>In terms of condition, fitness for purpose and accessibility, Broad Street has restricted parking for staff and no space for visitors. Ambulance bay outside that people park in and ignore the road markings so it cannot be utilised. Security on site out of hours.</td>
<td></td>
<td>In terms of condition, fitness for purpose and accessibility, BCH is ideal with ample parking space for staff and visitors. Ambulance bay outside. 24 hour security on site.</td>
</tr>
</tbody>
</table>

Table 13 showing the total weighted scores:

<table>
<thead>
<tr>
<th>Table 13 Estate priority weighting</th>
<th>Weighting</th>
<th>Broad Street</th>
<th>Upney Lane</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weighting</td>
<td>Score</td>
<td>Wtd Score</td>
<td>Score</td>
</tr>
<tr>
<td>Condition/Flexibility</td>
<td>10</td>
<td>7</td>
<td>70</td>
</tr>
<tr>
<td>Best value and potential improvement</td>
<td>10</td>
<td>3</td>
<td>30</td>
</tr>
<tr>
<td>Addresses health inequalities</td>
<td>8</td>
<td>4</td>
<td>32</td>
</tr>
<tr>
<td>Addresses shortfall in primary care premises</td>
<td>8</td>
<td>3</td>
<td>24</td>
</tr>
<tr>
<td>Spread across ONEL</td>
<td>4</td>
<td>3</td>
<td>12</td>
</tr>
<tr>
<td>Total weighted score</td>
<td>168</td>
<td>326</td>
<td></td>
</tr>
</tbody>
</table>

On the basis of the above, the preferred site for any future service consolidated onto one site and offering a borough-wide service would be Upney Lane at Barking Community Hospital.

---

25 All travel times provided by googlemaps.co.uk
4.3. Clinical viability and the appropriate service model

**Estimating reduction in attendances**

- Drawing on the audit evidence above, it is estimated that that walk in attendances could reduce by 24% due to:
  - 12% or 7,440 of patients who attend the walk in centres and are referred back to their GP. As these patients would go to their GP as the first port of call, this duplication in attendances is expected to reduce.
  - 12% or 7,440 of patients who attend for second opinions. This reduction would be expected to occur over time and some activity should always be expected given patient behaviour and choice.

- In addition, a further 8% (5,269 or 17% of Broad Street total activity) were attendances for blood tests. As these were pre-agreed with the patient, these will not be re-commissioned as walk in patients but as planned care.

While 33% of patients attended and received advice only, in other words, no active treatment at the walk in centre or any referral to another service, the proportion of these patients would reduce if the service were more closely linked to primary care. This has not been included in the estimate for reduction since it is difficult to estimate.

**Unregistered and vulnerable patients**

A new model would need to ensure that high levels of patient registration are maintained and that patients are encouraged and supported to register with a GP.

**Protocols to manage duplication**

To manage the impact of frequent attenders, a patient protocol could be introduced similar to those in place at some walk in centres which also have a patient list. The example below sets a four-stage process including patients being referred back (repatriated) to their own GP practice:

<table>
<thead>
<tr>
<th>Time</th>
<th>Attendance</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Takes place within three months from date of the first attendance</td>
<td>1</td>
<td>Patient is asked for the reason for attending in preference to their own GP surgery. This is recorded and sent to the patient’s registered GP to provide an opportunity for the GP to discuss.</td>
</tr>
<tr>
<td>2</td>
<td>Patient is asked for their reason for attending rather than attending their own GP surgery. This is recorded and sent to the patient’s registered GP as an alert.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Registered GP Practice contacted to have clinician to clinician discussion</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Outcome sent to patient’s GP, and contracting manager and the walk in centre can now discuss number of Walk In appointments and options with patient to register.</td>
<td></td>
</tr>
</tbody>
</table>
4.4. Financial impact

The total cost saving of each of the four options over 4 years is set out in Table 14 below. These are the potential total revenue savings taking account of costs of some activity moving to other points of urgent care access. Note these forecasts do not take account of any cost or investment required in primary care and year 1 assumes a part-year effect:

<table>
<thead>
<tr>
<th>Table 14 Financial impact/potential savings of options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potential / cost v do nothing option 1</td>
</tr>
<tr>
<td>Option 1</td>
</tr>
<tr>
<td>Option 2</td>
</tr>
<tr>
<td>Option 3</td>
</tr>
<tr>
<td>Option 4</td>
</tr>
</tbody>
</table>

4.5. Impact and implications

There would be no material impact on patient choice if the number of sites were reduced, as patients have several points of access at any given time as illustrated in Section B1.1.1

Impact on competition: Any new walk in service at Broad would be openly re-procured. The service at Upney Lane is currently under contract. The CCG is currently negotiating the contract with NELFT for 2013-14 and there is the opportunity to review the walk in centre service model with NELFT as part of this contract. If there is a significant change the CCG may decide to re-procure.

Activity analysis and modelling assumptions are set out in Section 5.

4.6. Summary of options appraisal and preferred model

- **Option 1** Do nothing – retain both walk in centres
  
  Given the findings of the audit, survey and increasing activity and cost of urgent this option is not cost-effective and does not fit with the commissioning intentions or aim to improve access to a patient’s GP as first point of contact for urgent primary care.

- **Option 2** Reprocure a service at Broad Street walk in centre, close Upney Lane
  
  The facilities at Broad Street (particularly lack of X-ray and location and suitability of estates make this a less favourable option than Option 3.

- **Option 3** Retain and remodel a service at Upney Lane walk in centre
  
  This is the preferred option

- **Option 4** Do not reprocure a walk in service at Broad Street and close Upney Lane walk in centre
It is felt that this option would be too disruptive a service change and would potentially cause a surge of additional pressure on primary care and other urgent care services.

From the above appraisal, **Option 3** is suggested as the preferred option since it would:

- Consolidate resources and maximise the use of prime estate for a borough-wide service in one location, reducing patient confusion
- Provide a single minor ailments and minor injuries service with x-ray facilities as well as referral to other borough based services on site such as sexual health
- Help to reduce duplication from patients attending multiple places
- Seek to vary the service model at Upney Lane to become an urgent primary care service including pre-agreed attendances with GPs during core and extended hours which would provide a more equitable service across the borough and further reduce duplication\(^{26}\). Maintain the ready access to unplanned primary care that is valued by walk in centre users.

5. **Key assumptions and dependencies**

Risks and sensitivity analysis, comments and issues are in **Appendix D**.

5.1. **Walk in centre modelling assumptions**

From activity modelling using the clinical data available in the audit, if Broad street closed (option 3) then out of the activity that currently goes there then:

- 24% of activity would be removed (patients being referred back to their GP and second options)
- 8% of blood tests (17% of Broad Street activity) would be removed and recommissioned as planned care
- Of the remaining walk in activity:
  - 18% of patients would attend Upney Lane walk in centre
  - 5% would attend other walk in centres including the Loxford
  - 48% would go to a GP in Barking and Dagenham
  - 20% would go to a GP outside Barking and Dagenham
  - 2% would go to an urgent care centre
  - 7% would continue to go to an A&E.

Population growth is included in line with the JNSA for the forecast period at 2.37%.

The effects of these shifts both on activity and cost are shown in Table 15 below (note that the part year effect in year 1 is not included below):

\(^{26}\) See impact and implications in Section 4.5 immediately above
<table>
<thead>
<tr>
<th>Activity</th>
<th>Broad Street</th>
<th>Upney Lane</th>
<th>Other/Loxford</th>
<th>GP in B&amp;D</th>
<th>GP non B&amp;D</th>
<th>UCC</th>
<th>A&amp;E</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y1</td>
<td>25,723</td>
<td>31,557</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>57,280</td>
</tr>
<tr>
<td>Y2</td>
<td>-</td>
<td>7,559</td>
<td>1,936</td>
<td>20,730</td>
<td>8,623</td>
<td>847</td>
<td>3,193</td>
<td>42,888</td>
</tr>
<tr>
<td>Y3</td>
<td>-</td>
<td>7,738</td>
<td>1,982</td>
<td>21,222</td>
<td>8,827</td>
<td>867</td>
<td>3,269</td>
<td>43,905</td>
</tr>
<tr>
<td>Y4</td>
<td>-</td>
<td>7,921</td>
<td>2,029</td>
<td>21,725</td>
<td>9,036</td>
<td>888</td>
<td>3,346</td>
<td>44,945</td>
</tr>
<tr>
<td>TOTAL (of years 2-4)</td>
<td>-</td>
<td>23,218</td>
<td>5,948</td>
<td>63,677</td>
<td>26,486</td>
<td>2,602</td>
<td>9,808</td>
<td>131,959</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Net cost £</th>
<th>Broad Street</th>
<th>Upney Lane</th>
<th>Other/Loxford</th>
<th>GP in B&amp;D</th>
<th>GP non B&amp;D</th>
<th>UCC</th>
<th>A&amp;E</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y1</td>
<td>482,580</td>
<td>553,378</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1,035,959</td>
</tr>
<tr>
<td>Y2</td>
<td>-</td>
<td>144,784</td>
<td>45,226</td>
<td>-</td>
<td>-</td>
<td>35,322</td>
<td>335,358</td>
<td>560,589</td>
</tr>
<tr>
<td>Y3</td>
<td>-</td>
<td>155,339</td>
<td>49,390</td>
<td>-</td>
<td>-</td>
<td>36,159</td>
<td>343,203</td>
<td>584,091</td>
</tr>
<tr>
<td>Y4</td>
<td>-</td>
<td>166,662</td>
<td>53,870</td>
<td>-</td>
<td>-</td>
<td>37,016</td>
<td>351,337</td>
<td>608,885</td>
</tr>
<tr>
<td>TOTAL (of years 2-4)</td>
<td>-</td>
<td>466,786</td>
<td>148,485</td>
<td>-</td>
<td>-</td>
<td>108,496</td>
<td>1,029,798</td>
<td>1,753,565</td>
</tr>
</tbody>
</table>
5.2. Dependencies

Dependencies fall into two main types – those which relate to the commissioning of other clinical services linked to the walk in centre contacts and to the development of the localities model as in Tables 16 and 17 respectively below:

<table>
<thead>
<tr>
<th>Table 16: Clinical contractual dependencies</th>
<th>Broad Street</th>
<th>Upney Lane</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Commissioning process</strong></td>
<td>The National Commissioning Board will commission the GP list and the CCG any additional services</td>
<td>The CCG will commission the walk in service through the Community Services contract as described in Section 4.5 above</td>
</tr>
<tr>
<td><strong>Commissioning of clinical services</strong></td>
<td>GP List: affects commissioning decision about the size of any GP list by the National Commissioning Board</td>
<td>Variation to any new service model would be negotiated with the current provider in the first instance</td>
</tr>
<tr>
<td></td>
<td>Care for residents of nursing home: would be commissioned together with the GP list above (although this could be allocated to any GP practice locally)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Blood testing service provided within the walk in centre contract 27 - a separate commissioning decision of this planned care is recommended</td>
<td></td>
</tr>
</tbody>
</table>

27 Part 2b of the WIC service specification: “health screening and chronic disease surveillance, including: monitoring of chronic disease, such as blood pressure checks; phlebotomy; cholesterol and blood sugar testing.”
Table 17: Locality development dependencies

Delivery will be through five stages in addition to commissioning:

<table>
<thead>
<tr>
<th>Stage</th>
<th>Dependency</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Understand current activity/baseline</td>
<td>Developing a baseline of whole population needs for primary care access</td>
<td>Stage in hand with the CCG actively examining PC capacity</td>
</tr>
<tr>
<td>2. Agreement of service model</td>
<td>Designing a model which responds to this evidence base, taking a whole system approach, led locally by patients and clinicians in a bottom-up approach to design a ‘radical model’ at a local level</td>
<td>The pilot locality practices have signed up and are actively shaping the pilot</td>
</tr>
<tr>
<td>3. Pilot approach</td>
<td>Testing the model a model is being piloted in Dagenham before rapid, wider implementation across the six CCG localities. Design will include the primary care workforce requirements and potential for the model to be adopted in other service areas. Stakeholder engagement will be a key feature of redesign.</td>
<td>Proposed from February 2013</td>
</tr>
<tr>
<td>4. Agreement of business model</td>
<td>To deliver agreed service model: Evaluating the model and confirming a network business case and workforce strategy</td>
<td>2013</td>
</tr>
<tr>
<td>5. Implementation/Borough-wide diffusion</td>
<td>Will draw on engagement, evaluation of good practice and outcomes harnessed through the demonstrator sites and align with the diffusion of the integration model</td>
<td>2013</td>
</tr>
<tr>
<td>6. Commissioning process</td>
<td>Agreement of commissioning process</td>
<td>2013</td>
</tr>
</tbody>
</table>

6. Resource Requirements and Cost

The reduction in urgent primary care expenditure invested in the walk in centres is required in order to:

- Release funding for investment in other service improvements in primary care, both in GP list capacity and in the development of the localities model
- Respond to the need to reduce overall urgent care expenditure.

In terms of financial impact of any service change, consideration would be given to two distinct elements:

For 2013-14 there would be a part year effect given any change, if agreed, would not be implemented until October 2013) and 14-15, including through the CCG’s commissioning intentions to identify:

Note that this total does not include savings from re-commissioning blood tests separately or increased rental income which would be additional savings.
C. Recommendations and next steps

1. Recommendations

The CCG Board and the NELC Board are asked:

1. To endorse the Urgent Care Case for Change, consider options 1-4 for the walk in centres and endorse Option 3 as the preferred option, which would remove walk in services from Board Street and close Broad Street walk in centre, and to agree to consult the public on that basis
2. To seek the HASSC’s scrutiny of the consultation process including its duration, proposed as a 6-week consultation starting in February 2013
3. To seek the HASSC to delegate authority to their chair and vice-chair to review the consultation document and plan in early February
4. To advise the Head of Primary Care Commissioning of the above
5. The CCG to consider the commissioning of blood tests in the Borough
6. If the decision is to consolidate onto one site, the following be explored:
   - The best use of the premises at the current walk in centre at Barking Community Hospital
   - Whether space vacated at Broad Street (10 clinical rooms plus associated space) could provide accommodation for additional primary care capacity and resolve wider GP estates issues of below standard CQC Premises.

2. Timescales

<table>
<thead>
<tr>
<th>Table 18: Proposed timeline for walk in centre proposals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walk in centres</td>
</tr>
<tr>
<td>Consultation</td>
</tr>
<tr>
<td>Consider and agree service</td>
</tr>
<tr>
<td>Notice of changes</td>
</tr>
<tr>
<td>New service in place</td>
</tr>
<tr>
<td>Localities model</td>
</tr>
<tr>
<td>Pilot</td>
</tr>
<tr>
<td>Decision</td>
</tr>
<tr>
<td>New service in place from</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestone 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>The CCG intends to take the decision to consult on 29 January 2013</td>
</tr>
<tr>
<td>The NELC Board will consider the CCG’s decision on 31 January</td>
</tr>
<tr>
<td>The Adult Services Select Committee (HASSC) will scrutinize and comment on the decision and documentation at 6pm on 31 January</td>
</tr>
</tbody>
</table>
Milestone 2
- Engagement / consultation could subsequently run from February to March
- The Shadow Health and Wellbeing Board would be consulted on CCG commissioning plans
- After consideration of consultation feedback and any amendments to the proposals, a decision on the future of the services could be taken from late March/April 2013
- Contract extension /variation and procurement processes to be confirmed

Milestone 3
- Any service changes could be implemented from the end of October 2013.

Appendices
This business case summarises the detailed findings of a number of supporting documents which are appended to this report. These will also be accessible at: http://www.barkingdagenhamccg.nhs.uk/

Appendix A
Walk in centre audit report
Attached as separate document

Appendix B
Walk in Centre patient survey report
Attached as separate document

Appendix C
Stakeholder summary
Attached below

Appendix D
Risk and sensitivity analysis, comments and issues
To follow

Appendix E
Case for Change summary and detailed report
The case for change document: http://www.barkingdagenhamccg.nhs.uk/BarkingAndDagenhamNews/urgent_care.htm
## Stakeholder summary

A summary of what stakeholders said and the CCG responses is set out below:

<table>
<thead>
<tr>
<th>Table 19: Stakeholder feedback</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>You said</strong></td>
<td><strong>The CCG will act:</strong></td>
</tr>
<tr>
<td>How long will it take to deliver what is set out in the Urgent Care Case for Change?</td>
<td>This is an ambitious time table and the CCG would like to start the first pilot locality from February 2013. The pilot will run for three months then will be evaluated. The CCG hope to implement services across the borough by Autumn 2013.</td>
</tr>
<tr>
<td><strong>Modernisation of Primary care</strong>&lt;br&gt;The business case needs to include:&lt;br&gt;i) Explicit details on how GP primary care will be modernised to meet the challenges and ensure improved access&lt;br&gt;ii) How going to share infrastructure – particularly IT is a key enabler – sharing better patient information will lead to improved health outcomes&lt;br&gt;iii) Urgent care access to improved diagnostics – understanding was a diagnostics hub yet to be satisfied – would want this addressed in business case</td>
<td>How the localities will share infrastructure is a consideration in the localities modelling. This is referred to in outline in this business case but more information will be available after the pilot from February 2012.</td>
</tr>
<tr>
<td>The CCG should investigate whether GPs are currently working to capacity and consider the possibility of GPs using premises more efficiently or GPs working in shifts to increase productivity</td>
<td>The CCG will consider all options as part of their planning</td>
</tr>
<tr>
<td>Concern about GP capacity to take on walk in centre patients when residents already struggle to get appointments with their GP.</td>
<td>Capacity is a problem in some GP practices and there is also a problem with managing duplication of attendance - when patients present at A&amp;E and Walk-in Centres as well as their GP practice. Better co-ordination is needed to avoid patients bouncing around the system or passing through secondary care as this is neither cost effective nor good for the patient experience.</td>
</tr>
<tr>
<td>Residents are being refused registration with a GP due to capacity issues.</td>
<td>We would like to hear from patients who experience this as there are currently no closed patient lists in Barking and Dagenham</td>
</tr>
<tr>
<td>You said</td>
<td>The CCG will act:</td>
</tr>
<tr>
<td>----------</td>
<td>------------------</td>
</tr>
<tr>
<td><strong>Skill mix</strong>: staff should be trained at the walk in centres to provide services such as blood tests</td>
<td>As part of its Localities modelling, Barking and Dagenham CCG will look at skill mix and workforce A review of how blood testing is offered in B&amp;D</td>
</tr>
<tr>
<td><strong>How will referrals be managed? Will patients need to go to different hospitals?</strong></td>
<td>The CCG is committed to promoting services close to home with better care and less travelling. GPs need to improve their knowledge of conditions in order to reduce hospital admissions. Patients will only be referred to outpatients when they need to see a specialist. The aim is to provide more choice of locations to receive care e.g. Barking Community Hospital</td>
</tr>
<tr>
<td>People are going to <strong>A&amp;E</strong> as it is open 24 hours a day and it is accessible. GP services leave much to be desired.</td>
<td>A&amp;E might be open but that does not mean it is the best place to get urgent care or when it is a primary care condition which could be better managed by your GP practice. Most patients are part of a group practice and could see another GP in the group if they can’t see their own GP. Many practices are open later as they operate extended hours. We need to communicate what is appropriate to patients and explain opening hours of GP surgeries, especially when they change. Add point here about appropriateness of care as well as access,</td>
</tr>
<tr>
<td><strong>What is the demand for ambulances</strong> in the borough and what the status of London Ambulance Service funding?</td>
<td>The London Ambulance Service receives its funding at a pan London level. Demand for services is high across London.</td>
</tr>
<tr>
<td>Services should be offered to patients with a <strong>long term condition</strong> so that they don’t need to access A&amp;E</td>
<td>The CCG is developing systems to ensure that hospitals have strong links with community long term conditions teams so that patients can have support in their local area</td>
</tr>
<tr>
<td>Any decision on walk in centres should be taken whilst considering potential <strong>negative impact on A&amp;E</strong></td>
<td>The CCGs in Barking and Dagenham as well as Havering and Redbridge are working closely with BHRUT to consider all options for managing A&amp;E attendances.</td>
</tr>
<tr>
<td>We are always told to contact the <strong>out of hours service</strong> even if we contact the practice at 10am</td>
<td>The CCG will review the nursing home enhanced service and follow up this point with the provider who raised this.</td>
</tr>
<tr>
<td>You said</td>
<td>The CCG will act:</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Some GPs are refusing to sign Do Not Resuscitate forms</td>
<td>This problem does need to be addressed. The CCG will follow up this issue with</td>
</tr>
<tr>
<td></td>
<td>the practice(s) concerned and explore the introduction of standard protocols.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>There have been allegations that Walk in Centres have begun to charge</td>
<td>Any concerns of this nature are always raised with a provider directly.</td>
</tr>
<tr>
<td>individual patients if they cannot provide a passport or valid visa</td>
<td>In addition, the CCG would encourage all patients to register with a GP so that</td>
</tr>
<tr>
<td>and are applying secondary care rules about charging. This leaves some</td>
<td>they receive appropriate services within primary care.</td>
</tr>
<tr>
<td>patients without adequate primary care provision</td>
<td></td>
</tr>
<tr>
<td>Domiciliary care needs to be addressed</td>
<td>The CCG will address through integrated care and will focus on working</td>
</tr>
<tr>
<td></td>
<td>collaboratively and improving services provided during opening hours.</td>
</tr>
<tr>
<td>Walk in centres should be better signposted than they are currently</td>
<td>The CCG recognises that signposting is very important and will be working with</td>
</tr>
<tr>
<td></td>
<td>all health professionals across Barking and Dagenham to ensure there is</td>
</tr>
<tr>
<td></td>
<td>effective signposting to urgent care services.</td>
</tr>
<tr>
<td>You need to communicate with the public; lines of communication must</td>
<td>The CCG and GP practices have already taken steps to communication e.g. through</td>
</tr>
<tr>
<td>come first be clear what it is you want to communicate.</td>
<td>the campaign “A&amp;E won’t kiss it better” but plan to continue with these</td>
</tr>
<tr>
<td></td>
<td>messages.</td>
</tr>
</tbody>
</table>
Walk-in centres in Barking and Dagenham

A consultation on proposals to close the walk-in service at Broad Street, Dagenham, and improve urgent primary care services in the borough

All comments must be received by 5pm on 21 May 2013
For most people, using the NHS means a visit to their family doctor (GP). GPs have always had a say in developing local health services, but now, as part of the NHS reforms, they are taking on much greater responsibility to commission (which means to plan, buy and monitor) NHS services. To do this, they have joined together as a new group called Barking and Dagenham Clinical Commissioning Group (CCG). From April 2013, the CCG will commission most local health services, from cancer care to mental health, hospital operations to prescriptions. All GP practices in the borough are part of this CCG.

Barking and Dagenham CCG recognises the very real challenges it faces in terms of necessary improvements to the health of the local population. It is no secret that we have high rates of poor health locally – not unusually for a London borough with corresponding rates of deprivation. Despite this, we are determined to tackle these challenges head on and to work together to improve the health of our residents and patients.

The CCG has been reviewing access to urgent care services in Barking and Dagenham in response to patient feedback on the current system, which is difficult to navigate and faces increasing demand. We recognise that urgent care services in the borough are not meeting the needs of local people.

In common with our partners elsewhere in the public sector, the CCG faces some tough decisions. We will inherit limited resources and a restricted budget, so we will have to make some efficiency savings in 2013/14.

We want to be open about this and have been working hard, looking at ways of doing so without having a detrimental effect on people’s health.

In recent months across England, NHS walk-in services – where people simply walk in off the street and ask for help - have been increasingly under the spotlight. Clinicians have become concerned that rather than easing pressure on other services, such as A&E, they are simply creating extra demand and bypassing existing services such as GPs, pharmacists, out of hours services and sensible self-care. As a result, many walk-in services have closed.

Barking and Dagenham Primary Care Trust, who the CCG will replace, has a contract with Care UK, the provider of the Walk in Centre at Broad Street, which is coming to an end. To help decide if the CCG should invest in this service in the future, a review of the walk-in services has been carried out. This included an independent audit to see who was using these services and why. We have two walk-in...
centres at the moment – one at Broad Street in Dagenham and the other in Upney Lane, Barking, at Barking Community Hospital.

The audit showed that a third of people attending them needed no treatment at all. We also found that many people were using the service to simply get a second opinion, to save them from waiting to see their own GP, because they didn’t have a GP or because they didn’t know where else to go. This concerns us greatly because we know that a GP doesn’t just treat your obvious problem – he or she has your records, knows what medicines or treatment you have had previously and can treat the whole person. Increasingly we help people manage long term conditions effectively; something a walk-in service just can’t do.

The review did not give us the evidence we think we need to justify investing our limited resources in the service at Broad Street, based on the needs of the whole of the borough. As a result, we have developed proposals to close the walk-in service at Broad Street, Dagenham.

The challenge for us, then, is to make it easier for people in Barking and Dagenham to get high quality urgent care when they do need it, and to make sure they know where they can get it. We believe that those people who are using Broad Street walk-in service at the moment can be cared for by other, existing services.

We are now asking the public and stakeholders for their views. The project is led by Dr Richard Burack, Clinical Lead for Urgent Care, supported by Dr Jagen John. Both are local GPs with additional clinical leadership responsibilities in the CCG. Dr Burack works at the Lawns Medical Centre and Dr John at King Edwards Medical Centre.

We would like to know what you think. Please take a look at the information in this document and send us your thoughts. We look forward to hearing your views.

Dr Waseem Mohi, Clinical Director and Chair
Dr Richard Burack, Clinical Lead, Urgent Care
Dr Gurkirit Kalkat, Clinical Lead, Primary Care
Dr Jagan John, Deputy Clinical Lead, Urgent Care
Dr Arun Sharma, Clinical Lead, Locality Model
**Our current walk-in services**

<table>
<thead>
<tr>
<th></th>
<th>Broad Street Medical Practice and Walk-in Centre</th>
<th>Barking Community Hospital Walk-in Centre</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opening times</td>
<td>Mon-Fri 7am-10pm Sat-Sun 10am-6pm</td>
<td>Mon-Fri 7am-10pm Sat-Sun 9am-10pm</td>
</tr>
<tr>
<td>Location</td>
<td>Morland Road, Dagenham, RM10 9HU</td>
<td>Barking Community Hospital Upney Lane, Barking IG11 9 LX</td>
</tr>
<tr>
<td>Activity</td>
<td>Approximately 80 patients a day or 560 patients a week</td>
<td>Approximately 80 patients a day or 560 patients a week</td>
</tr>
<tr>
<td>Service type</td>
<td>Minor ailments and minor injuries Nurse led with health care assistants and a doctor available at co-located health centre</td>
<td>Minor ailments and minor injuries Nurse led with emergency care practitioners and a doctor available</td>
</tr>
<tr>
<td>Other related services</td>
<td>There is a GP practice on site which also provides complex care to residents of Park View Care Home</td>
<td>Located at Barking Community Hospital</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>No diagnostic equipment</td>
<td>X-ray equipment</td>
</tr>
<tr>
<td>Exclusions</td>
<td>Children under 2 years</td>
<td>None</td>
</tr>
</tbody>
</table>

A survey of the use of walk-in centres showed the majority of people attended for minor injuries and ailments, with the most common complaints for both walk-in centres being:

1. Injuries (including cuts, fractures and dressings) 31%
2. Respiratory conditions 22%
3. Skin related ailments (including infections) 13%
4. Reproductive and urinary 10%
5. Ears and eye related ailments 7%

Whilst some of the fracture care and more complex injuries might require further training in core GP practice, almost all other cases seen at the centre could be seen in a local GP surgery. In fact many conditions would be better seen by a GP as there would be a high proportion of patients needing follow ups and reviews.
Walk-in services do not encourage better health. The easy availability of walk-in appointments is discouraging residents from visiting or registering with a GP. The walk-in staff often see patients who wouldn’t need urgent services if their condition was properly managed by a GP. One third of people attending them needed no treatment at all.

A&Es, urgent care centres and walk-in centres do not provide the best care for many conditions. A busy A&E or walk-in centre is not necessarily the best place for many people (for instance people with a mental health problem) to receive care. GPs can and do provide this service. A GP can also ensure patients receive the full range of preventative and other health services, such as immunisations and health checks.

GPs and nurses tell us there are too many people visiting walk-in centres who are not managing (or being helped to manage) their long term condition, so they end up seeking urgent help later on.

The system is complicated. Patients often do not understand where they need to go and can get passed from one service to another.

The urgent care system (A&Es, GP urgent appointments, GP out of hours service, walk in centres and urgent care centres) is expensive to manage and run. If a patient goes to two or three places to seek advice or care – the NHS can pay from two to five times the cost compared with simply booking an urgent appointment with a GP.

We need a simpler, better system so that local people can get the urgent care they need.

On page 9 we talk about our plans for other urgent care services in the borough.
Our proposals

The CCG proposes to close the walk-in service at Broad Street. The centre would continue to house a GP practice. This would:

- Encourage people to use their GP as their first point of contact. This is essential if we are to help patients keep healthier and better manage long-term conditions.
- Help us to achieve the savings we know we will need to protect other health services in the borough.
- Improve the likelihood of residents registering with, and accessing, health services (including urgent care) through their GP practice.
- Make the system more efficient by removing duplication.
- Mean all patients who require an urgent ‘walk-in’ appointment and who cannot be seen by their GP would still be able to attend the walk-in services at Barking Community Hospital, Loxford or the urgent care centres attached to Queen’s, King George or Newham hospitals.

If the walk-in service at Broad St was closed:

- More people would be encouraged to register with, or visit, their GP.
- The NHS would make savings of around £530,000 a year which would safeguard other valuable health services and contribute to meeting the whole of the borough’s health needs. The Broad Street site would remain as a health facility with a GP based there.
So where would people go if Broad Street walk-in service closed?

Their own GP
Nurses and staff at the walk-in centres told us they regularly treat patients for conditions that would be better managed by a GP. In fact 12% of patients attending the walk-in centres would have been better off going to their GP – and would have been treated first time.

The audit showed another 12% of people visiting the centres were asking for a second opinion. That’s duplication that we simply can’t afford.

Most of the people using the walk-in centre are registered with a local GP. We need to make sure they can get the service they need from their own GP.

One way that the CCG is looking to improve things is by getting GPs to work more closely together in groups of GP practices to provide more, and better services closer to people’s homes. This way GPs can share expertise and appointment slots to help patients.

Ask your GP for an urgent appointment
Many people say they are unable to book an urgent appointment when they need one with a GP – especially at weekends and in the evenings. And yet over 70% of people visited the walk-in centre whilst their own GP surgery was open1. In addition, the Out of Hours GP service is not as widely known as it used to be.

Register with a GP
Barking and Dagenham has a highly mobile population – people often come to the borough to live and to work for short spells and then move on. This means that many of them don’t bother to register with a GP. When they get ill or injured, they are likely to go straight to A&E or to a walk-in service despite the fact that in many cases, their condition could easily be dealt with by a GP. We estimate that around 10% of patients using walk-in services are not registered.

Case study: The benefits – Abbas

Now
Abbas is generally feeling unwell. He has a sore throat, a headache and is coughing a lot. He visits the walk-in centre (which is some distance from his home). Abbas is told he has a cold and is advised to go home, drink plenty of fluids, rest, and take painkillers if required.

The future
Abbas rings his GP who can give the same advice as he would get with a visit to the walk-in centre but Abbas doesn’t have to leave the house or pay for travel. He doesn’t use up an urgent appointment at the GP surgery and he doesn’t infect anyone whilst he is there.

1 Walk-in centre audit, 2012
Case study: The benefits – Kay

Kay has a problem breathing – a common condition for people attending the walk-in centres – but the principles apply to many other illnesses.

Now
Kay is having difficulty in breathing at home. She goes to the walk-in centre (which is some distance from her home) in some discomfort, where she has to explain her previous medical history for the nurse to make a considered diagnosis. Kay can’t remember all the medication she is on so the nurse cannot prescribe more or different drugs and sends Kay home. The condition worsens in the night and Kay goes to A&E. The doctors there stabilise her and admit her. The next day Kay is discharged and is advised to get an urgent appointment with her GP. Kay has difficulty in getting an appointment, but does get one at which the GP changes her prescription.

The future
Kay rings up the GP who brings up her medical history. With this information the GP does a diagnosis on the phone and suggests a change in drugs. Kay can walk the short distance to the GP surgery and picks up the prescription.

- One short journey
- No trip to A&E
- Better care so that the patient is in less pain for a shorter time
- A better patient experience
- Less cost

Call 111
The new NHS 111 service is now available in Barking and Dagenham 24 hours a day, 7 days a week. Local residents can call 111 when they need urgent medical help or advice, but when it isn’t a 999 emergency. Callers will have their symptoms assessed, be given advice and directed straightaway to the local service that can help them best.

Talk to your pharmacist
Local managers have told us that our walk-in centres often encourage people to ask for advice regarding minor issues that are better dealt with at home or at a pharmacist.

Self care
Many people who attend our walk-in centres don’t need to be treated by a nurse or doctor (they could have treated themselves or gone to a pharmacy).
Our plans for urgent primary care in Barking and Dagenham

Everyone should be able to know how, and be able, to register with a GP so they can access high-quality primary care. Making sure this happens is a priority for the CCG.

We think that their GP surgery should be the first port of call for people needing urgent care. People should be able to:

- ‘Phone before they go’ – to get good information from their GP surgery before having to travel to see one, make an appointment or go to another urgent care service
- Be seen quickly at a local GP surgery if they have an urgent care need which needs a personal visit
- Get all their primary care at a local GP surgery during week days as a minimum – ideally at their own GP’s practice but if not, another practice nearby, in their area.
- In order to improve access to high-quality primary care during the day, GP practices in the borough have organised themselves into six groups (localities). This means they can share facilities and equipment, specialist staff, knowledge, and better manage demand for urgent care at peak times – for instance you may be offered advice or appointments at a neighbouring GP practice. Older people are already benefiting from this type of service.

In the evenings and at weekends we think people should be able to access urgent care just as easily as during the day. We think people should be able to:

- Phone 111 for advice or to make an urgent appointment with their GP
- Get an urgent appointment at their GP
- Where appropriate, be referred to the out of hours service
- Visit an urgent care centre during the night (for instance at a hospital or a walk-in centre) when GP practices are closed.

Developing the service at Barking Community Hospital

We want to build on the successes of the walk-in centre at Barking Community Hospital by using the facilities available there to support our plans. Over the next year we plan to develop the services we offer at the hospital; such as the new X-ray equipment used by the minor injuries unit, to ensure we can accommodate any extra patients from Broad Street.
Frequently Asked Questions:

Q: Are you proposing to close the Broad St GP surgery?
A: No, current GP services at Broad St would continue under our proposals. Patients registered there would continue to see their GP.

Q: What would happen if everyone who used to go to Broad St goes to Barking Community Hospital?
A: We think that the vast majority of people who live around Broad Street would phone or visit their GP, visit a pharmacist or decide to care for themselves. But if some people decided to go to the walk-in centre at Upney Lane, Barking Community Hospital, there is room for them.

Q: Why are you proposing to close the walk-in services at Broad St and not at Barking Community Hospital?
A: We have looked at:

- The buildings and facilities. Whilst Broad St is in satisfactory condition, the building at Barking Community Hospital is new and purpose built and is being developed as the borough’s community hospital. There are other health facilities and services at the hospital which could mean more convenient access for some patients to other services. For example, direct access to X-ray.

- Barking Community Hospital could absorb any increase in attendances from people who used to go to Broad St walk-in centre – whilst Broad St would struggle with more patients if we closed Barking Community Hospital walk-in centre.

- We need more good quality facilities for GP practices in Dagenham. If we were to close the walk-in centre in Broad St, we could use the space that would become available for an extra GP practice.

- Access to Barking Community Hospital is better than Broad Street. There is ample parking at Barking and the hospital is a two minute walk from the nearest train station.

Q: Why aren’t you proposing to close both walk-in centres?
A: We have looked carefully at options to close both. This would save more money and would encourage more people to register with a GP, where they would get more consistent care to look after their long term health. However, on balance, we think that some patients still benefit from having access to an urgent care facility at Barking Community Hospital at the moment and that the services at the hospital could be modified to fit with the plans for improving primary care.

Q: You say that local residents will get better healthcare this way, but what happens to people who don’t, or can’t, register with a GP?
A: It is very important that we get as many people to register with a GP as possible. However if someone can’t or hasn’t registered, the walk-in centre at Barking Community Hospital, or Loxford or the urgent care facilities at Queen’s Hospital, King George Hospital, Newham and will be able to treat anyone – and the new 111 service will respond to anyone in need.

Q: Is this not just about cutting back on services and saving money?
A: We do need to make efficiency savings and we’ve been very open about that. By reducing duplication where possible, we can manage the expected increase in demand for other health services locally. There would be some savings from not paying for a service at Broad Street (estimated at £538,000 a full year).
Q: Will people only be able to get urgent care at Loxford, Queen’s, Newham or King George Hospitals in future?
A: No. If people are registered with a GP they can request an urgent appointment with their GP. But our research shows that a great many patients using walk-in centres just need advice. So people can ring their GP surgery including during out of hours or the new 111 telephone number, or visit a pharmacy. In our proposals, there would also still be urgent care services at Barking Community Hospital.

Q: If people are already finding it hard to get to see their GP, won’t closing the walk-in centre make this even harder as they will be even busier?
A: We know that we need to improve access to GPs as people can’t always get through to their practice and we are looking at ways of doing this. But we are not talking about more people needing to see their GP than now, rather about helping the same number of people manage their urgent health needs better.

Q: Won’t more people just go to A&E – which we know is already too busy?
A: By making sure that we improve access to GPs locally, through putting the 111 number in place and by continuing to provide walk-in services at Barking Community Hospital we think that there should not be any more people needing to go to A&E than do at present. And for those that do go there the Urgent Care Centres at the front of our local A&E services have been set up to deal with people who need primary care only.
What do you think?

We want to know what you think. Whether you are a service user, carer, staff member, representative group, community organisation or local resident, you can write to us or fill in the questionnaire at the back of this document and post it free of charge to:

Barking and Dagenham CCG, FREEPOST IY 426, ILFORD IG1 2BR

Alternatively, you can email your comments to: WIC.consultation@onel.nhs.uk

For further information about the consultation process or to read the background documents, including the business case and the walk-in audit, please take a look at our website at: www.barkingdagenhamccg.nhs.uk

We also plan to have two public drop-in events where you can come along, ask questions of the experts, share your opinions and find out more. These will take place at the following places:

19 March, 2-7pm
Barking Learning Centre
2 Town Square
Barking IG11 7NB

23 April, 3-7pm
Dagenham Library
1 Church Elm Lane
Dagenham RM10 9QS
Questionnaire

We welcome any feedback or ideas you have, but we are particularly interested in your answers to the following questions. You do NOT have to answer all questions and please use extra paper if necessary.

Question 1. Are you providing this response:
- [ ] In a personal capacity
- [ ] As a representative of a group

The case for change (see page 5)

Question 2. Do you think we need to change the current way of providing urgent primary care services?
- [ ] Yes
- [ ] No
- [ ] Don’t know

We are keen to know why you made this choice – please write below...

Our plans for urgent primary care (see page 9)

Question 3. What do you think about our plans for urgent primary care? For instance more appointments at GP surgeries – especially in the evenings and weekends; more telephone advice; and more services being made available in local GP surgeries.

Question 4. Please tick the three services shown below that you think would most improve care in the borough. (There is no need to rank services if you don’t think they would make a positive difference).
- [ ] Phone advice from local GPs who are able to access local information
- [ ] GPs to open earlier for bookable appointments for registered patients
- [ ] GPs to open later for bookable appointments for registered patients
- [ ] GPs to open at weekends for bookable appointments for registered patients
- [ ] A wider range of services in community pharmacies
- [ ] Improve GP premises
- [ ] Increase the number of urgent appointments at GP surgeries
- [ ] Access to urgent appointments with a neighbouring GP

Question 5. Are there new services that should be developed at Barking Community Hospital?
Our proposal (see page 6)

Question 6. We are proposing to close the walk-in service at Broad Street. Do you think we should discontinue the walk-in service at:

- Broad Street
  - Yes
  - No
  - Don’t know
- Barking Community Hospital
  - Yes
  - No
  - Don’t know
- Both Broad St and Barking Community Hospital
  - Yes
  - No
  - Don’t know

Please explain why you made these choices

Question 7. Are there other any suggestions you have to improve urgent care in the borough?

Question 8. If we go ahead with our proposals, what else should we consider? Please use this box for any other comments you have.

Please tell us a little about yourself (this section is NOT compulsory). If you wish to remain anonymous, your views will still be taken into account, however we would be grateful if you would fill in other data so that we can assess how representative respondents are and whether there are differences to the answers given by different groups of people.

a) Name

The borough you live in...

b) Would you like to be kept up to date with information about the NHS (including this programme)

- Yes
- No

If so, please give us your email or postal address.

c) Are you... (Circle all that apply)

- Male
- Female
- Prefer not to say

Responding as a

- Service user
- Carer
- Local resident
- Other
- Prefer not to say

Employed by the NHS?

- Yes
- No
- Prefer not to say

Aged....

- Under 16
- 16-25
- 26-40
- 41-65
- 65+
- Prefer not to say
d) Ethnic background (please tick all boxes that refer to you)

White
- British
- Irish
- Any other White background

Black
- Black British
- Black Caribbean
- Black African
- Any other Black background

Asian
- Asian British
- Indian
- Bangladeshi
- Pakistani
- Chinese
- Any other Asian background

Mixed
- White and Black Caribbean
- White and Black African
- White and Asian
- Any other ethnic group
- Prefer not to say


e) Which belief or religion, if any, do you most identify with?

- Agnostic
- Atheism
- Buddhism
- Christianity
- Hinduism
- Other
- Prefer not to say

- Islam
- Judaism
- Sikhism

f) Do you consider yourself to have a disability?

- Yes
- No
- Prefer not to say

Please send your questionnaire, free of charge to: FREEPOST I Y 426, ILFORD IG1 2BR
Or email your comments to WIC.consultation@onel.nhs.uk or fill in the questionnaire on our website at: www.barkinganddagenhamccg.nhs.uk
All comments must be received by 5pm on 21 May 2013

Confidentiality
If you are responding on behalf of an organisation or you are representative of service users / the public e.g. an MP or councillor your response may be made available for public scrutiny.

If you are responding in a personal capacity:
- and you would like to be kept informed of our work then please insert your name and address on the questionnaire.
- your response (but not your personal details) will be shared with decision-makers to enable them to consider your views fully.
- whether or not you provide your name and contact details, your response will not be published but unidentifiable quotes may be used to illustrate comments made.
Tell us what you think

There are a number of ways in which you can give your views:

- Complete the questionnaire on our website: www.barkinganddagenhamccg.nhs.uk
- Complete the questionnaire in this document, take it out and send to: Barking and Dagenham CCG, FREEPOST I Y 426, ILFORD IG1 2BR
- Write a letter to Barking and Dagenham CCG, FREEPOST I Y 426, ILFORD IG1 2BR
- Email: WIC.consultation@onel.nhs.uk

All comments must be received by 5pm on 21 May 2013
APPENDIX 3

Title: Update on the Walk-in Centre Consultation Process

Report of the Barking and Dagenham Clinical Commissioning Group

Report Authors: Zoë Anderson, Senior Public Affairs and Consultation Manager

Contact Details: Telephone: 020 8926 5011
E-mail: zoe.anderson@onel.nhs.uk

Accountable Director
Conor Burke (Accountable Officer, CCG)

Summary:
The consultation on the future on the Walk-in Centres started on 27 February 2013 and will run for 12 weeks closing on 21 May 2013. This report updates the Select Committee on the consultation so far, listing the consultation activities for Members’ information and providing detail of how it has been promoted within the community.

Dr Mohi (Chair of the Clinical Commissioning Group) and Sharon Morrow (Chief Operating Officer, CCG) will be present at the meeting to field further questions and comments from Members of the Walk-in Centre issue.

Recommendation(s)
The HASSC is asked to:
- Note the consultation arrangements giving comments on its scope and reach; and
- Continue to scrutinize the Walk-in Centre proposal ahead of the HASSC submitting its formal response.

1. Introduction
1.1. The urgent care system (A&Es, GP urgent appointments, GP out of hours service, walk in centres and urgent care centres) is complicated for patients to use and expensive to manage and run. We need a simpler, better system so that local people can get the urgent care they need.

1.2. In recent months across England, NHS walk-in services – where people simply walk in off the street and ask for help - have been increasingly under the spotlight. Clinicians have become concerned that rather than easing pressure on other services, such as A&E, they are simply creating extra demand and bypassing existing services such as GPs, pharmacists, out of hours services and sensible self-care. As a result, many walk-in services have closed.

1.3. Barking and Dagenham CCG believes that walk-in centres in Barking and Dagenham are not providing the best care for local people and not providing the best value for money. In particular:
The easy availability of walk-in appointments is discouraging residents from visiting or registering with a GP.

One third people attending them needed no treatment at all.

A&Es, urgent care centres and walk-in centres do not provide the best care for many conditions.

A busy A&E or walk-in centre is not necessarily the best place for many people (for instance people with a mental health problem) to receive care. GPs can and do provide this service.

GPs and nurses tell us there are too many people visiting walk-in centres who are not managing (or being helped to manage) their long term condition, so they end up seeking urgent help later on.

As a result, Barking and Dagenham CCG is holding a consultation on proposals to close the walk-in service at Broad Street, consolidate walk in services at Barking Community Hospital and improve other urgent care services in the borough.

2. Promoting the consultation

Two public drop-in events have been organised where people can come along, ask questions, share their opinions and find out more.

- Barking Learning Centre, 19 March, 2-7pm - 2 Town Square Barking IG11 7NB
- Dagenham Library, 23 April, 3-7pm - 1 Church Elm Lane Dagenham RM10 9QS

An advertisement was placed in the Barking and Dagenham Post promoting the consultation and the drop in sessions – one in early March and another in early May.

At the first drop-in session on 19 March we engaged with around 30 people and received 10 responses to the consultation.

The second session is on 23 April – the CCG is happy to update the scrutiny committee after this event.

A media release announcing the launch of the consultation was sent to local media and resulted in several pieces of coverage.

The CCG has offered to meet with councillors in the affected wards around Broad Street/Upney Lane, but none have yet taken up this offer. The CCG believes this would be a good opportunity to consider issues fully, and would welcome take up of this offer.

Electrical copies of the consultation were sent to:

- All GP practices in Barking and Dagenham
- LBBD health scrutiny committee
- LBBD Health and wellbeing board
- Barking and Dagenham MPs – Margaret Hodge and Jon Cruddas
- All LBBD councillors
• Local media
• London Assembly members for the area
• Transport for London
• Strategic Health Authority (NHS London)
• Care UK (providers of the Broad Street service)
• Barking and Dagenham LINk
• Barking and Dagenham CVS
• Barking and Dagenham Patient Engagement Forum

2.8 Hard copies of the consultation were also sent to:
• All GP practices in Barking and Dagenham
• WICs
• Dagenham Central Library
• Barking Learning Centre
• Barking and Dagenham Town Hall
• Barking and Dagenham CVS
• Barking and Dagenham LINk
• Children’s centres in Barking and Dagenham

3. Equalities impact assessment
3.1 A desktop equalities impact assessment (EIA) was undertaken alongside the preparation for the pre-consultation business case. Plans are in hand for a more detailed EIA to be completed by the end of the consultation. This will include:
• Identifying and reviewing evidence for analysis
• Summarising evidence across the equality strands
• Developing and delivering a plan of EIA stakeholder events
• Collating and summarising feedback.
Health and Adult Services Select Committee

17 April 2013

Title: Review on Type 2 Diabetes Services across the London Borough of Barking and Dagenham (Final Version)

Report of the Corporate Director of Adult and Community Services

Open For Decision

Wards Affected: None

Key Decision: No

Report Author: Mark Tyson, Group Manager Service Support & Improvement

Contact Details:
020 8227 2875
Mark.Tyson@lbld.gov.uk

Accountable Divisional Director:
Matthew Cole, Director of Public Health

Accountable Director:
Anne Bristow, Corporate Director Adult and Community Services

Summary:
The final version of the in-depth scrutiny report on Type 2 diabetes is appended for agreement by the Health & Adult Services Select Committee (HASSC), bringing to a conclusion its 2012/13 in-depth scrutiny review. HASSC have previously been presented with a first draft of the findings and recommendations of the scrutiny review and comments from both the Chair and Members of HASSC have been incorporated into this final report.

Councillor Maureen Worby, Chair of the Health and Wellbeing Board and Dr Waseem Mohi, Chair of the Clinical Commissioning Group received and discussed the findings of the scrutiny review undertaken by the HASSC at the meeting on 6 March 2013. A number of comments were made by Cllr Worby and Dr Mohi which were supported by the Select Committee and have been incorporated into the report. HASSC also supported a number of assurances made by the Chairs of the Health and Wellbeing Board and the CCG, including that:

- The findings of the scrutiny review will influence the next iteration of the Health and Wellbeing Strategy;
- The CCG are reviewing diabetes literature and will particularly review information packs given to patients in light of the concerns raised by HASSC;
- The CCG recognised that standards of care across the borough are not consistent and issues will be addressed through a programme of peer review;
- The CCG have established a diabetes forum to drive forward improvements, including extending and targeting diabetes service to find all groups within the community and developing expertise among GPs.

Once the final report is approved by HASSC, it will be passed to the Health and Wellbeing
Board for formal response and consideration of the recommendations. HASSC will receive a monitoring report in approximately six months time to establish the progress made in the implementation of the recommendations of the report.

**Recommendation(s)**

HASSC is requested to agree the final version of the report, and raise any final comments that they have.

**Reason(s)**

Type 2 diabetes is a serious health concern for Barking & Dagenham with more than 9,000 people already diagnosed. The Borough continues to see a change in the diversity of its population and this, together with health challenges such as obesity which are associated with Type 2 diabetes, is likely to impact on the numbers of people likely to develop diabetes over the next twenty years.

As such, the review of Type 2 diabetes addresses the following priority within the Community Strategy and Corporate Plan:

- Improve health and wellbeing through all stages of life

**Background Papers Used in the Preparation of the Report**

- None.

**List of appendices:**

**Appendix 1: Review on Type 2 Diabetes Services across the London Borough of Barking and Dagenham: Final Version**
Scrutiny Review
Health & Adult Services Select Committee

September 2012 – March 2013

Review on Type 2 Diabetes Services across the London Borough of Barking and Dagenham
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreword</td>
<td>3</td>
</tr>
<tr>
<td>Executive Summary</td>
<td>4</td>
</tr>
<tr>
<td>Recommendations</td>
<td>5</td>
</tr>
<tr>
<td>About this Scrutiny Review</td>
<td>7</td>
</tr>
<tr>
<td>About the Health &amp; Adult Services Select Committee (HASSC)</td>
<td>7</td>
</tr>
<tr>
<td>Scope of the review</td>
<td>8</td>
</tr>
<tr>
<td>Conduct of the review</td>
<td>8</td>
</tr>
<tr>
<td>What is Diabetes?</td>
<td>11</td>
</tr>
<tr>
<td>Who is at risk of developing Type 2 diabetes?</td>
<td>13</td>
</tr>
<tr>
<td>Theme 1: Prevalence</td>
<td>14</td>
</tr>
<tr>
<td>What we currently know about prevalence</td>
<td>14</td>
</tr>
<tr>
<td>Predicted prevalence of diabetes</td>
<td>15</td>
</tr>
<tr>
<td>Variances in prevalence data across the borough</td>
<td>15</td>
</tr>
<tr>
<td>Gap between diagnosis and predicted prevalence</td>
<td>17</td>
</tr>
<tr>
<td>Recommendations</td>
<td>18</td>
</tr>
<tr>
<td>Theme 2: Provision of health checks</td>
<td>19</td>
</tr>
<tr>
<td>Establishing national standards for diabetes care</td>
<td>19</td>
</tr>
<tr>
<td>The nine health checks</td>
<td>20</td>
</tr>
<tr>
<td>Patients' perception of health checks</td>
<td>22</td>
</tr>
<tr>
<td>Recommendations</td>
<td>25</td>
</tr>
<tr>
<td>Theme 3: Provision of information</td>
<td>26</td>
</tr>
<tr>
<td>Why is the provision of information important?</td>
<td>26</td>
</tr>
<tr>
<td>How can patients in Barking and Dagenham currently access information?</td>
<td>27</td>
</tr>
<tr>
<td>Recommendations</td>
<td>30</td>
</tr>
<tr>
<td>Theme 4: Hospital admissions</td>
<td>32</td>
</tr>
<tr>
<td>Integrated services for better diabetes management</td>
<td>33</td>
</tr>
<tr>
<td>Recommendations</td>
<td>35</td>
</tr>
<tr>
<td>Theme 5: Annual cost of diabetes</td>
<td>36</td>
</tr>
<tr>
<td>Recommendations</td>
<td>37</td>
</tr>
<tr>
<td>Conclusion</td>
<td>38</td>
</tr>
<tr>
<td>Appendices</td>
<td>39</td>
</tr>
</tbody>
</table>
Foreword

The number of people in the borough living with Type 2 diabetes continues to rise. However, we have learned that it is one of those conditions where with the right help and advice, individuals can live healthy lives for longer.

For those living with diabetes, the right care and lifestyle changes can help them avoid complications such as blindness and amputation. For everyone else, making good choices now can reduce the risk of diabetes developing or can help limit the severity of the condition.

It has been a real eye opener to speak to people who live with Type 2 diabetes in the borough. We have heard about the impact that the condition has on people’s lives day-to-day and the very real issues that people who live with Type 2 diabetes experience in terms of information, support and care.

We are pleased that diabetes is showing as a priority in the Health & Wellbeing Strategy and would urge the Health & Wellbeing Board to fully consider this report and take forward our recommendations.

The Select Committee would like to express their thanks to those who attended Committee meetings and supported our investigation. The effort and contribution of everyone we met indicated a clear commitment and energy amongst all of those working to improve diabetes care in Barking and Dagenham.

Cllr. Sanchia Alasia
Chair, Health & Adult Services Select Committee
Executive Summary and Recommendations

Type 2 diabetes is a serious health concern for Barking and Dagenham with more than 9,000 people already diagnosed. With the changes to the ethnic makeup of the population and the challenges associated with increases in adult obesity, experts believe that the numbers of people likely to develop diabetes in the next twenty years are set to rise by 50%.

In addition to primary care and community services required to support and maintain the health of people living with Type 2 diabetes, the development of complications as a result of poor management of the condition will continue to put pressure on existing services.

Members of the Health & Adult Services Select Committee (HASSC) were concerned by the expected increase in prevalence and the release of a National Audit Office report in 2012 which highlighted the need to improve the national delivery of high standards and value for money in diabetes care. As a consequence, the Committee decided to carry out an in-depth scrutiny which reviewed the current provision of services and information available to people living with Type 2 diabetes in the Borough. The scrutiny review was carried out between September 2012 and February 2013.

The Select Committee’s investigations looked closely at the services and support available in the Borough for people who had just been diagnosed and were living with Type 2 diabetes and how they could be helped to manage their condition more effectively.

A number of issues were identified including the expected prevalence and diagnosis rates for Type 2 diabetes in Barking and Dagenham and the lack of up-to-date baseline data. The review also highlighted a lack of consistency in the execution of diabetes health checks across GP surgeries as well as the up-take of annual appointments by patients, especially in light of the number of emergency admission rates for diabetes-related illness. Additionally, HASSC questioned the availability of information for people who were already diagnosed and newly diagnosed with Type 2 diabetes which might help them better understand their condition, particularly in regard to self management and long-term complications.

HASSC were pleased to see that, broadly speaking, all of the right services were in place and working to a good standard. However, with a renewed emphasis on integrated working and sustained activity to improve the take-up of health checks both for diabetics and those at risk, the borough could do more to prevent the awful complications of this condition. Given the high costs of diabetes-related medication in the borough, this could also release valuable resources for this and other priorities.

The detailed recommendations made by HASSC are presented on the following two pages.
Recommendations

A number of proposals were suggested throughout the scrutiny process, and these have been collated to form the following recommendations.

Recommendation: Prevalence data

It is recommended that a future iteration of the Joint Strategic Needs Assessment provides a clearer account of the source of competing data and the ‘best estimate’ that the borough is using to monitor its progress and identify the challenge it faces in addressing undiagnosed diabetes.

Recommendation: Improving screening and diagnosis

It is recommended that a programme of proactive screening opportunities is established, linked to improved entry routes to an integrated diabetes care pathway, with more medical professionals seeking opportunities for the proactive identification of diabetes in their patients and service users, and for GP’s to take a more pro-active role in diagnosis.

Recommendation: Patient understanding of health checks

Specifically, it is recommended that action is taken to improve patients’ understanding of the annual diabetes health checks, what they should expect to receive, and their importance in preventing complications.

Recommendation: Clinicians’ adherence to health check process

It is further recommended that the CCG takes steps to ensure that all clinicians are familiar with the NICE recommendations for the Annual Health Check and have arranged the provision of high-quality interventions, with associated processes for prompt arrangement of patient appointments and their reminders.

Recommendation: Performance monitoring of the health check process

For the longer term, it is recommended that the data is improved and the baseline for understanding uptake of the nine health checks is brought up to date, with on-going robust monitoring thereafter.

Recommendation: Information and advice

The Committee recommends that the whole range of information provided to people already diagnosed and people newly diagnosed with Type 2 diabetes is reviewed, ensuring that it gives them what they need to know to improve self-management of their diabetes and their understanding of long-term complications.

Recommendation: Young people’s support (Type 1 and Type 2)

That the Health & Wellbeing Board facilitates consideration of how young people with diabetes (either Type 1 or Type 2) could be supported in the Borough, inviting the participation of the health group of the Barking & Dagenham Youth Forum.
Recommendation: Younger adults developing Type 2 diabetes

That the Diabetes Support Group participates in a short review of the support needs of younger adults developing Type 2 diabetes, and how they may be met from a service user led group, led by an agency to be identified by the Health & Wellbeing Board.

Recommendation: Learning from South West Essex

That the Health & Wellbeing Board ask Public Health professionals to work with commissioners and North East London NHS Foundation Trust to understand the reasons why services which are on the face of it similar appear to be linked to different outcomes for patients, and to capture the lessons for future local commissioning.

Recommendation: Reviewing the integrated care pathway

That the Health & Wellbeing Board oversees a review of the care pathway to ensure that all opportunities for joint working are being harnessed and that the flow of patients between services is effective.
About this Scrutiny Review

The Health and Adult Services Select Committee agreed to carry out an in-depth scrutiny review of diabetes services and support for diabetics in Barking and Dagenham. The review focuses on Type 2 diabetes and how Type 2 diabetics could be helped to manage their condition more effectively.

Following initial scoping discussions, the Select Committee agreed a project plan for the scrutiny review at their meeting on Wednesday 4 July 2012. The scrutiny review has been primarily conducted through a number of themed investigative sessions over the period from July 2012 to March 2013.

Over the course of the review, the Select Committee conducted their investigations through a number of different channels, and received information from a wide range of sources, including:

- Clinicians at Barking, Havering & Redbridge University Hospitals Trust (BHRUT)
- Porters Avenue Integrated Diabetes Service
- North East London Foundation Trust (NELFT)
- NHS North East London and the City (NELC)
- Barking & Dagenham Clinical Commissioning Group (CCG)
- Barking and Dagenham Council
- South West Essex Community Services – Diabetes (SWECS)
- Diabetes UK
- Patients and carers from Barking & Dagenham Diabetes Support Group and other patient engagement forums
- Clinical and GP specialists
- Pharmacists
- Retinopathy services
- Barking and Dagenham Local Involvement Network (BDLINk)

Members also invited people living with Type 2 diabetes to participate in a survey to give the Committee more insight into how patients manage their diabetes, what services patients use and their thoughts and experiences of service provision in Barking and Dagenham. The results of this, along with the information gathered in sessions and site visits have also informed the findings and analysis of this final report.

About the Health & Adult Services Select Committee (HASSC)

HASSC consisted of the following nine Councillors in the 2012-13 municipal year:

- Councillor S Alasia (Chair)
- Councillor E Keller (Deputy Chair)
- Councillor L Butt
- Councillor J Davis
- Councillor A Gafoor Aziz
- Councillor M McKenzie MBE
- Councillor C Rice
- Councillor A Salam
- Councillor J Wade
Elaine Clark, Secretary of the Barking & Dagenham Diabetes Support Group was appointed as a Co-opted Member of the Select Committee to give advice and lend expertise to the evidence gathering. In her role as Co-optee Elaine was the voice for local diabetics (and their carers) ensuring that the opinions of the support group and their experiences of local services were raised during the Committee's discussions.

Matthew Cole, Joint Director of Public Health provided professional advice and support to the Committee.

Anne Bristow, the Corporate Director of Adult and Community Services, nominated as the HASSC Scrutiny Champion, supported the Select Committee throughout the review and provided expertise and guidance.

Scope of the review

HASSC particularly wished to explore how diabetics could be helped to manage their condition effectively. Members noted the timely release of a National Audit Office report on the need to improve the national delivery of high standards and value for money in diabetes care.

In establishing the review, HASSC identified five areas which it would explore as part of the review and these form the basis of this report:

**THEME 1: Prevalence**
What is the expected prevalence of Type 2 diabetes against the number of known diagnosed diabetics?

**THEME 2: Provision of health checks**
How does Barking and Dagenham compare with the targets - are people with Type 2 diabetes having the nine annual health checks recommended by the National Diabetes Framework?

**THEME 3: Provision of information**
How sufficient is the readily available information for people living with Type 2 diabetes?

**THEME 4: Hospital admissions**
Is the current provision of services reducing high hospital admission rates?

**THEME 5: Costs of diabetes**
What is the annual spend on diabetes-related treatments for Barking and Dagenham?

Conduct of the review

The scrutiny review took place around five themed sessions.

A Patient Perspective Session was held in September 2012 to explore the experiences of patients and carers with Type 2 diabetes and services in the Borough. The session allowed patients and carers to talk to Members about their experience of living with Type 2 diabetes, the problems they have faced since diagnosis and how they access services. Representatives attended from patient engagement groups such as the Barking and Dagenham Diabetes Support Group, Patient Advice and Liaison Service (PALS) at Barking,
Havering & Redbridge University Hospitals NHS Trust (Queen’s Hospital) and Barking and Dagenham Local Involvement Network (BDLINK).

The session was very useful and Members were able to ask how diabetics manage Type 2 diabetes on a day-to-day basis and their experiences of diabetes care provision and availability of information in the borough.

In December 2012, representatives from Diabetes UK and South West Essex Community Diabetes Service (SWECS) attended to talk to Members about examples of Good Practice. Members were able to look at service provision and performance at SWECS to understand how it compares to Porters Avenue Services. Members were also able to consider some of the issues raised by Diabetes UK about quality of foot checks.

Two sessions were held in January and February 2013 which focused on Service Provision across the Borough. Representatives were invited from a number of care services including Clinical services (GP’s and GP’s with Special Interest [GPwSI]), Low Vision/Retinopathy services, Community Nursing, Mental health Services, Pharmacists and staff from the Integrated Diabetes Service at Porters Avenue. Members had an opportunity to discuss some of the key issues of service provision including service integration, quality of service and how to improve the patient experience.

A copy of the notes from each of the session is included in Appendix 1.

Site Visits

In addition to information gathering sessions, Members also carried out two site visits.

Members attended a Barking & Dagenham Diabetes Support Group meeting. This really helped Members experience first-hand the work that the support group do in terms of keeping its members informed about diabetic health issues and services available. On the evening of the site visit, a nurse from Porters Avenue attended to talk about the importance of foot health and long term complications of ignoring foot care.

Members also visited Porters Avenue Integrated Diabetes Services where they were able to meet with staff and discuss in more detail problems around educating young people about diabetes and the importance of a healthy lifestyle and what we can do as a Borough to raise awareness about diabetes among the general population.

Survey

In order to better understand the patient perspective, the Committee proposed a survey of people who are currently living with Type 2 diabetes and people who care for someone with Type 2 diabetes. The survey was distributed between 28 November 2012 and 31 January 2013 and aimed to find out more about diagnosis, provision of information, support for both patients and carers and accessing services and education programmes. A copy of the survey can be found at Appendix 2.

In order to ensure the highest return rate possible, the survey was distributed through a number of routes, including on-line via the Council, Barking & Dagenham LINk and Clinical Commissioning Group websites, with additional hardcopies of the survey were provided to the B&D Diabetes Support Group and GP surgeries with diabetic clinics. Council officers and volunteers also undertook sessions at the Barking Learning Centre and Dagenham Library during January 2013.
The survey closed on 31 January 2013 with a total of 62 responses received. The findings from the survey are included throughout this report and a full analysis of the results may be found in Appendix 3.

It is important to note that since Type 2 diabetes affects only approximately 7.3% of the Borough population, the number of respondents was expected to be relatively low.

A note of caution should be given about the survey results. The number of respondents cannot be considered representative of all patients living with Type 2 diabetes in the Borough since the demographics of the survey respondents are not reflective of the demographics of the general population of the Borough:

- 81% of the respondents were between 40-74 (40-59 year olds 44%, 60-74 year olds 38%)
- 67.3% were from a ‘White British’ background
- 86% stated ‘English’ as their first language
What is Diabetes?

Diabetes is the name used to describe a metabolic condition of having higher than normal blood sugar levels. There are different reasons why people get high blood glucose levels and so a number of different types of diabetes exist.

Most of the food we eat is turned into sugars for our bodies to use for energy. The main sugar is called glucose, which passes through the gut wall into the bloodstream. However, in order to remain healthy, blood glucose levels should not go too high or too low.

Therefore, when blood glucose levels begin to rise after eating, the level of a hormone called insulin should also begin to rise. Insulin works on the cells of the body to make them extract glucose from the bloodstream. Some of the glucose is then used by the cells for energy and some is converted into glycogen or fat (both of which are stores of energy). When blood glucose levels begin to fall (between meals), the level of insulin falls. Some glycogen or fat is then converted back into glucose which is released from the cells into the bloodstream.

The pancreas, an organ that lies near the stomach, makes insulin to stimulate the cells of our bodies to extract glucose from the bloodstream. Insulin is produced in the beta cells of the pancreas. When you have diabetes, your body either doesn't make enough insulin or can't use its own insulin as well as it should. This causes sugars to build up in the blood.

Type 1 Diabetes

- Type 1 develops if the body cannot produce any insulin. It usually appears before the age of 40 and especially in childhood. It is the less common of the two types and accounts for around 10% of all people with diabetes.
- Type 1 cannot be prevented and is treated by daily insulin doses – taken either by injection or via an insulin pump – as well as a healthy diet and regular physical activity. In Type 1, the insulin-producing cells in the pancreas have been destroyed. It is not known exactly why these cells have been damaged.

Type 2 Diabetes

- Type 2 accounts for around 90% of people with diabetes. It is treated with a healthy diet and increased physical activity. In addition, tablets and/or insulin may be required.
- Type 2 develops when the body can still make some insulin, but not enough, or when the insulin produced does not work properly (insulin resistance). Risk factors for developing Type 2 include family history, ethnicity, being overweight or having a large waist, high blood pressure, heart disease or having had a heart attack.

Diabetes is becoming increasingly common throughout the world, including the UK, due to increased obesity.

If left untreated, diabetes can lead to complications such as loss of feeling in fingers and toes (a condition called diabetic neuropathy), kidney problems, heart problems, loss of vision (through a condition called retinopathy) and other disorders. At advanced stages, diabetes can cause kidney failure, lower-extremity amputation, blindness and stroke.
However, complications can be prevented or significantly delayed by keeping good control of the diabetes, blood pressure and cholesterol levels.

**The symptoms of diabetes**

Diabetes is predicted by a clear set of symptoms, but it still often goes undiagnosed. The main initial signs of diabetes are:

- Increased thirst;
- Increased need to urinate;
- Increased hunger.

Type 1 diabetes symptoms often appear suddenly and can additionally include:

- High levels of sugar in the blood and urine;
- Weight loss;
- Weakness;
- Tiredness;
- Mood swings;
- Nausea;
- Vomiting.

Type 2 diabetes symptoms tend to come on very gradually, and include most in the list above. Additionally, skin infections, blurry vision, tingling or dry skin are also relatively common symptoms. The gradual onset of symptoms means that it is important that people are not tempted to dismiss the symptoms as simply getting old.

**Possible complications of diabetes**

Short-term complications include a very high blood glucose level, which is not common with Type 2 diabetes, but is more common in untreated Type 1 diabetes when a very high level of glucose can develop quickly. However, a very high glucose level develops in some people with untreated Type 2 diabetes.

Long-term complications, where blood glucose levels are higher than normal over a long period of time, can gradually damage blood vessels. This can occur even if the glucose level is not very high above the normal level. This may lead to some of the following complications (often years after the disease first develops):

- Atheroma (furring or hardening of the arteries). This can cause problems such as angina, heart attacks, stroke and poor circulation.
- Kidney damage which sometimes develops into kidney failure.
- Eye problems which can affect vision (due to damage to the small arteries of the retina at the back of the eye).
- Nerve damage.
- Foot problems (due to poor circulation and nerve damage).
- Impotence (again due to poor circulation and nerve damage).

The type and severity of long-term complications vary from case to case. Some people do not develop any at all. In general, the nearer the blood glucose level is to normal, the lower the risk of developing complications. Risk of developing complications is also reduced if you deal with any other risk factors that may be present, such as high blood pressure.
Who is at risk of developing Type 2 diabetes?

Type 2 diabetes often develops in people who are over the age of 40 years old and who may also have one or more of the following risk factors:

- A close family history of the condition, in parents, or siblings;
- Being overweight or obese;
- Having a waist measurement of more than 80cms (31.5in) if you are a woman, or 94cms (37in) if you are a man.

In addition, there are increased risks for certain groups within the community, including particular ethnic groups or those who have experienced other serious health conditions. Some examples include:

- People of South Asian origin (Indian, Bangladeshi and Pakistani) are six times more likely to develop Type 2 diabetes than any other ethnic group;
- There are links to other common conditions such as Poly Cystic Ovarian Syndrome, although the links are not fully understood;
- Those with heart disease or who have had a heart attack.

A condition called ‘impaired glucose intolerance’ may also precede a diagnosis of diabetes, often by many years, and will be evidenced by moderately raised levels of blood glucose. Both conditions (impaired glucose intolerance and diabetes) can be brought on during pregnancy.
Theme 1: Prevalence

What we currently know about prevalence

The Association of Public Health Observatories (APHO) data shows that average registered adult prevalence of diabetes in England is about 5.5%, and that 90% of adults with diabetes have Type 2 diabetes. Whilst this sort of diabetes usually appears in adults who are middle aged or older, there are an increasing number of children and younger people being diagnosed and this is linked to rising obesity prevalence in young people.

The Joint Strategic Needs Assessment 2012 found that in Barking and Dagenham, at the end of March 2012, 9,523 people had been diagnosed with diabetes, a rise of 14% since 2009/10, although it is estimated that at least 1,642 people remain undetected as at November 2012.

**Figure 1 - Prevalence of diabetes in Barking & Dagenham**

<table>
<thead>
<tr>
<th>Year</th>
<th>Actual number of people with diabetes</th>
<th>Predicted number</th>
<th>Estimated undetected</th>
<th>Diagnosed prevalence</th>
<th>Predicted prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009/10</td>
<td>8,349</td>
<td>9,426</td>
<td>1,100</td>
<td>4.5</td>
<td>5.1</td>
</tr>
<tr>
<td>2011/12</td>
<td>9,523</td>
<td>11,049</td>
<td>1,642</td>
<td>4.9</td>
<td>5.7</td>
</tr>
</tbody>
</table>

Source: Public Health Observatory Diabetes Prediction Modelling and Quality Management and Analysis System QMAS

However, a Diabetes Audit undertaken by the NHS Information Centre in 2010/11 reported 9,125 diabetes registrations, which is consistent with the increase from 4.5% diagnosed prevalence to 4.9% shown above.

**Availability of Baseline Data for Barking & Dagenham**

As part of the scrutiny process, Members raised some concern that there was a disparity of information relating to prevalence data for diabetes in Barking and Dagenham. The data presented to Members throughout the scrutiny process all agree that the prevalence of diabetes is increasing although there is a lack of consistency around the figures themselves.

**Figure 2 - Variations in prevalence of diabetes data**

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Porters Avenue</th>
<th>JSNA 2013 / Public Health Observatory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data</td>
<td>9305 (6.12%)</td>
<td>9,523 (4.9%)</td>
</tr>
</tbody>
</table>
However, what service providers at all of the sessions agreed is that the figure is set to increase due to the changing socio-ethnic make-up of the borough.

**Predicted prevalence of diabetes**

With increases in adult obesity and the challenges associated with poor diet and lack of exercise, the incidence of diabetes is predicted to increase over the coming years. Estimates indicate that diabetes is expected to increase by about 50% over the next twenty years as related conditions such as obesity continue to rise, so that by 2030, 14,000 people are expected to be living with diabetes in Barking and Dagenham.

The data also indicates that the gap between the actual number of people diagnosed and the expected diabetes prevalence is narrowing across the borough. While this could reflect an increase in levels of diagnosis, the changes in ethnic make-up of the Borough means that the model could actually be an underestimate.

**Figure 3 - Predicted prevalence of diabetes in B&D**

![Graph showing predicted prevalence of diabetes](image)

While this could reflect those from a elderly patients, (APHO), Disease prevalence Models (2010) and Quality Outcomes Framework 2009-2011 data (from QMAS)

**Variances in prevalence data across the borough**

The prevalence of diagnosed diabetes in Barking and Dagenham varies from 2.4% to 7.9% between GP practices in the borough as of November 2012.

The JSNA 2010/11 argues that difference in prevalence across GP practices is directly related to the variation in demography such as the number of elderly patients, those from a
minority ethnic group, and those who are obese: all factors which increase the likelihood of a person developing Type 2 diabetes. The JSNA also suggests that:

“*further analysis is needed to determine whether there is any correlation between poor diabetes control and the population demography of the practice population, or whether the variation in control is more likely to be due to the effectiveness of the support patients receive, and the systems and processes within the practices which help support good management.*”

The three demographic factors most closely associated with the likelihood of developing Type 2 diabetes, obesity, ethnicity and age (particularly where two or more of these factors are combined) are prominent in the demographic make-up of the population and must be taken into account when predicting future prevalence models.

**Obesity**

Obesity is a firmly established risk factor for developing Type 2 diabetes and as increased levels of obesity in the population rise, so too will the likelihood of Type 2 diabetes.

The ‘Annual Report of the Director of Public Health for Barking & Dagenham 2013’ found that Barking and Dagenham is estimated to have the highest percentage of obese adults in London, with more than one in four adults obese, the third highest rate of child obesity in England at Year 6 [10-11 years] (26.9%) and the second highest at Reception age [4-5 years] (13.7%).

Adult obesity is a serious problem in Barking and Dagenham with one in four adults with a BMI (Body Mass Index) of more than 30. The Annual Report also found that obesity rates vary according to socio-economic status, with *"low income and deprivation having a greater impact on female obesity levels than male. In addition, there is a higher prevalence of obesity among some ethnic groups, in particular among Black Caribbean and Pakistani women....The high costs of obesity result from the increased risk of many chronic conditions, including diabetes...."*

**Ethnicity**

The 2011 census shows that an estimated 16.4% and 18.14% of the borough’s population is South Asian and African/African-Caribbean respectively, some of the ethnic groups that are more significantly affected than others by Type 2 diabetes. Type 2 diabetes is up to 6 times more likely in people of South Asian descent and up to three times more likely in African and African-Caribbean people.

This means that an expected continued increase in the prevalence of Type 2 diabetes is also likely. At present there is no diagnosis data available which shows the breakdown of Type 2 diabetes against ethnicity.

**Age**

The 2011 census data shows that a majority of residents in the Borough are in the age range most likely to develop Type 2 diabetes (40+ years) and this should be taken into account when combined with other factors such as ethnicity and obesity when predicting future prevalence models.
Gap between diagnosis and predicted prevalence

With an estimated 1,642 people living with undetected diabetes, the Committee was interested to hear from witnesses about the potential improvement that could be made in diagnosis rates. Representatives attending the sessions confirmed that there is little funding for local screening events although Pharmacists and staff at Porters Avenue do run ad hoc events and that commissioners may wish to explore the option of Pharmacists providing screening tests to help make screening for Type 2 diabetes more easily accessible.

In addition, there was a consensus that all medical practitioners, GPs amongst them, require ongoing training about Type 2 diabetes to ensure that all opportunities are being taken to identify those at risk and living with the disease, as well as to keep up to date with current medication and research.

Given the changing demographics of the borough, it was also suggested to Members that work is required which looks at actively screening people who have a high risk of developing diabetes such as people from African/Afro-Caribbean and Asian backgrounds.

Funding for screening programmes should also be considered to help make screening more accessible as well as thinking more proactively about other ways of screening people for diabetes for example, holding sessions at pharmacies, supermarkets, holy places and car parks in order to reach people who do not routinely go to GP surgeries.

Members also felt that commissioners need to ensure that guidelines are being followed to check other disease registers for people who may potentially have diabetes e.g. asthma register.
Recommendations

The Committee felt that a lack of accurate baseline data, for both diagnosis and expected prevalence data, will make it more difficult to accurately predict future trends and commissioning requirements especially in light of the fact that current prediction models are based on historical data (2010/11).

Members suggest that baseline data should include the actual number of people already diagnosed with Type 2 diabetes together with a demographic breakdown.

**Recommendation: Prevalence data**

It is recommended that a future iteration of the Joint Strategic Needs Assessment provides a clearer account of the source of competing data and the ‘best estimate’ that the borough is using to monitor its progress and identify the challenge it faces in addressing undiagnosed diabetes.

**Recommendation: Improving screening and diagnosis**

It is recommended that a programme of proactive screening opportunities is established, linked to improved entry routes to an integrated diabetes care pathway, with more medical professionals seeking opportunities for the proactive identification of diabetes in their patients and service users, and for GP’s to take a more pro-active role in diagnosis.
Theme 2: Provision of health checks

Establishing national standards for diabetes care

There are a number of national guidelines which set out the standards for diabetes services which commissioners must incorporate when commissioning local diabetes services. The two main guidelines are the National Service Framework for Diabetes and the National Institute of Health and Clinical Excellence (NICE) Quality Standards for Diabetes.

The National Service Framework for Diabetes

The National Service Framework (NSF) was established to improve diabetes services through setting national standards to “drive up service quality and tackle variations in care.” The Framework aims to enable more people to live free of diabetes and free from the complications of diabetes and their consequences.

Under the NSF, diabetes services should be:

- **Person-centred**: empowering the individual to adopt a healthy lifestyle and to manage their own diabetes, through education and support which recognises the importance of lifestyle, culture and religion, and which, where necessary, tackles the adverse impact of material disadvantage and social exclusion.
- **Developed in partnership**: ensuring goals and the respective responsibilities of the individual and the diabetes team are agreed and clearly set out in a regularly reviewed care plan.
- **Equitable**: ensuring that services are planned to meet the needs of the population, including specific groups within the population, and are appropriate to individuals' needs.
- **Integrated**: drawing on the knowledge and skills of health and social care professionals across a multidisciplinary diabetes health care team, including primary care and social care as well as specialist services.
- **Outcomes oriented**: narrowing the inequalities gap between those groups whose outcomes are poorest and the rest; minimising the risk of developing diabetes and its complications and maximising the quality of life for individuals by empowering staff to deliver, evaluate and measure care.
- **Delivering this vision** and embedding these principles in practice requires staff throughout the NHS to understand the experience of diabetes and diabetes care, and to recognise the expertise of people who live with diabetes. The aims will be to empower people with diabetes through skills, knowledge and access to services to manage their own diabetes and fulfil their potential to live long lives free of the complications that can accompany diabetes.

In particular, the NSF sets out the expected health checks and treatment options that should be available to all type 2 diabetics. In particular, Standards 10 and 12 seek to ensure that all young people and adults with diabetes will receive regular surveillance for the long-term complications of diabetes, and that all people with diabetes requiring multi-agency support will receive integrated health and social care.
The National Institute of Health and Clinical Excellence (NICE), Quality Standards for Diabetes.

The National Institute of Health and Clinical Excellence (NICE) published a Quality Standard for diabetes in 2011 which supports the existing NSF and provides a definition of ‘good quality’ care. The NICE quality standards enable:

- health and social care professionals to make decisions about care based on the latest evidence and best practice.
- patients understand what service they can expect from their health and social care providers.
- NHS trusts to quickly and easily examine the clinical performance of their organisation and assess the standards of care they provide.
- commissioners to be confident that the services they are providing are high quality and cost-effective.

The standards include giving people knowledge to understand their condition to help with self-management through structured education programmes, access to specialist diabetes advice, care planning discussions and annual checks. A summary of the standards is included in Appendix 4. Full details of the standard are available on-line: [http://guidance.nice.org.uk/QS6](http://guidance.nice.org.uk/QS6)

### The Nine Health checks

To help achieve these standards, NICE recommend nine key health tests which people living with Type 2 diabetes should have annually to help monitor and manage their diabetes and to reduce the risk of complications such as amputations. The nine annual health checks for people with diabetes are:

1. Weight and BMI Measurement
2. Blood pressure
3. Smoking status
4. Blood test (HbA1c – blood glucose levels)
5. Urinary albumin test (or protein test to measure the kidney function)
6. Serum creatinine test (creatinine is an indicator for renal function)
7. Cholesterol level check
8. Eye check (retinopathy screening)
9. Foot check

### Uptake of Recommended Nine Health Checks in Barking and Dagenham

The National Diabetes audit 2010/11 found that only 51.2% of people living with diabetes in Barking & Dagenham are receiving all 9 of the annual essential healthcare checks.
The National Diabetes Audit (2010/11) reviewed the performance of the annual health checks in Barking and Dagenham and found that just over half (51%) of people with diabetes get all of them annually; the corresponding national figure is 54%. The audit was undertaken over a three year period (1 April 2008 to 31 March 2011) and Barking and Dagenham were identified as performing in the bottom 25% of PCTs.

The audit also found that people with Type 1 diabetes are less likely than those with Type 2 to receive all the tests annually – 38% against 53% – and that in both categories, people under 55 are less likely to receive all the tests than people over 55 years.

The table below gives an overview of performance against each test, as identified by the National Diabetes Audit 2010/11.

### Figure 6 - Percentage of all patients in B&D receiving NICE recommended care processes

<table>
<thead>
<tr>
<th>Care Process recorded</th>
<th>Percentage of registered patients in PCT</th>
<th>Percentage point change since 2009-2010</th>
<th>Median score across all PCTs</th>
<th>National quartile ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Care Processes*</td>
<td>51.2%</td>
<td>+16.69%</td>
<td>55.5%</td>
<td>3</td>
</tr>
<tr>
<td>Blood Creatinine</td>
<td>91.0%</td>
<td>-0.25%</td>
<td>93.1%</td>
<td>4</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>94.6%</td>
<td>-0.62%</td>
<td>95.2%</td>
<td>3</td>
</tr>
<tr>
<td>BMI</td>
<td>87.7%</td>
<td>-3.74%</td>
<td>90.0%</td>
<td>4</td>
</tr>
<tr>
<td>Cholesterol</td>
<td>90.1%</td>
<td>-0.49%</td>
<td>91.7%</td>
<td>4</td>
</tr>
<tr>
<td>Eye Screening</td>
<td>82.3%</td>
<td>+25.23%</td>
<td>82.4%</td>
<td>3</td>
</tr>
<tr>
<td>Foot Exam</td>
<td>84.9%</td>
<td>-0.05%</td>
<td>84.5%</td>
<td>3</td>
</tr>
<tr>
<td>HbA1c**</td>
<td>89.6%</td>
<td>+0.37%</td>
<td>92.9%</td>
<td>4</td>
</tr>
<tr>
<td>Smoking Review</td>
<td>84.1%</td>
<td>-3.68%</td>
<td>85.7%</td>
<td>3</td>
</tr>
<tr>
<td>Urinary Albumin</td>
<td>71.2%</td>
<td>+10.87%</td>
<td>76.3%</td>
<td>4</td>
</tr>
</tbody>
</table>

*People registered with diabetes receiving all nine key processes of care processes

**For patients under 12 years of ages, ‘all are processes’ is defined as HbA1c only as other care process are not recommended in the NICE guidelines for this age group.
The latest Joint Strategic Needs Assessment still bases its judgment of performance against these essential annual health checks on the basis of the 2010/11 data. Whilst the sample size was small, a more recent indicator is provided by the Patient & Carer Survey commissioned by the Select Committee. It suggests that there has been relatively little consistent improvement in the take-up, although the consistency of eye checks appears to be positive. However, this cannot compare to the standard of data in the original 2010/11 audit. The clinicians who addressed the Committee during the review confirmed that they see Barking and Dagenham as having a low percentage of people having annual health reviews, with significant variation in take-up numbers across different practices.

This continued questionable performance suggests that more robust and consistent data needs to be employed to drive improved delivery.

Figure 7 - Prevalence of annual health checks in Barking & Dagenham

<table>
<thead>
<tr>
<th>Health Check</th>
<th>Annually</th>
<th>Sometimes</th>
<th>Never</th>
<th>Didn’t Know they should</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kidney check (creatinine and albumin)</td>
<td>59.2%</td>
<td>4.1%</td>
<td>8.2%</td>
<td>4.1%</td>
</tr>
<tr>
<td>Blood pressure</td>
<td>77.6%</td>
<td>16.3%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Weight check</td>
<td>73.5%</td>
<td>14.3%</td>
<td>2.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Cholesterol level</td>
<td>77.6%</td>
<td>10.2%</td>
<td>2.0%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Eye check</td>
<td>98.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Leg and feet check</td>
<td>71.4%</td>
<td>10.2%</td>
<td>2.0%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Blood glucose levels (HbA1c)</td>
<td>42.9%</td>
<td>6.1%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Support for smoker</td>
<td>8.2%</td>
<td>6.1%</td>
<td>10.2%</td>
<td>4.1%</td>
</tr>
<tr>
<td>Personal health and care plan*</td>
<td>26.5%</td>
<td>10.2%</td>
<td>16.3%</td>
<td>8.2%</td>
</tr>
</tbody>
</table>

*This information was requested in the survey to ascertain how many people reviewed their care plan annually.

Diabetes Patient and Carer Survey 2012-13 LBBD

Patients’ perception of health checks

The JSNA 2013 suggests that the diabetes focus group (consulted as part of the JSNA review) felt low levels of annual checks may be due to the following factors:

- Not being invited annually – patients were often reminding their practice that they were due testing not vice versa;
• Lack of automated invitations;
• Inability to get appointments at convenient times especially for people of working age (hence the lower completion rate in under 55 year olds).

Members felt that additional work is need to better understand why this may be the case and to work towards not only encouraging patients to have their annual check but to ensure that GPs maximise the number of annual reviews that they do.

Only a small percentage of people indicated that they didn’t know they should be having annual checks, which therefore suggests that, by and large, patients are aware that annual check-ups should take place. In terms of the low take-up, therefore, there are three possible conclusions which may be drawn from this:

• The patient does not understand the importance of having annual checks or does not understand what the Annual Health Check involves;
• GPs may not be reinforcing the importance of the tests and actively encouraging patients to have an annual check up;
• In some cases, there may be other reasons, unique to individuals, as to why regular health checks are not being followed up.

Clinicians who participated in the scrutiny process said that GPs and nurses should ensure that they explain to the patients the purpose of the annual review and what to expect. They felt that booklets explaining what happens in the annual reviews are essential as significant number of people do not seem to understand what to expect.

The Committee were concerned that if the annual checks are not regularly taking place, patients are more likely to develop future complications which may have been avoided. Members recommend that information about the importance of annual health checks, and what patients should expect from them, is provided to people with diabetes.

Foot Health

People with diabetes are more likely to be admitted to hospital with a foot ulcer than with any other complication of diabetes. This is due to the fact that diabetes can cause poor circulation and reduced feeling in the feet, as well as inhibiting healing. The Annual Foot check should include:

• Testing sensation and pulse
• Examination for signs of deformity, infection or ulceration
• Checking footwear is suitable
• Discussing any pain or previous ulceration

The ‘Healthy Feet’ campaign promoted by Diabetes UK focuses on providing advice about maintaining healthy feet and the importance of annual feet checks.

The National Diabetes Audit found that 84.9% of people with diabetes in Barking and Dagenham received a foot check in 2010/11. The audit also showed that of those who did receive the annual foot check, patients reported that the level of the foot check is poor. It should be noted that this information is based on patient satisfaction and what is not clear is whether the patient understood what they should expect from their annual foot check. Given that this is the most common complication, it is concerning that it ranked in the bottom five of the regular health checks amongst respondents to the Patient & Carer
Survey. However, it appears to correlate with the feedback from clinicians who attended the Committee, who reported that the quality of foot checks among local practitioners varied and that not all of the elements of the foot checks were being completed. For example, feedback received by clinicians from patients indicates that some GPs do not check footwear or routinely carry out a pulse test. They also reported that some patients said that their GPs did not even inspect their feet. Representatives of the CCG attending the sessions advised Committee Members that it needed to increase awareness of the importance of foot checks and health checks in general to ensure that they are being carried out properly.

**Care plan review**

It has already been discussed that one of the factors for reducing the risk of complications is to adopt a healthy lifestyle which includes good diet and exercise and yet the figures from the Patient & Carer survey show that of those who responded, only 26.5% regularly review their care plan. What is not clear is of the 73.5% not reviewing their care plan, how many are no longer following it; and whether there had been any significant health changes as a result.

Pharmacists attending the Service Provision session expressed concern that care plans often didn’t take into account all of the different services available, because the care plan always end at surgery level. The representatives suggested that GP’s should work to develop partnerships between pharmacists, other professionals and the public to enhance shared care, especially in changing patterns of behaviour among patients to move towards ‘self-care’.

**Eye health: diabetic retinopathy screening**

As is shown in the data on health checks, the proportion of people offered a retinopathy screen is high. This also leads to the number of people with diabetes in Barking and Dagenham who have retinopathy diagnosed by screening being above the national average. However, at present only around 80% of people accept the offer of retinopathy screening. Encouraging more people to take up the offer of screening and reduce their risk of eye disease progressing is another important opportunity to improve their health.

The borough’s Vision Strategy 2010-2015 identified that of those people with diabetes who were screened, over 1,750 had some degree of retinopathy. It further identified that over 2,100 people with diabetes had failed to attend their retinopathy screening appointments, which roughly correlates to the 20% identified in the JSNA as not taking up the offer. This has led to additional appointments being offered to encourage everyone to have at least 3 fixed appointments for screening, plus an open offer of being able to phone up and choose a screening date at any time.

Retinopathy services provided evidence to the Committee during the review. At the session on 31 January 2013, representatives from the Retinopathy Service at Porters Avenue reported concern that, while there is good uptake for the retinopathy screening, patients do not always understand that they also need to have the annual NHS eye test. This potentially leaves other health issues, such as glaucoma, undetected. The results from the Patient & Carer survey showed that 98% of respondents had an annual eye check but it doesn’t indicate whether that included the NHS standard eye test, and there is no
method for tracking whether patients are having both retinopathy screening and an NHS eye test at present.

**Overview of the issues presented around health checks**

What has become apparent through the scrutiny is that the current screening process for complications associated with diabetes is not performing as well as it should be, in certain areas. This view is supported by pharmacists, GPs and healthcare workers who attended the information gathering sessions.

Members heard that training for GPs is provided across the borough, but that clinicians suggested that the training focuses primarily on medication and could be enhanced to provide wider professional development around encouraging patients to more effectively self-manage their diabetes.

When the issues above were presented to representatives from the CCG in March 2013, the CCG agreed that the standards of care across the borough, particularly in regard to the standard and adherence to the 9 NICE health checks was not consistent from all GP surgeries. HASSC welcomed the assurance that the CCG would address these findings through a programme of peer review and would also review GP training on diabetes.

**Recommendations**

Based on the information received by the Committee, Members concluded that there was a need to raise awareness amongst both diabetic patients and their community health professionals (GP’s and practice nurses in particular) about the importance of the annual health checks.

**Recommendation: Patient understanding of health checks**

Specifically, it is recommended that action is taken to improve patients’ understanding of the annual diabetes health checks, what they should expect to receive, and their importance in preventing complications.

**Recommendation: Clinicians’ adherence to health check process**

It is further recommended that the CCG takes steps to ensure that all clinicians are familiar with the NICE recommendations for the Annual Health Check and have arranged the provision of high-quality interventions, with associated processes for prompt arrangement of patient appointments and their reminders.

**Recommendation: Performance monitoring of the health check process**

For the longer term, it is recommended that the data is improved and the baseline for understanding uptake of the nine health checks is brought up to date, with on-going robust monitoring thereafter.
Theme 3: Provision of information

From the outset of the diabetes scrutiny review, Members were particularly interested in looking at the information and advice which was available to people with Type 2 diabetes. At the Patient Perspective session issues were raised that the availability of information was poor, specifically the guidance and help provided by GPs to those who are newly diagnosed, and about the complications which may be associated with poor management of diabetes.

Those whom the Committee interviewed displayed some measure of consensus on the point that information is poor, especially around managing the condition and the long term impact if diabetes is not managed well. One representative said that:

“*Information and communications are very poor in the borough [about long term complications]. I was not told about what to do after I lost my leg for 6 years. I started losing my sight 4 years ago and had to pack up work. I drove an automatic car before that but losing my sight has meant life has changed.*”

It was also felt that the lack of information about the seriousness of the condition can cause people to think that it “*…it won’t happen to them…..*” And that having the right information early enough might make people take diabetes more seriously.

Patient representatives and GP’s generally agree that complications related to Type 2 diabetes may be preventable with education about self-management.

Service providers felt that while there is information available, as a Borough we should be taking a more targeted approach to produce better outcomes, for example, targeting the general population with information about the signs and symptoms of diabetes.

Why is the provision of information important?

Both patients and health care professionals who participated in the scrutiny process agreed that good quality information about Type 2 diabetes is essential to help:

- Reduce the risks of developing Type 2 diabetes;
- Recognise the signs and symptoms of Type 2 diabetes and get early diagnosis;
- Inform people how to manage their condition effectively post-diagnosis;
- Reduce the likelihood of developing long-term complications.

The Joint Strategic Needs Assessment cites research that found that many patients locally had not been informed about what their target levels of blood sugar were, and so could not actively participate in their own care. Others saw their results – for example, glucose control or cholesterol – and thought them high but their medications weren’t changed and they were not given any instructions. Service providers generally agreed that providing patients with better information about their condition and the service expectations would improve self-management and help to change patterns of behaviour to develop a healthier life-style.

Standard 3 of the National Framework supports this view and identifies the importance of empowering people with diabetes in order to help them gain more control over the day-to-
day management of their condition to “enable them to experience the best possible quality of life.” This includes areas such as:

- Knowing how to recognise and act upon symptoms
- Dealing with acute attacks or exacerbations of the disease
- Making the most effective use of medicines and treatment
- Understanding the implications of professional advice
- Establishing a stable pattern of sleep and rest and dealing with fatigue
- Accessing social and other services
- Managing work and the resources of employment services
- Accessing chosen leisure activities
- Developing strategies to deal with the psychological consequences of illness
- Learning to cope with other people's response to their chronic illness.

One of the key learning points from the scrutiny process is that people living with Type 2 diabetes are required to make lifestyle changes which they may find difficult to adapt to at the beginning.

**How can patients in Barking and Dagenham currently access information?**

As part of the scrutiny process Members requested a review to see what information was already available. The review has identified a number of different ways in which a person living with Type 2 diabetes could access information.

**General Practice**

In contrast to the feedback from the patient perspective session, the data from the Patient & Carer survey suggests that GPs are the primary source of information at point of diagnosis, with 62.5% receiving information from this source. A large proportion of those attending the patient perspective session had lived with diabetes for a number of years, and it is reasonable to interpret this difference as indicating that, since their experience of being diagnosed, the process has improved for patients.

**Figure 8 - ‘Who gave you information?’**

![Bar chart showing who gave patients information about their diabetes](image)
78.7% of respondents also thought that the knowledge and support from their GP was helpful or very helpful with only 8.5% saying that their GP gave them no explanation or information upon diagnosis.

Figure 9 - ‘How helpful was your GP?’

<table>
<thead>
<tr>
<th>Information</th>
<th>Response (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information about diabetes</td>
<td>72.3%</td>
</tr>
<tr>
<td>How to manage my diabetes</td>
<td>78.7%</td>
</tr>
<tr>
<td>Information about diabetes medication</td>
<td>46.8%</td>
</tr>
<tr>
<td>Dietary information</td>
<td>66.0%</td>
</tr>
<tr>
<td>How to live with diabetes</td>
<td>40.4%</td>
</tr>
<tr>
<td>Long term health impacts of diabetes</td>
<td>53.2%</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>8.5%</td>
</tr>
</tbody>
</table>

Members also noted that GPs were providing information across a broad range of subjects including managing diabetes and the long-term health impacts of diabetes.

Figure 10 - ‘What sort of information did they give you?’
Of those that responded, 89.6% said that this information was ‘fairly helpful’ or ‘very helpful’ which suggests that GPs are a good source of information once a patient has been diagnosed. It is also a very different position reflected during the patient perspective session and reflects the GP education and training around Type 2 diabetes.

On-line Resources

There are a number of resources available to people with Type 2 diabetes on-line. Information on the websites is comprehensive and covers a broad range of areas including:

• Identifying the symptoms of diabetes;
• Information about Type 2 diabetes;
• Diabetes at different life-stages: children, young people, older adults;
• Living with Type 2 diabetes;
• Food and recipes and tips on healthy life-style;
• Treatments;
• Self-management including information about annual health checks;
• Complications;
• Support and user forums.

Some of the best websites include Diabetes UK and NHS Choices.

Information about national frameworks and what patients should expect from their annual health checks are also available via the Diabetes UK and the Department of Health websites.

Education Programmes

Porters Avenue offer an education programme called DESMOND (Diabetes Education and Self-Management for Ongoing and Newly Diagnosed) for anyone who has been diagnosed with Type 2 diabetes. It is a one-day programme which helps develop knowledge and understanding about Type 2 diabetes, how to control it, and the long-term impacts of the condition. The target audience are people with poorly controlled diabetes, hypoglycaemia and new and existing Type 2 diabetics.

Voluntary Support Groups

In Barking and Dagenham there is only one voluntary support group available to people living with Type 2 diabetes, the Barking & Dagenham Diabetes Support Group. The group provides advice and support to patients as well as carers of people living with diabetes. The group meets regularly and is attended by healthcare professionals.

While the Support Group is open to anyone with Diabetes or affected by Diabetes (such as a carer) the majority of people who attend the Support Group are 50+. The Support Group found that when younger people did attend they tended not to become regulars. Parents of young children with diabetes have attended, and they are often referred to the Havering Family Diabetes Group in Harold Hill. This group has other parents and a crèche facility as well as offering different programmes for people living with diabetes. It is not known how many people have been referred to this group.

Members were appreciative of the energetic work that the Diabetes Support Group put into improving services for their members. However, with an increasingly younger cohort of
people living with diabetes, the Committee would like to see if there was an opportunity for the Support Group to look at ways to attract younger members.

Members also felt that there is a lack of co-ordinated support for children and young people within the Borough and recommended that this should be explored in more detail.

**Information provided to professionals to support their work**

It was also clear during the patient perspective session that patients were not aware of the services available to them, for example financial advice. This point was also raised by a GP with a special interest (GPwSI) who attended the session on 13 February. He noted that GPs do not always have enough information about what services are available in the Borough. For example, in 2010 a booklet was issued to GPs advertising the different exercise schemes available which proved useful when GP’s were developing a care plans with patients. This booklet has not been re-issued. The feedback from GPs suggests that they would be happy to sign-post services if they knew what was available.

As an example, DABD UK provides a range of services to support independent living and to promote independence. This service is available to patients living with Type 2 diabetes, and their welfare benefits service provides a free and confidential advice on matters such as help completing benefit forms, benefit entitlement checks and income maximisation. DABD representatives attended the B&D Diabetes Support Group on 11 February 2013 to advertise their services, but it is clear that more could be done to put this information into the hands of professionals working with those with diabetes.

It was clear from both the information gathering sessions and site visits that better sign-posting of services is required. This is not limited to patients and carers but also to GPs and other service providers.

When CCG representatives were presented with these findings in March 2013, HASSC were pleased to be assured that the CCG are currently reviewing diabetes literature and will particularly review information packs that are given to patients in light of the concerns raised by HASSC.

**Culturally relevant information**

In Section 1, it was advised that the survey respondents were not reflective of the Borough demographics as a whole. What the scrutiny could not identify is how difficult it is for people from different ethnic backgrounds to access information particularly where there are language barriers.

Porters Avenue offers a variation on the DESMOND programme which is specifically aimed at people from different ethnic backgrounds and includes an interpreter.

Members felt that any work around information and sign-posting services should take into account the diverse demographics of the population of Barking and Dagenham.

**Recommendations**

Members recommend that further work is required to ensure that there is adequate information and support for people living with Type 2 diabetes in the Borough.
Recommendation: Information and advice

The Committee recommends that the whole range of information provided to people already diagnosed and people newly diagnosed with Type 2 diabetes is reviewed, ensuring that it gives them what they need to know to improve self-management of their diabetes and their understanding of long-term complications.

This could include, but not limited to:

- Affordable healthier food options (at home and in the workplace)
- Active involvement in negotiating, agreeing and owning goals
- Understanding the consequences of different choices

The Committee also recommends that this review takes account of the need to ensure that the information and advice reflects the changing diversity of the population, and is easily accessible by the target audiences.

Support for younger people

Although it is outside the scope of the scrutiny, Members were concerned that there is not enough targeted support for younger people in the Borough, for both Type 1 and Type 2 diabetes. There are likely to be two age groups affected: firstly, younger people, including children, who may be more likely to have Type 1 diabetes; secondly, and more within the scope of this report, those between the ages of approximately 30-50 who may be developing Type 2 diabetes as a result of lifestyle factors.

The Committee felt that work needed to be carried out to explore what both of these groups would like, noting that their needs are likely to be different, and to foster a service user-led response to the need for more support services in each case. For the younger age range, it may be that the health group of the Barking & Dagenham Youth Forum would like to undertake some work on this issue.

Recommendation: Young people’s support (Type 1 and Type 2)

That the Health & Wellbeing Board facilitates consideration of how young people with diabetes (either Type 1 or Type 2) could be supported in the Borough, inviting the participation of the health group of the Barking & Dagenham Youth Forum.

Recommendation: Younger adults developing Type 2 diabetes

That the Diabetes Support Group participates in a short review of the support needs of younger adults developing Type 2 diabetes, and how they may be met from a service user led group, led by an agency to be identified by the Health & Wellbeing Board.
Theme 4: Hospital admissions

Barking and Dagenham has the highest emergency admission rate to hospital in London. Around 40% of hospital admissions are unplanned and a “significant proportion of these are related to conditions such as congestive heart failure, diabetes, asthma, angina, epilepsy and high blood pressure, which generally should be managed without emergency admission.” (Annual Report of the Director of Public Health, 2013)

In 2011-12 there were 100 admissions per 1,000 population in Barking & Dagenham, which was an increase of 11.4% from the level in 2010-11. More significantly, for those conditions (called ‘ambulatory care sensitive conditions’) that give rise to a higher risk of admission, the rate was 16.5 per 1000 population at a total cost of £5.5m per year. Diabetes is one of these conditions. The pressure on accident and emergency services and the use of hospital beds is substantial, adding to the challenges that Barking, Havering and Redbridge University Hospitals NHS Trust face in meeting the demands of the local population.

It is therefore the complications arising from poor management of diabetes that place a pressure on local hospital services. Both the Director for Public Health Annual Report and the JSNA 2013 found that in Barking and Dagenham the rate of emergency admissions for diabetes is above the national average (in the top 10% in London) and is also high for planned admissions.

The JSNA suggests that this indicates a lack of sufficient support and care in the community, with care being hospital-focused. This view was supported by the B&D Diabetes Support Group who suggested that when someone has a problem but can’t get hold of a GP, they ring the emergency doctor who advises them to go to A&E. This may be an issue regularly raised with the general population, but it is an added concern given the risks facing those managing their diabetes.

![Figure 11 - Rate of Emergency Diabetic Admissions per 100 on the diabetes register (2010/11)](image)

<table>
<thead>
<tr>
<th>Location</th>
<th>Rate of Admission (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>1.6</td>
</tr>
<tr>
<td>London</td>
<td>1.6</td>
</tr>
<tr>
<td>Barking &amp; Dagenham</td>
<td><strong>2.1</strong></td>
</tr>
<tr>
<td>Havering</td>
<td>1.6</td>
</tr>
<tr>
<td>Redbridge</td>
<td>1.1</td>
</tr>
<tr>
<td>Waltham Forest</td>
<td>1.2</td>
</tr>
</tbody>
</table>

Source: NHS comparators (2010/11 data)

Admission rates also vary between wards with Valence and Alibon wards having the highest annual hospital admission episodes.
Members were concerned that the data surrounding hospital admission rates is based on 2010/11 data and felt that baseline data for 2011/12 should be made available.

**Integrated services for better diabetes management**

**South West Essex Community Services (SWECS) Diabetes Service**

Representatives from South West Essex Community Diabetes Service (referred to here as SWECS) were invited to attend a HASSC session on 12 December 2012 to discuss the community diabetes services.

South West Essex has a prevalence of 5.4% of adults with diabetes. The service was commissioned in April 2011 to provide a diabetes hub within the community, and has since been cited for its excellent outcomes, particularly in reducing diabetes-related hospital admissions. The team includes 1 assistant practitioner, 7 diabetes nurses and 1 nurse consultant, 1 specialist dietician and Clinical consultants from Basildon Hospital.

Representatives from SWECS advised members that since the start of the integrated service, staff have found that patients are showing better care and management of diabetes, improved glycaemic control and improved quality of life. In particular, there are no longer any outpatients at Basildon Hospital with patients being seen at one of 13 outreach clinics across the Borough. The service includes diabetes education (similar to Porters Avenue) and has around 4,000 patients and includes home and care home visits.

Members were interested to note the reasons that SWECS gave for the reduction in hospital admissions, which included:

- **Good relationship with acute colleagues**
  Staff work closely with ambulance staff who report that repeat admissions often don’t want to say anything in case they get “into trouble” with their GP for not looking after themselves. Ambulance staff refer repeat admissions to the ‘Hub’
so that nurses can make a home or care home visit. Nurses also work closely with GPs to help review their diabetic patients.

- **Urgent referrals**
  SWECs nurses have adopted a *no barriers* attitude which means they will see patients without a referral if they receive urgent calls from GPs or Basildon Hospital to avoid a person going to A&E.

- **Work in partnership with GP practices**
  SWECs nurses work in GP practices not only to help with the shortfall in expertise and resources in GP practices but also to up-skill staff. They also run an annual conference for all staff in their area and a forum every 3 months to promote diabetes education. They also noted that a large group of nurses means that there is a lot of expertise and support amongst each other.

- **Patients are being moved through the pathway quickly.**

When the Committee compared the information presented about SWECs to that provided by Porters Avenue Integrated Diabetes Service, they were interested to note the similarities, and the opinion of many of the professional witnesses that there is little practical difference in the operation of the two services. However, it is clear that the outcomes being achieved are markedly different. The Committee were surprised to hear that there had been relatively little exchange of knowledge and best practice between the two services. The Committee suggested that an exchange of information would be of particular benefit to integrated community services locally as they look for ways to improve the outcomes from the local diabetic care pathway.

**Integration of Services in Barking & Dagenham**

The Committee heard from some clinicians that there was scope to review the care pathway to improve its integration across different services, to ensure that all the relevant players are included, and to understand how each service can offer support. Taken together with a review of best practice, Members felt that commissioners in Barking and Dagenham need to review the way in which individual services work together to form a more holistic approach to patient management. As an example, care plans should take into consideration how pharmacists access support and advice.

Members of the Committee also reflected that, with the changes in responsibility across the health system, any review of integrated service delivery may need to confirm that the correct information sharing protocols are in place to ensure that patient information is passed between services safely and efficiently.

At a meeting in March 2013 in which CCG representatives were presented with the findings of this report, HASSC were pleased to be assured that the CCG have established a diabetes forum to address areas for improvement. The diabetes forum will particularly look at developing services at Porters Avenue and learning from national and local best practice examples, such as South West Essex.
Recommendations

**Recommendation: Learning from South West Essex**

That the Health & Wellbeing Board ask Public Health professionals to work with commissioners and North East London NHS Foundation Trust to understand the reasons why services which are on the face of it similar appear to be linked to different outcomes for patients, and to capture the lessons for future local commissioning.

**Recommendation: Reviewing the integrated care pathway**

That the Health & Wellbeing Board oversees a review of the care pathway to ensure that all opportunities for joint working are being harnessed and that the flow of patients between services is effective.
Theme 5: Annual cost of diabetes

At a national level, spending on diabetes is amongst the highest. In Barking and Dagenham some elements of the cost are notably high.

In particular, Barking & Dagenham have the fifth highest number of prescription items and spending costs in London. In 2009/10, NHS Barking & Dagenham spent £2.4m on anti-diabetic prescription items, which equates to £287 per known diabetic at the time. In 2010/11 the overall cost for anti-diabetes items (measured per diabetic patient) was found to be higher than any other Outer North East London (ONEL) borough. This suggests that people may not be managing their condition as effectively as they could be.

Figure 13 - Cost of Anti-diabetic items per patient

<table>
<thead>
<tr>
<th>Cost of anti-diabetes items per diabetes patient across ONEL boroughs</th>
</tr>
</thead>
<tbody>
<tr>
<td>£300.00</td>
</tr>
<tr>
<td>£290.00</td>
</tr>
<tr>
<td>£280.00</td>
</tr>
<tr>
<td>£270.00</td>
</tr>
<tr>
<td>£260.00</td>
</tr>
<tr>
<td>£250.00</td>
</tr>
<tr>
<td>B&amp;D £324.03</td>
</tr>
<tr>
<td>Havering £308.10</td>
</tr>
<tr>
<td>Waltham Forest £284.73</td>
</tr>
<tr>
<td>Rebridge £289.70</td>
</tr>
</tbody>
</table>

Source: Yorkshire and Humber Public Health Observatory (YHPHO), Diabetes health intelligence

Testing equipment

The 2013 review of the Joint Strategic Needs Assessment has pointed out that certain aspects of expenditure are high, such as blood glucose testing strips. It cites evidence that home blood sugar testing in Type 2 Diabetes does not influence long term control but yet the spending is high in the borough, and this may be one area in which expenditure could be reduced. In particular, it recommends that these costs “be reviewed by the Clinical Commissioning Group, as there are obvious costs savings with no detriment at all to patient care.”

However, anecdotally, home testing is popular with patients who feel it offers an element of control, despite the evidence that, in the main, this doesn't always translate into better management of blood sugar levels, so any removal of this option would need to be managed carefully to maintain the commitment of diabetics to their treatment and food regimes.

Adherence to medicines programmes

Expenditure may also be affected by patients not taking medication correctly. Pharmacy representatives who addressed the Committee advised that, while medicines are still the most 'common therapeutic intervention', patients are not taking them correctly:
• 30-50% prescriptions are estimated not to be taken as intended;
• 5% of hospital admissions are due to the preventable adverse effects of medicines (*all medicines, not just diabetes medicines*);
• For 41% patients, there had been little or no explanation of the side effects of their medication, which can affect adherence to the prescribed regime.

**Recommendations**

In terms of the recommendations arising from this section, Members are minded to support the Joint Strategic Needs Assessment's own recommendation to review cost of testing equipment. Additionally, the Committee considers it sensible to factor into the review of the care pathway the opportunities to improve cost-effectiveness of community services and to improve adherence to medicine programmes by individuals.

Therefore there are no specific recommendations relating to cost above and beyond those already identified by Public Health and clinicians.
Conclusion

Diabetes is a big problem and is set to grow in the future especially in light of its association with related conditions such as obesity. There is currently little funding for targeted screening events to identify people with a higher risk of developing diabetes which could have a real impact on improving the current levels of diagnosis. The review has highlighted the need to find better ways to engage with the people most likely to develop Type 2 diabetes to raise awareness about the condition and help people recognise the early symptoms.

For those people who have already been diagnosed, early detection aligned with good quality information and advice could help patients to better understand and manage their condition. Providing patients with knowledge about life-style choices can help to reduce the likelihood of developing avoidable long-term complications such as blindness and lower limb amputation – which places additional pressures on social care resources and the acute sector, but most importantly stops people living fulfilling and healthy lives.

The cost of diabetes medication is higher in Barking and Dagenham than elsewhere and there are real gains to be made both in terms of improving people’s health and lowering costs. Furthermore, General Practice needs to be consistent with the standard of diabetic care provided across the borough. Increased performance monitoring against NICE’s nine annual health checks could help to drive up the quality of diabetic patient care, as well as helping patients to manage their condition more effectively and prevent long-term complications from developing.

The presentation by South West Essex Community Diabetes Services has demonstrated the benefit of integration and communication between professionals and it is hoped that professionals within Barking and Dagenham can meet with North East London Foundation Trust to understand the reasons why similar services appear to be linked to different outcomes for patients, and to capture these lessons for future local commissioning to improve the way in which patients move between services and prevent the need for secondary care.

We welcome the move of Public Health to the local authority and the opportunity that this brings for more joined-up thinking about the way in which work on other health conditions may impact Type 2 diabetes, for example, tackling issues around obesity and smoking cessation will help to reduce the levels of people likely to develop the condition.

This report identifies ways in which the Health & Wellbeing Board may wish to address some of the issues when developing future delivery plans and we are pleased that the Chair of the Health and Wellbeing Board has assured the Select Committee that the findings of this review will inform the next iteration of the Health and Wellbeing Strategy. All of the main building blocks for effective diabetes service provision appeared to us to be in place, but greater emphasis needs to be placed on ensuring full take-up and improved promotion if every opportunity is to be harnessed to minimise the serious impacts of this condition. It is hoped that the recommendations identified by HASSC are taken forward.
Appendices

1. Session notes from the Committee’s investigations
2. Copy of the Patient and Carer Diabetes Survey
3. Findings from the Patient & Carer Survey results
4. Overview of the National Standards Framework for diabetes
5. Site visit ‘Menu of Involvement’
Appendix 1 Information Gathering Session Notes

Patient Perspective Session

Date of Session: 12 September 2012

Organisations: Barking and Dagenham Diabetes Support Group
Barking and Dagenham Local Involvement Network (BDLInk)

How long have you suffered from diabetes?

I've been a type 2 diabetic for 21 years. In this time I have had a leg amputated and suffered from kidney problems.

I was diagnosed 20 years ago. As a result of my diabetes I have lost ½ an eye, had a toe amputated, suffered from osteoporosis, and lost some of the sensation in my legs.

Type 2 for 10 years.

I have been a diabetic for 37 years, the only problem I have is mild neuropathy.

What were the first symptoms of diabetes that you noticed? What made you go to your GP?

I had an extremely stressful job and high blood pressure so I went regularly to my GP. Eventually the GP said I was diabetic but I’d had no symptoms to indicate it, it was “out of the blue”.

I had a chest infection and went into hospital and was diagnosed there with asthma and diabetes.

I was passing a lot of water and started to get infections so I went to my GP.

It’s in everyone but something sets it off.

Insulin is created naturally in the pancreas, but with Type 1, the body stops making insulin which makes it work properly. Mostly affects younger people under the age of 40.

With Type 2, the body makes insulin but either doesn’t make enough or the quality isn’t as good as it should be. You might need to change your diet e.g. not as much carbohydrates and sugar. If that doesn’t work you go on tablets and if that still doesn’t work you go on insulin. Taking insulin in this case doesn’t make you a Type 1.
They are two separate illnesses but as serious as each other if undiagnosed.

### How supportive was your GP when they told you that you had diabetes? (E.g. did they give you the right advice and information?)

When I took my mother to the GP he admitted that he knew very little and if she wanted to know she had to go to the hospital. She was referred immediately to hospital for tests.

Oldchurch Hospital gave mum and appointment for a month’s time. When she went to her appointment the doctor said she should have been dead by then and wondered why hadn’t come earlier.

On one occasion the GP was visiting mother and noticed her blood monitor and asked her to do a blood test on him as he thought he had it.

Mother was Type 1 so I knew what to stop eating. I lost 1½ stone in weight.

The first time I’d been to the doctor in 17 years as I was generally in good health. The GP was not very supportive.

My GP has changed but the GP I’ve got now doesn’t know much either.

### Can you tell us about how you felt when you found out you had diabetes

I never believed I would get it even though mother had it because read somewhere that it wasn’t hereditary. I was devastated.

Mother said start off on tablets but I went straight onto injections as a Type 1.

My mother was the only one who provided any support as she knew a little as she was a diabetic but she didn’t know very much because she didn’t really want to know more.

People generally didn’t know much about it so I read books, went to the library to research myself (we didn’t have the internet then) to read what to do. I did this until about 5 years ago. At that time I saw a nurse at the surgery for asthma and I came across information about the DAFNE programme. The nurse said someone in borough was doing that and that she would put her in touch with me. I met Elaine Whitlock who runs the service team at Porters Avenue who said they had a course which teaches people about diabetes. I would have to attend daily for week but the course was excellent.

I found out about the pen which meant that I could play around with mealtimes and as a schoolteacher that was brilliant. I had written to ask about it earlier but was advised that had to apply to the hospital and be referred to see if I was suitable to handle a pen.
DAFNE revolutionised my life for handling and managing my diabetes.

**Can you tell us about your day-to-day routine**

I check my blood sugar level as soon as I get up. I check 3-4 times per day. Most evenings I don’t take insulin as in morning my level is very very low. I don’t find it difficult to wake up and get up out of bed.

I check my blood sugar levels and a car worker visits me to help with showering, dressing and breakfast. I take 32 tablets and 4 injections a day to keep my insulin levels steady plus other medication for the pain in my legs and aspirin to thin the blood. I’m pretty much housebound unless there is a care worker to visit and take me out. I only get out once a week due to budgets for having carers. I have injections 4 times a day and 32 tablets.

Not everyone who gets diabetes is overweight, I was 13 stone but due to insulin, I put on weight. It’s not always true and GPs say that being overweight is why people get diabetes.

I take tablets to absorb my help absorb diabetes medication which is normally around 120 units and 100 units. I also take medication for my heart and neuropathy (my nerves are dying off below knees).

**Is there a stigma around diabetes? (e.g. weight)**

Yes. I was only 12 stone before I was diagnosed but since having my leg amputated I have put on 15 stone. My family know I’m not a big eater. It was also uncomfortable using a prosthetic limb.

**Is it difficult to take the stigma?**

The point is that [name withheld] is not overweight.

Type 2’s tend not to be overweight.

There was a recent report in a paper where a doctor in Canada said that if you’re diabetic it’s your own fault.

That’s insulting.

Some doctors say you are a ‘bit diabetic’. You can’t be a bit you either are or you aren’t.
How did you feel when you found out your family member had diabetes?

My mother was diagnosed with diabetes very late in life. Mum had been to her GP with weight loss and had blood tests. At the hospital she was checked for infection and was asked if she’d lost weight and I said another GP investigating that so nurse left it. Mums health stabilized. She also suffered depression. Her weight remained fairly stable.

When we were in the GPs surgery I saw a poster giving the 6 symptoms of diabetes including excessive tiredness, genital itching and weight loss so I asked for an appointment to see the nurse. Mother did urine sample and blood sugar test which was 3 times higher than it should be.

Mother had an elder sister at the same GP surgery but around the time that mum was diagnosed (aged 76 at diagnosis) the surgery did away with over 75 health checks. One of the first things my aunt was asked for during a health check (when they still did them) was urine sample. If mother had been for a health check she might have been diagnosed sooner.

Once she was diagnosed she was quite good and was monitored regularly for the nine points test. The diabetes was caught and controlled but few years later she started getting back trouble and dementia. I took her to doctors for something else and mentioned the memory issues to the GP who thought it could be a complication of the diabetes. He sent her for an MRI which showed that the blood was not circulating around the brain as a direct result of complications due to diabetes. I think that if she had been diagnosed properly it might have been avoided.

I feel that the late diagnosis made things more difficult than needed to be for me and my mother which frustrates me.

It didn’t really affect my daily life too much although I had to go to the hospital with my mother for regular blood tests. The bigger impact was her dementia managing her diabetes was easy in comparison. We had 2 care workers visiting a day to help and give me respite. Financing her care was a concern.

If the doctor is interested in patients, and if their knowledge was as such, I’m sure that they should be able to do what’s necessary. But many have an ignorance of diabetes and don’t know what it is so they can’t follow up.

It is similar to many years ago with knowledge of sickle cell. As a country, diabetes has come a long way but it’s not as it should be and we still a lot to learn. There is a stigma being placed on weight. We need to look at Type 1 and where that crossover is, to be alert to yourself, about what is happening.

How has caring changed your life?

Mum did blood tests until the diabetes stable. The doctor did do annual checks but in the end the
diabetes became secondary to the dementia.

In due course mum needed two carers a day and I needed a respite.

Over the years there are complications developing which had a massive impact. Mum was very good with her diet and the nurse did advise her that she could have an occasional treat.

<table>
<thead>
<tr>
<th>My husband had diabetes for 11 years before he lost his sight. We had three teenage children and I had to become a full time carer.</th>
</tr>
</thead>
<tbody>
<tr>
<td>I couldn’t change my mortgage and had to go into shared ownership housing association.</td>
</tr>
<tr>
<td>He never came to terms with the blindness and our youngest daughter remained his little girl in his mind. There were lots of other complications such as kidney damage, several small strokes and heart attacks.</td>
</tr>
<tr>
<td>[Name withheld] was not a good diabetic, he smoke and drank.</td>
</tr>
<tr>
<td>Some days I would spend 8 hours a day at the hospital for 33 weeks while he was there as couldn’t be left alone. He was 51 and had dementia in end.</td>
</tr>
<tr>
<td>As for the impact, I was a widow at 50. He was not there to give his daughter away or for his grandchildren. Our youngest left school four years after he died and is now 18. I’m a single parent and as the family situation changes the emotions come back again.</td>
</tr>
<tr>
<td>It affects the whole family. You need the support in beginning. No one tells you what to do for example, if lose a leg and no one checks you are doing things correctly (e.g. medication). No one’s there, it’s not fair and it’s hard work. There was no information from GPs.</td>
</tr>
</tbody>
</table>

| Information and communications are very poor in borough. I was not told about what to do after lost my leg for 6 years. I started losing my sight 4 years ago and had to pack up work. I drove an automatic car before that but losing my sight has meant life has changed. I had my own house and there’s no help for you if you own your own home. |

| 2 years ago, ATOS told me I could go back to work but I need to be wheeled about it. |
| I had to stop work and because of my assets I was not eligible for benefits and had to sell my house. I have received help from the Independent Living Association but because of a cut to their funding they cannot support me as much; this is a shame because you get used to dealing with people and then it changes. DABD are hard to contact and I have no one to help me with form filling to get financial support. |

| My father was a stroke patient and my cousin had a stroke. People with disabilities don’t get the funding they used to and it’s very difficult. My cousin was told to sell his house to cover his costs, but he has six children, and where do you live once you’ve sold your house? |

| 44 |
As an authority, we would like to move into a direction of taking this into schools to catch it early. Educating children about health issues should be on curriculum so that they learn how to take care of own health.

We still have best system in country.

**Where should support come from?**

The tragedy is that complications are preventable with education. Hospital budgets take up 20% of in-patients for diabetes related issues worldwide. We eat too much of wrong stuff, you only have to look at the ingredients on the side of packets; it’s like a listing in a chemical factory.

Type 2 is preventable, Type1 isn’t. People think it’s not serious or it won’t happen to them. Getting children involved is a brilliant idea. People do not understand the complications that come with diabetes and better public awareness would help.

Type 2’s use services through the hospital.

I was diagnosed at Queen’s and one of things that was really apparent at the time was the inconsistency between what the hospital and GP said. The communications element and opinions of individual consultants, doctors and nurses about the right thing to do varies.

Diabetes is an individual thing as well as growing problem in the community. Individuals can help themselves by getting the right advice which is most important.

There are no hard and fast rules for dealing with it but we need experts to actually deal with individuals that are diagnosed in a way the patients can understand.

Individuals need to take responsibility too; it wasn’t until I had my leg amputated that I woke up to the challenge of living with diabetes.

People rely on hospitals instead of managing their condition properly, this is wrong and people need to use programmes like DAFNE and get better educated.

**What do you think is good about the services locally?**

Porters Avenue is excellent when you’ve been diagnosed. You are not given a 10 minute slot like at a GP surgery. The clinic gives you the time you need as diabetics have a lot of questions. The
leaders there insist the patient has time to talk.

I have to keep a daily diary for blood sugar levels, food, amount of carbohydrates, insulin, ratios, and driving. They go through it with you.

The GP hasn’t a clue. You need expertise in running these services.

The nurses at Porter’s Avenue inspire confidence; they have the doctor’s ear, are knowledgeable, and can spot the signs quickly. Non-specialist centres do not understand diabetics; the staff in those places do not have the right training. For example, I had a foot problem and was on crutches for a year and 2 weeks (and within 6 days of foot amputation). The Podiatrist sent me to a different doctor for different treatment and the foot healed. The GP wouldn’t have known about this treatment.

The same applies to Type 1 and 2. If the GP doesn’t know there is nowhere else to go.

Type 1’s go to hospital annually and this is no good as once per year although they are good when you are there.

We need a community service to help which not only deals with helping a diabetic but also prevention of complications. They try to get into communications and advise people about diabetes.

All of the facilities are in same building and should be expanded not reduced. Diabetes is on increase in B&D so the service needs expanding.

We no longer have to go ‘pillar to post’ because we have all of the specialists under one roof. Funding for this service needs to be protected.

The service isn’t there to go out to everyone.

There are also psychologists available at Porters Avenue. They have a complex care clinic weekly which sees 10 patients a day including a podiatrist and dietician.

You need to be referred but the service is brilliant.

Mum was referred to a dietician but they didn’t want to know due to funding issues.

Porters Avenue is an integrated service which works together. How did you get on before?

When I was first diagnosed services were brought in from Havering as there was nothing in B&D.

I came to the launch night of Porters Avenue. We would like a drop-in service especially at night when there is nowhere to go or anyone to call – even just for advice. B&D Diabetes Support Group people often call me or the Chair. We often need reassurance, especially as a carer, so it
would be good to have someone to talk to as carers get no information or training.

Porters Avenue has been there four years and is continuing to develop and we should be proud of it and promote it. You need it in beginning though not when it's too late.

I was in a car crash four years ago. The paramedic at the scene took my blood and asked where my insulin was as my blood sugar level was 23. I didn't know I was even diabetic so I went to the doctor who didn't even give me a diet sheet or any information. Mum had it and also had no information.

We have to be more forceful and demanding when going to see doctors. This is what actually happens. When we go to the doctor, challenge them to find out what is happening. We owe it to ourselves to get a second opinion. We depend on the NHS for care.

Thanks for saying something good about one of our services. When go to the doctor demand and ask questions, it doesn't matter if they think you are a trouble maker, it's for your own benefit. Make sure they are uncomfortable and know you want a second opinion. If you are not comfortable demand the service from them if they are not giving you the service you want, talk to someone.

**Question to Committee: What will happen now?**

We are trying to hear from a patient perspective from both carers and sufferers.

As a health committee we will come up with recommendations, continue to support what’s working well and look at changes that are required.

The meetings are in the public domain so you will be able to read about it.

More information is needed. There isn't information for people to find about it.

The B&D Diabetes Support Group run a stall once per month in Queen’s Hospital and provide pamphlets. We get about 50 odd people during the day and are often asked how people know if they will get diabetes.

When first diagnosed, my GP specialised in diabetes but said that if I kept doing what I was doing I’d know more than GP. A GP gets ½ day on average of training in their career on diabetes.
Good Practice Session

Date of Session: 12 December 2012

Organisations: Diabetes UK
South West Essex Community Diabetes Service (SWECS)

Diabetes UK

Diabetes UK is the UK’s leading diabetes charity and provides an on-line one-stop-shop for patients and carers which give information about living with and managing diabetes as well as signposting services and training programmes at a national and local level. Their presentation focused on the national picture of diabetes, as well as preventive activity and campaigns. The presentation gave the Select Committee ideas to what the Borough could be doing in regards to local campaigns and diabetes provision.

Notes from presentation by Diabetes UK

| Of Type 2, 90% remain undiagnosed and people can have it for 8-10 years before being diagnosed and usually as a result of being tested due to another condition e.g. heart attack. |
| Type 1 can develop at any age but generally before 40. |
| A report was published last week which stated that people with diabetes had a 48% higher risk of cardiac arrest/death. |
| B&D are in the bottom 25% in respect of patients having 5 of 9 of the annual tests. |
| Healthcare Essential is the key thing all patients should have annually. Survey’s often ask whether patients have the 9 health checks but since many people don’t know what they are they have no baseline [Note: the Patient & Carer survey does ask people to indicate each health check they have annually] |
| The key message to people is that there is no such thing as mild diabetes. |
| All health care professionals need to have a good understanding of diabetes not just GPs and diabetic nurses. |
| The NHS has an 18% target for diagnosing diabetes in the undiagnosed; this is quite low and reflects the failure of health services to do so. |
| Children’s Campaign started on 14 November and will last for 5 years. Need to raise awareness |
among GP’s of the importance of diagnosing diabetes in children quickly as it can develop and progress very suddenly.

### Q&A SESSION NOTES

#### How can B&D link up to national campaigns?

NHS Foot Profile is a good example of what B&D could do. Diabetes UK figures for B&D reflect the expected numbers.

Middle-age to older people tend to get Type 2 but it is progressive and slower and is often overlooked due to age. Need to encourage people who are over 40, Black/Asian, family history of diabetes or overweight to get risk assessed.

#### Why is there often no information in GP surgeries?

Diabetes UK do have a “Measure up” campaign and do regular road shows but if a person has had another medical condition, they are often automatically tested for diabetes without being advised.

#### What are the key components to good practice?

The population of individual boroughs requires a different approach. Generally, everyone should have annual checks and their needs to be support and help to keep health to a good level and a multidisciplinary foot care team to help reduce unnecessary amputations.

#### Is there anything else a person can do other than use medication?

Type 1 must have insulin and watch their diet. Type 2 can be managed by diet/exercise alone although some have oral medication. A third go on to take insulin as Type 2 is progressive.

#### What are the main issues coming through for patients?

Diabetes UK recently did a survey around foot checks as many GPs did not do them properly. GPs are getting paid but the level of the check is poor.

Emotional/psychological support is also necessary as diabetics have a higher rate of depression generally. Severe mental issues are higher due to diabetic needs.
How can we improve our services in B&D to work with Diabetes UK?

Need to meet with the area manager to talk about what can be done. Make sure that the “Healthcare Essentials”, “10 Steps to Healthy Feet” and children’s posters are available in schools and surgeries.

CCG Response:

The CCG are keen to improve services in B&D and met with a diabetes forum this week. The CCG are keen to receive feedback from HASSC.

GPs in the local area need awareness of health checks being done properly. If feedback from the Diabetes UK survey can be provided it will be used as we are CCG are keen to make a change/improvements.
South West Essex Community Services (SWECS)

SWECS are a newly commissioned model for the delivery of community diabetes services in South West Essex and have been identified as good practice by the North East London Foundation Trust (NELFT). As NELFT are one of our community service providers, it was thought that this community-level organisation would be able to give Members a focus as to what the facets of a good diabetes service delivery model should look like and to shape some of the questions that they may ask local providers during site visits and future HASSC sessions.

Notes from presentation by SWECS

Area covers Purfleet to Wickford.

York and Humber found that 6.2% of people have diabetes in B&D and 6.6% in Thurrock which is what is expected based on the population levels.

In Thurrock in 2011 a scoping exercise took place and the Community Diabetes Service was commissioned to enable care to be delivered closer to home.

The service includes 3 consultants from Basildon Hospital and a specialist diabetes dietician. There are no outpatients at Basildon any more.

Patients are usually referred by their GP and triaged at the Hub at Orsett. There are 13 outreach clinics plus Orsett and patients are able to choose where they want to be seen once they have been triaged.

Run the DESMOND (Type 2) and DAFNE (Type 1) courses at all outreach clinics.

Also run Group Carbohydrate sessions and recent evaluation indicates that it has been well received by patients who seem to prefer the group sessions. The group aims to dispel the myths around diabetes.

There is an Insulin pump clinic (for Type 1) for people struggling to use insulin and a recent audit shows that it has done very well over the 18 months it has been running.

Nurses undertake visits to people in their own homes/care homes.

They work closely with ambulance staff who report repeat offenders to them (people often don’t want to say anything in case they get into trouble with their GP for not looking after themselves) and refer people to the Hub so that nurses can make a visit.

Nurses will see patients if they receive urgent calls from GPs or Basildon Hospital.
They run an annual conference for all staff in their patch and a forum every 3 months.

Nurses work in GP practices to help with the shortfall in expertise and resources.

Since the service was set up there has been a marked reduction in unplanned hospital admissions.

Q&A SESSION NOTES

What are the 2 or 3 key things that you think makes a service work well?

No Barriers – something is always done.

Large group of nurses means that there is a lot of expertise and support amongst each other.

Good relationship with acute colleagues.

What is the difference between an insulin injection and an insulin pump?

The injection lasts as long as the insulin should last, the pump sits under the skin and gives little shots and can be increased/ decreased as required.

Which carbohydrates should diabetics cut out?

There are sugar and starch in all carbs including rice, potatoes. A typical day involves a carb-heavy diet e.g. cereals for breakfast, bread at lunch, rice/potatoes for dinner, crisps for snacks. However, fruit also contains high levels of sugar. A better snack option would be nuts.

A dietician is very helpful at getting people into good eating patterns.

Do you have links to other services such as local IAP team for therapeutic interventions?

In SWECS there are links to the South East Partnership (SEP). Also a specialist nurse in SE Essex who works for the mental health team.

Why is SWECS working so well and yet Porters Avenue (which has similar services) is not
### as successful? Whey has there been no crossover of learning?

Michelle Stapleton advised that she will contact her counterpart at Porters Avenue to begin discussions about information and best practice sharing.

### What other options do patients have? What are the waiting times? What are the levels of care and intervention by GPs? Is the service showing value for money? Do you run a GPwSI Service?

The GP with a Special Interest (GPwSI) Service was decommissioned when the new service was started. Month on month figures are going down – 900 have been diagnosed this month.

Blood glucose strips were expensive and costs have been reduced by 5% in this area alone.

MS advised that clinical staff made a case to work with the acute trust and predicted savings around decommissioning approx £1m.

Patients are being moved through the pathway quickly.

### People often go to A&E because they can’t get GP appointments or have no way of getting advice after hours.

Urgent cases are seen by the Hub although they do not have the medical history but they get a GP referral and access it this way. They would love to have an out of hours/walk-in services.

### What are you doing in terms of preventing diabetes?

This is not part of the service remit but is a public health remit although it makes sense to be part of the service. Need a public health remit attached to a diabetes service.
## Clinical Services

Works out of King George and Porters Avenue, previously Redbridge and GPwSI Service at Havering.

<table>
<thead>
<tr>
<th>Date of Session:</th>
<th>31 January 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisation:</td>
<td>Clinical Services</td>
</tr>
<tr>
<td></td>
<td>Low Vision / Retinopathy Services</td>
</tr>
<tr>
<td></td>
<td>Community Nursing</td>
</tr>
<tr>
<td></td>
<td>Mental Health Services</td>
</tr>
<tr>
<td></td>
<td>Integrated Diabetes Service</td>
</tr>
</tbody>
</table>

There are less and less referrals to hospitals as most patients are referred to Porters Avenue. Of all the referrals who come to hospitals only 10-15% of them are diabetics.

Cases are quite complex. After 3 consultations patients are usually discharged back to community services where despite new medication being prescribed in hospital the local GP often changes the medication. This is often due to changes in the NHS and hit and miss management.

Porters Avenue works reasonably well although it is not cheap to run. Patients get referred and are able to see everyone under one roof except retinopathy services. It is a very good services and a recent questionnaire to patients show an outcome of 98% satisfaction with the service.

Need to look at training of GPs with a special interest (GPwSIs) to ensure a direct result on outcomes for patients.

The GPwSI service started 3 years ago.

The prevalence of diabetes is increasing. In 2005 there were 5.4% of people known to have been diagnosed with diabetes, now that figure sits at 6.2% although it is more likely to be nearer 8% due to lifestyle and ethnicity changes in the Borough population.

80% of patients are treated in community practices. Some GPs are not interest or trained in diabetes and training should be ongoing. GPwSIs are a good model but not value for money as new standardized payments can vary across the country.
<table>
<thead>
<tr>
<th><strong>Low Vision Services / Retinopathy</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Offer a service for people with learning disabilities to ensure that they receive appropriate eye care. The service is part of the Community Learning Disability Team.</td>
</tr>
<tr>
<td>Generally, people with learning disabilities have poorer health and there are approximately 550 known to the team.</td>
</tr>
<tr>
<td>People with Type 2 diabetes can develop sight loss via diabetic retinopathy.</td>
</tr>
<tr>
<td>There is a vision strategy group in the Borough which looks at issues associated with people with disabilities.</td>
</tr>
<tr>
<td>A Low Vision Service is available at Porters Avenue. There are moves to make it a more enhanced service by providing specialist services through opticians. The new service was recently approved by the Health &amp; Wellbeing Board.</td>
</tr>
<tr>
<td>Diabetics should have annual retinol eye screening tests.</td>
</tr>
<tr>
<td>Not many people know the difference between a retinol screening and a standard eye test and this is one of the main problems in B&amp;D. People used to get a full eye check which included a check for different diseases (including diabetes retinol screening) but in 2009 this changed and retinol screening became an independent test from the standard eye check. The service has found that many people who have the retinol test do not have a standard eye check so often miss being diagnosed with issues such as glaucoma. As a diabetic, people are not receiving the service they should be.</td>
</tr>
<tr>
<td>There is currently no link between opticians and retinol screening services so it is difficult to easily track whether a patient has had both tests.</td>
</tr>
<tr>
<td>There are 12 practices in Havering which carry out an enhanced service already, it works very well and this is the model B&amp;D used until 2009. In Havering a patient can choose where they have their sight test done received the combined standard eye test and retinopathy test at the same appointment.</td>
</tr>
<tr>
<td>It was noted that there are some accessibility issues to the current service as it not commissioned as part of Porters Avenue.</td>
</tr>
<tr>
<td>The commissioning issue should be referred back to the commissioners.</td>
</tr>
</tbody>
</table>
This is similar to the Catalyst Scheme set up with opticians. There are potentially 600 people who could use this service but only approximately 140 have taken it up. It was suggested that the enhanced service was not doing very well in the Borough and this is often because the optician will need to see someone on 2-3 separate occasions because the tests can be quite frightening (e.g. eye drops and flashing lights).

### Community Nursing

There are exclusion criteria around this service and that service users must have a learning disability (this excludes people with substance issues).

There are at least 7 people with learning difficulties at the Support Group which enjoy attending sessions but find it hard to understand what is being discussed and this can make things difficult for people with diabetes where they are required to understand issues around medication and self-management. As a result they often end up in and out of hospital.

A nurse attends the Support Group meetings and advised that this matter is a big concern. A diabetic nurse from Porters Avenue also attends the sessions and ensures that any service users are referred to Porters Avenue.

If a patient is required to go to a day centre their blood sugar levels are not monitored as there are no policies or training around this in the day centres. Staff at the day centres liaises with Porters Avenue to arrange staff training and look at what is being done for the service user.

Services try to take a person-centred approach and try to ensure that staff at the day centres understands that where a service user is displaying challenging behaviour that it may be due to the fact that they are diabetic and have low blood sugar levels.

A DES (Direct Enhanced Service) scheme is in place to provide training for GPs to enable GPs to provide an annual health check for people with learning disabilities. Those signed up must achieve their targets as part of the Health Action Plan (HAP).

For people who are living independently, some chose to have their annual checks and it is difficult to identify whether they have been until they have their annual HAP review. It would be useful to get a report of all people who have had tests to date.

### Mental Health Services
S75 agreement for Mental Health Services includes general population and older adults with learning and psychological issues.

Physical and mental health is complex especially among Type 2 diabetics including staying connected, exercise, lifestyle and stress. There is no easy typology for depression as there is for other mental disorders such as schizophrenia but people with mental health issues are twice as likely to have Type 2 diabetes. Someone with Type 2 diabetes is twice as likely to suffer from depression due to the range of complex psychological needs associated with their condition.

There are a range of treatments in community services and in the Integrated Services to be able to detect and work with people with different psychological requirements including different people from ethnic backgrounds.

NELFT have a specialist psychological IAP service and works with GPs with less specialism in diabetes and a combined approach to physical and mental health with multi-disciplinary teams.

### Integrated Diabetes Services

<table>
<thead>
<tr>
<th>Topic</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>There are more sessions to work with people from BME which provide interpreters.</td>
<td>Work with the voluntary sector to increase awareness at mosques and temples.</td>
</tr>
<tr>
<td>The Complex Care Clinic is a good way to look at all issues associated with a patient to reduce acute admission.</td>
<td></td>
</tr>
<tr>
<td>Increased confidence as a result of the DAFNE and DESMOND education programmes as well as a user group for patients.</td>
<td></td>
</tr>
<tr>
<td>There are also strong links with B&amp;D Support Group who helped structure the services at Porters Avenue when the service was first set up.</td>
<td></td>
</tr>
<tr>
<td>Work with GPs to help improve diagnosis and identify people at risk.</td>
<td></td>
</tr>
<tr>
<td>The Integrated Care management service works with community teams to look after people with Type 2 diabetes.</td>
<td></td>
</tr>
<tr>
<td>Flexible clinic times (e.g. before and after work) help to improve accessibility.</td>
<td></td>
</tr>
</tbody>
</table>
### General Comments

Need to support Public Health and health promotion strategies. The CCG need to improve diabetes management. NELFT should look to having a more generic team with a single access point to help reduce the need for referral.

The B&D Support Group would like to see more service progression and education of GPs and people generally. They also noted that they are grateful for the service and support provided by Porters Avenue to the B&D Support Group. They also believe that diabetics need a holistic package which includes physical, mental and clinical help as well as support groups.

Links with the CCG are essential as services should be developed with clusters.

There needs to be a focus on early intervention/detection as people can’t work on self-management unless they know they have a condition.

The same applies for identifying diabetics in depression cases. Support is also needed for carers.

Education in care homes and for nurses in residential nursing homes/people with learning disabilities required.

On 30 January a representative from the B&D Support Group spoke at the Barking Job Centre to the disability advisers to help them understand about the impact of diabetes and how it affects patients and carers for example if someone misses an appointment because a family member had a diabetic episode it is a real issue for the carer.

There is a high risk group (people with learning disabilities) who need help cooking and are currently enrolled on college courses to gain cooking skills. Some also have diabetes but they are being taught to bake cakes. Educators need to change their way of teaching. Colleges also sell junk food but they should be helping people make healthier choices. Colleges give a different message to the client group than the community nursing teams.

Need to encourage GPs to send people to a DESMOND/DAFNE programme.

Need to think about how we get the message across to the broader population:

- People at risk need a targeted approach
- Social care – carers education
• Awareness of looking after people with alzheimers/dementia

### Q&A SESSION NOTES

#### How we can improve links between services? Do we need an investigation into how we can improve the communications issue?

There is no holistic approach/communications between services. For example, although there is a retinopathy screening service at Porters Avenue the pictures are not sent to hospital staff if a hospital referral is made.

Advised that Havering have a computer system which allows them to do this.

#### What improvements need to be made? What are the next steps?

Things have improved having a health psychologist on board as it is important to help ‘change behaviour’. Need to grow this service alongside other mental health teams.

Nursing/residential homes require staff training (and resources) for working with the elderly population to ensure they are getting the care they need.

Intervention is essential but also need to work with carers and train them to be able to give insulin injections in the future so that clients aren’t required to wait in for a district nurse.

If someone has a problem but can’t get hold of a GP they ring the emergency doctor who advises them to go to A&E. Help lines, especially for people living independently are necessary even just for advice.

#### Why is the Retinopathy Service at Porters Avenue is not as good compared to Havering?

The main issues are access/IT issues rather than the service itself.

Patients give good feedback about the retinol scan but it’s more the issue of having to get the results from the patients or ringing the GP if the patient is referred.

#### Are there any GP’s or anyone else it would be useful for HASSC to meet?

Advised that Havering have a computer system which allows them to do this.
Dr Kalkat and Dr Goraparthi look at broad level service, possibly retinol screening personnel.

There are ways in which service could be improved. People do see that the work is being done properly but the issues around accessibility remain. Havering have a rate of 5% of people not taking up the Service, this is higher in B&D. She felt it worked better pre-2009.

**Some patient’s prescriptions get changed or take a lot of medication – who assess medication?**

At hospital specialist take a holistic point of view as it diabetes affects different parts of the body different so different medications are recommended for each issue. Doctors recommend a biannual check up for medication for patients not on insulin and three times annually if the patient is on insulin.
### Service Provision Session

**Date of Session:** 16 February 2013

**Organisations:**
- GP with Special Interest (GPwSI)
- Retinopathy Services
- Pharmacy Services

<table>
<thead>
<tr>
<th>Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater role for patients to take on responsibility for their own care.</td>
</tr>
<tr>
<td>Pharmacies and voluntary organisations could work together to provide more help to patients.</td>
</tr>
<tr>
<td>Pharmacists can help with lifestyle, management of minor ailments (Minor Ailments Scheme in B&amp;D).</td>
</tr>
<tr>
<td>No difference between PG and Pharmacists in terms of dealing with long term medication.</td>
</tr>
<tr>
<td>Other areas for contribution could include providing education, self-care skills, benefits advice, care plans (these always end at surgery level) as well as what can be done in terms of preventing and support and communications.</td>
</tr>
<tr>
<td>Need to develop new skills to support patients locally. There is regular training available and up to 150 pharmacists attend regularly. But there is a need to ensure Continuing Professional Development (CPD).</td>
</tr>
<tr>
<td>There is a stage on medicines. Pharmacists try to look at reducing hospital admissions. They have looked at respiratory ailments and diabetes will be next.</td>
</tr>
<tr>
<td>Patients often have loyalty to the same Pharmacy/Pharmacist as they develop a relationship, especially those with long-term conditions.</td>
</tr>
<tr>
<td>Joint work between GP and Pharmacists needed. Each pharmacist can carry out up to 400 medication reviews each year. Pharmacists go through the disease and treatment as well as lifestyle choices.</td>
</tr>
<tr>
<td>Pharmacist can help with sign-posting services as they look at all of the patient’s conditions.</td>
</tr>
</tbody>
</table>
Good practice examples e.g. weight management and vaccination at Tower Hamlets and Newham.

Need to publicise what pharmacists can offer.

No integrated system between the newly diagnosed to help them find their way around health and social care systems. Need to find a model to help people use the system effectively as well as working with carers and voluntary organisations and develop links with these groups.

There is a fundamental need to identify why people waste medication. It is largely down to support around changes in a healthy lifestyle and help with educating patients to self-management and self-care.

Patient satisfaction feedback from pharmacists indicate that more work is needed around repeat prescriptions and making the system easier for patients.

There is a role for pharmacists in terms of diabetes prevention. Access is not an issue as most people live within a 20 minute walk from a pharmacist and there are usually good opening hours including weekend services.

Pharmacists could help with screening diabetes patients.

Some pharmacists put up posters on a voluntary basis. The PCT has been asked to circulate information about reviews and new meds service – these will go out in the next few weeks. Some pharmacists also do prick tests for diabetes.

**Retinopathy Service**

Screen diabetics for eye problems, the sooner conditions are picked up the easier it is to treat them.

B&D and Havering had a diabetic eye screening programme with closed as the service had an uptake of only 47%.

The Homerton is in Hackney and a centralised fixed site at Porters Avenue.

A patient experience survey was undertaken at Porters Avenue in November 2012.
GP with a Special Interest (GPwSI)

Unhealthy eating habits as a child can cause an increased risk especially if the family has unhealthy habits. Made worse by obesity and lack of exercise.

If screening is done early on many could get diagnosed before the symptoms start.

Cycle of diabetes care: Diagnosis ⇐ look at lifestyle ⇐ refer to special education programme ⇐ medication ⇐ increase meds as diabetes progresses ⇐ complications (secondary care)

Public Health needs to help reduce diabetes prevalence especially in children and family units through school education and an increase in sports at school.

Need to ensure that we screen people early as age is a strong risk factor (40-74) for developing diabetes. People should be screen in this age group regularly but B&D do not screen enough. Should be using the pharmacies to help with the screening process. Last year pharmacists attended a mosque to carry out a screening event. Similar activities could be carried out in supermarkets/car parks. It is difficult for GPs to screen effectively but this activity could be commissioned in collaboration with surgeries/pharmacies.

There needs to be some work done around advertising to people that they need to be screened and reinforce the symptoms of diabetes.

There is a big variation relating to what happens in different GP surgeries e.g. some surgeries have a higher prevalence of diabetes but the practice is not doing a good job. This could be down to demographics, organisation of surgeries, and education of GP/practice nurses. Commissioners need to understand why there is such a variation in this area.

It is important to manage blood pressure and cholesterol levels. Patients need to be advised that there have double the risk of a heart attack and kidney problems if they have diabetes. We need to be reinforcing the seriousness of the disease and explaining the different issues. Providing leaflets to support and reinforce this would help as people only hear the first two points after receiving bad news. Dr Kalkat said that there is not enough money to do this but patient-friendly information and language issues in printed material need to be addressed.

Reinforce the DESMOND and other training programmes among patients as not enough people are being referred. Many patients don’t realise they are entitled to attend.
People do not understand what to expect from GP/Nurses especially in annual reviews. EG feet checks should be done properly and the review should include reviewing footwear but due to time pressure this does not always happen which is unfortunate as foot problems are hard to treat.

Training sessions across the PCT (cluster-based) is already offered but is mostly based on medications and not enough education is given about providing holistic care and patient interview techniques. GPs need to know how to work with a patient’s lifestyle to help them develop suitable self-management techniques.

Internet resources, email etc… are possible options especially an on-line user forum but there are confidentiality issues associate with this. Patients also need to understand what services are available before we could consider doing something like this.

Community Care - less than 5.5% of patients come to the clinic. Need to see a bigger impact in B&D and work closer with GPs and cluster practices. All services need to be more seamless so that all health professionals understand how to access the service.

Self Help is important as people are more likely to take their medication properly and be more prepared in their annual health review.

Additional comments sent by Dr Goriparthi after the HASSC meeting

Obesity epidemic - we need Public Health to:

  a. help manage this problem and to work to reduce unhealthy dietary habits and inactivity in children and adults
  b. work with schools to provide healthy meals, encourage healthy living lessons, and increase time for physical activity
  c. work with family units to help with healthy habits if children are noted to be overweight
  d. help poorer population to have affordable fruits and veg and sports centre passes etc
  e. advertise healthy living messages at schools, pubs, parks, holy places etc

Pre-diabetes - make available intensive dietary physical activity courses to:

  a. help people delay the conversion into full blown diabetes
  b. GPs/practice nurses need to explain clearly the importance of healthy living to delay Diabetes and reduce complications in this group

Diabetes diagnosis - prevalence of Diabetes is increasing but still several people with
diabetes remain undiagnosed. GPs need to actively screen people with risk factors for diabetes early and we need to consider about other ways of screening people for diabetes e.g. at supermarkets, pharmacies, holy places, parks to catch people who do not routinely go to GP Surgeries.

**Diabetes management** - once diagnosed a good explanation from GPs/ Nurses needs to take place on more than one occasion to help patients understand Diabetes. We need to make available information booklets to give to patients so that they can read and understand further about what they discussed. All patients need access to proper education courses like DESMOND and all patients should be offered exercise referral.

**Medication** - GPs should make sure that the medication that they prescribe is working by repeating the blood tests appropriately and stopping medication if not effective regular audits to help this process.

**Annual reviews** - GPs/nurses have to explain to the patients about the purpose of the annual review and what to expect. Booklets to explain what happens in the annual reviews are essential as significant no. of people do not seem to understand what to expect. Locally we are very low in the percentage of people getting annual reviews and there is significant variation across different practices. We need to better understand why this is so, and we need to encourage patients to attend and encourage GPs to make sure that they maximise the no. of annual reviews that they do.

More **seamless pathway** for the patients across the different Tiers of service is essential. It would be better for more patients to be managed within their GP surgeries. The CCG is looking into GPwSIs and DSNs are considering how to work more closely with practices to support them.

**Special groups** - we need to identify people who would require a different type of service that routine service will not be able to provide. People who are housebound or with Learning difficulties or with palliative care needs and we need to work closely with the teams looking after these people to better identify their needs and improve the support that Diabetes services can provide people with significant medical problems like Kidney or Heart need. More closely working across different department’s people with significant language barriers will need to have easy access interpreting services -already available and working people need services outside the normal working times. Diabetes affects young working people and needs several appointments over the year. It is hard for people to keep taking significant time of work to attend these day time appointments.

CCGs already looking at how to use peer-led education support and pressure to help reduce variation and improve the service offered by the GPs.
No. of GPwSIs - I have conflict of interest so, I am not the right person to discuss this but it would be important for the members to consider what the role of GPwSI would be in the future is the role is to see and manage patients at Tier 2 level (higher than usual GP care) like we are doing now or is the role in the future to work more closely with practices, train local GPs/Nurses to help them manage their Diabetic patients at Tier 2 Level.

Consultant/Secondary care support - we would need more consultant time and support to help oversee the local services for Clinical Governance some other areas had more consultant input and have shown that this can help create closer links between primary and secondary care and helped reduce the need for patients going to hospital.

Special GPs – Work closely with the LD team and outbound patients or where English is not the first language as approach needs to be different. Working people require extended surgery hours including late nights and weekends to increase access to services.

Other Issues

Member comment: We need to make sure that the report states that the survey is not representative of all diabetes patients.

Pre-diabetes, patients have a slightly elevated blood sugar level. We need to identify how we can organise a co-ordinator programme for pre-diabetes patients.

Q&A SESSION NOTES

Pharmacists do a good job and there is a good link between pharmacists and patients. The relationship building element has gotten better and they are very helpful and friendly. We would like to see better integration between pharmacists and GPs.

The patient repeat prescription service makes it more complicated for patients to get a repeat prescription especially if the medication is not in good supply and they have to wait for it to be ordered.

Pharmacists could also do things such as peak flow tests and check that the condition is being controlled. There has been a 60% increase in prescriptions over the past 10 years and there is a strategy to train technicians and a contract with Barking College for an apprentice scheme (the aim is to get 200 people onto the apprentice scheme) to increase
the number of pharmacists.

**IAP leaflets:** Work has started to trial this and it has gone very smoothly. All pharmacists are trained to give proper support to patients as well as giving out leaflets and sign-posting people to the correct place.

Need to strategically review the care pathway to ensure that all the relevant players (including pharmacy) are included and understand how pharmacists can offer support through pathways (e.g. new meds service, meds use reviews. Because work is not co-ordinated between the GP-Pharmacist-Patient, activities appear to produce no real outcome. Should advise the patient to get a med use review from the pharmacist before a request for a repeat prescription is made.

**Member Comments**

**Member Question about Results sharing**

Response: There is a national stand to report results to patients within 3 weeks and to cc the GP. There is an 87% achievement rate for this target in B&D.

**Member Comment:** It is nice to see B&D have a high achievement rate for sharing retinopathy screening results. At the last meeting it was indicated that our service does not perform as well as Havering. It was also said that pictures were not sent to Queens as this was not possible with the current system.

Response: This is not true as there is a web-based programme that any doctor can request a login for to obtain the pictures. Every diabetes patient is advised to see an optician annually but if urgent action is required they are automatically referred to an ophthalmology department.

**Member Question: What is the difference between annual optician and retinopathy service tests?**

Response: In the previous service, opticians did the diabetes test as well as the standard eye test. Opticians now just do the general eye health check and sight test. Retinopathy is not done as part of the standard check as there are different standards for retinol screening. There are double checks I the retinopathy screening service to ensure quality assurance.

**Member Question: It is important that exercise and healthy living are part of the self-management process. What can GPs do to promote this?**

Response: GPs ask how much patients currently engage in but more could be done to
explore this issue with the patient. In 2010 there was a booklet of exercise schemes across the borough which was sent to GPs and was helpful when GPs gave advice to patients. However, this book hasn’t been updated so it’s difficult to sign-post services without knowing what’s still available.

**Member Question:** The Adult College could do out-reach work in PA or at the new Ripple Road Centre. Could be used to do some of this work?

Response: It would be good to see a central telephone number which patients could ring to understand choices and services available.

**Member Question:** Is there any rationalisation of medication?

Response: Sometimes medications are no longer effective. There was an audit carried out last year to look at effectiveness of medication after 6 months or at least at the point of the annual health review.

**Member Question:** Where there are side-effects do GPs advise patients of the most serious or common ones?

Response: Yes they do.
Meeting with Chairs of the Barking & Dagenham Clinical Commissioning Group and Health & Wellbeing Board

Date of Session: 6 March 2013

Representatives: Cllr Maureen Worby, Chair of the Health & Wellbeing Board
Dr Waseem Mohi, Chair of the Barking & Dagenham Clinical Commissioning Group

Q&A SESSION NOTES

How high is diabetes on the Health & Wellbeing Board's (H&WB) list of priorities?

There is no special priority per se as the approach of the Health & Wellbeing Strategy is based on life stages and diabetes will have a role to play in each of those stages. The H&WB Board welcomes the focus of HASSC and money has been put aside to look at diabetes, although not as much as HASSC would like to see. It is important not to let diabetes slip through the net. The H&WB Board will wait to see a more detailed action plan.

With a predicted increase of 50% in the prevalence of Type 2 diabetes, what improvements will H&WB make?

H&WB need to get the processes right. Promotion and prevention work to catch it early on and ensure that people take diabetes seriously. The Board hopes to tackle some of the causes of Type 2 diabetes such as obesity/age-related issues/smoking. There needs to be joined up thinking around prevention work which will have a knock on effect of reducing Type 2 diabetes prevalence.

The CCG has signed up for health improvement plans to identify gaps in 2013/14. An audit, led by Dr Kalkat, is already underway to investigate this. There has been no improvement in care despite commissioning a community service. Detection and early treatment of diabetes is important and we need to make sure that people get the message early. Patient education in GP practices and community services needs to be smarter and the CCG will work with the H&WB Board to identify how we can better target information.

The health picture for the borough is changing rapidly and we need to understand the scale of the problem. Detection and prevention during childhood is increasing. We need to be able to identify groups of people via primary health care teams and look at ways of improving the health of these groups. Health checks in some practices are very advance
although poor in others especially around the nine annual diabetic health checks. A peer review scheme has been developed to look at practices which are underperforming and providing training for GPs and practice nurses as part of the continuous review of process.

There is a lack of posters in GP practices and hospitals which raise awareness of early diagnosis. Is there also any automatic testing for diabetes in the same way people are automatically tested for HIV?

Patients over 14 years old are entitled to free health checks, and this includes a screen for diabetes. There is a need to get the message to young people as although a majority of people diagnosed with Type 2 diabetes are over 40 years old, a small number of patients are as young as 16.

Recent work has been done in collaboration with the Barking and Dagenham (BAD) Youth Forum. This group may be able to advise how to get the message to a young age group. It might be worth considering commissioning BAD to do some work for us around lifestyle advice.

People are not routinely tested for HIV whenever they provide a blood sample. Only people donating to a blood bank or using maternity services are routinely tested.

Can the CCG confirm that they are committed to funding literature?

Literature is already available on computer for GPs to print off in the surgery. Packs of literature on diabetes are also delivered by Pharmaceutical companies.

The current packs are being reviewed at present to ensure the information is up to date as they were designed 4-5 years ago. 10,000 packs were distributed 2 years ago.

The B&D Support Group found that despite GPs having high stocks of the packs, none of their members were ever offered one. The group has also never been asked to participate in a focus group with the CCG.

A recent survey revealed that there needs to be better work with patients and the CCG is looking at membership of the Health Improvement Partnership as part of this.

What work is being done to target people with mental health issues who have diabetes?

A lot of work is being done with GPs to ensure people with mental health issues have
annual health checks.

General practices target all mental health patients to ensure that they have annual health checks as well as the diabetes health checks as medications can often cause diabetes. IAP services are also accessible for diabetic patients due to high levels of depression.

We need to understand what the baseline is in order to better gauge how to target groups. How do we target specific groups and deliver services to those groups?

What can we do to improve services? How can we help get information to the newly diagnosed?

The H&WB Board do not deliver services directly. The CCG is responsible for delivering and commissioning services. H&WB Board can try to influence what the CCG commissions and it can monitor performance and hold the CCG to account.

Diabetes is a recognised problem for community services and there are also other issues which affect the health economy of patients and this affects what the system can do. Health checks can be advertised along with the range of services we can offer.

Maintaining quality of care is important and the CCG are looking at prescribing efficiency across ONEL and to ensure that good use is being made of the DESMOND programmes as well as improving patient/public engagement about diabetes.

There remains an issue of an out-of-hours service as many people are told to go to A&E when they phone for support.

Diabetes underpins the integrated case management strategy and is fundamental to the strategy going forward. Diabetes needs to be dealt with in an integrated way in order to keep people out of hospital.

Maintenance of diabetics within the community is essential as if a patient goes to A&E they will be admitted to hospital. Reacting to diabetic patients is critical.

The committee has heard evidence from patients and GPs that the 9 annual tests are not all carried out well for example foot checks. They also found that a patient’s ability to take in information when they are first told that they have diabetes is limited. The CCG need to look into this and consider how this will be tackled in future work. A report will go to H&WB Board to consider this as part of the priorities for 2014 so there is some time to undertake further investigations into this issue.
Routine MOT health checks can help to detect diabetes. At a national level, only 50% of diabetics are shown to receive the 9 annual diabetic health checks. In a recent review, many GP practices were above this figure but there are also a lot falling below it. This information has been shared with GPs in a league table in order to encourage peer reviews.
Appendix 2 Diabetes Survey

We are reviewing the diabetes services across Barking and Dagenham and we would like you to tell us about how you manage your diabetes, what services you use and what else you think we should be offering. Your response will help us make recommendations to the Council’s Cabinet about how services could be improved.

We would really appreciate it if you would take 10 minutes to answer a few questions.

Everything you tell us will be kept completely confidential, and will only be used as part of this review.

To thank you for completing the survey, you will have the chance to enter a prize draw to win an iPod Shuffle. The competition will close on the 4 January 2013 and the winner will be presented with their prize at Barking Town Hall during January 2013.

To enter, please provide your name and contact telephone number below and tick the box to confirm that you would like to enter the draw.

☐ Please tick if you would like to enter the prize draw

Name: ........................................................................................................................................

Contact Number: ........................................................................................................................

**If completing it on paper, please hand your survey back to the surgery reception**

If you would like to complete this survey on-line please go to the following link:

http://www.lbbd.gov.uk/DiabetesSurvey

For office use

Ref. [ ]
1. How are you affected by diabetes? (tick all that apply)

- □ I have diabetes *(Please jump to Section 1 below)*
- □ I look after someone with diabetes *(Please jump to Section 2 on page 5)*

Section 1

2. How long have you had diabetes?

- □ 0-2 years
- □ 6-10 years
- □ 16-20 years
- □ 3-5 years
- □ 11-15 years
- □ 21 years and over

3. What type of diabetes do you have

- □ Type 1
- □ Type 2

4. How do you manage your diabetes? (tick all that apply)

- □ Insulin
- □ Medication
- □ Diet
- □ Physical Activity
- □ Other (Please indicate ..............................................................)

5. If you selected “Medication” in Question 4, please state which medication you take

........................................................................................................

6. How helpful was your GP when you were first diagnosed?

<table>
<thead>
<tr>
<th>Not helpful</th>
<th>Not very helpful</th>
<th>Helpful</th>
<th>Very Helpful</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>My GP gave me no explanation or information</td>
<td>My GP didn’t give me very much information</td>
<td>My GP gave a brief explanation</td>
<td>My GP took time to explain diabetes to me</td>
</tr>
</tbody>
</table>

7. When you visit your GP do you:

Prepare a list of questions for your GP?

- □ Never
- □ Almost never
- □ Sometimes
- □ Fairly often
- □ Very often
- □ Always

Ask questions about the things you want to know?

- □ Never
- □ Almost never
- □ Sometimes
- □ Fairly often
- □ Very often
- □ Always

Ask questions about the things you don’t understand?

- □ Never
- □ Almost never
- □ Sometimes
- □ Fairly often
- □ Very often
- □ Always
8. Who gave you information about your diabetes? (tick all that apply)

☐ GP
☐ Hospital
☐ Family/Friend
☐ Nurse
☐ Local Diabetes Support Group
☐ Other (please specify below)

9. What sort of information did they give to you? (tick all that apply)

☐ Information about diabetes
☐ Dietary information
☐ How to manage my diabetes
☐ Other (please specify)
☐ Information about diabetes medication
☐ How to live with diabetes
☐ Long term health impacts of diabetes

10. Was this information helpful? (Please circle the one which applies)

☐ Not at all helpful
☐ Not very helpful
☐ Fairly helpful
☐ Very helpful

Please tell us what was helpful or unhelpful about the information you received?

---

11. Have you developed more health issues as a result of your diabetes?

☐ Yes
☐ No
☐ I didn’t know that might happen

12. If you answered “Yes” to Question 12 please say what health problems you have developed

☐ Vision problems
☐ Circulation
☐ Other problems (please specify below)
☐ Kidney problems
☐ Liver problems

---

13. Do you think they could have been avoided if you had received better advice and information about diabetes?

☐ Yes
☐ No
☐ Don’t Know

If I had understood the consequences I would have managed my diabetes better
I don’t manage my diabetes
14. Which of the following services have you heard of (tick all that apply)

<table>
<thead>
<tr>
<th>Heard of</th>
<th>Used this service</th>
<th>Porters Avenue Integrated Diabetes Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
<td>Diabetes UK</td>
</tr>
<tr>
<td>□</td>
<td>□</td>
<td>Barking &amp; Dagenham Diabetes Support Group</td>
</tr>
</tbody>
</table>

15. Which of the following programmes have you heard of (tick all that apply)

- DAFNE (Dose Adjustment for Healthy Eating) □ □ □
- DESMOND (Diabetes Education and Self Management for Ongoing and Newly Diagnosed) □ □ □

16. If you have attended did you find these programmes useful?

- DAFNE Not at all helpful □ Not very helpful □ Fairly helpful □ Very helpful □
- DESMOND Not at all helpful □ Not very helpful □ Fairly helpful □ Very helpful □

17. If you haven’t attended a programme please indicate why not?

- □ The time/day was inconvenient □ The location was inconvenient
- □ Nobody offered it to me □ I do not like group training
- □ Other reason – please state

18. Do you have annual check-ups for your diabetes? (tick all that apply)

<table>
<thead>
<tr>
<th>Check up</th>
<th>Annually</th>
<th>Sometimes</th>
<th>Never been checked</th>
<th>Didn’t know I should</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood pressure</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Cholesterol level</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Eye check</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Leg and feet check</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Kidney check</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Weight check</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Support for smoker</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Personal health and care plan</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>
Section 2 – Only complete this section if you look after someone with diabetes

19. Have you received any emotional support or counselling as a carer of someone with diabetes?

<table>
<thead>
<tr>
<th>Service</th>
<th>Heard of</th>
<th>Used this service</th>
<th>Not heard of</th>
</tr>
</thead>
<tbody>
<tr>
<td>Porters Avenue Integrated Diabetes Service</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Barking &amp; Dagenham Local Involvement</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Patient Advice and Liaison Service (PALS)</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Barking &amp; Dagenham Diabetes Support Group</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Diabetes UK</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

20. Do you think you have been given enough information about looking after someone with diabetes?

<table>
<thead>
<tr>
<th>Information</th>
<th>None</th>
<th>Too little</th>
<th>About right</th>
<th>Too much</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount of information received on diagnosis</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Amount of information received since diagnosis</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

21. Do you feel confident in administering medication for the person you are caring for?

<table>
<thead>
<tr>
<th>Confidence Level</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all confident</td>
<td>□</td>
</tr>
<tr>
<td>Not very confident</td>
<td>□</td>
</tr>
<tr>
<td>Fairly confident</td>
<td>□</td>
</tr>
<tr>
<td>Very confident</td>
<td>□</td>
</tr>
</tbody>
</table>

22. Please add any other comments below:

...................................................................................................................................................
...................................................................................................................................................
...................................................................................................................................................

Thank you for completing this diabetes survey.

We can make much better use of the information if we know a little about you. Please could you take a minute to answer the ‘about yourself’ questions on the next page?

If you would like to receive more information about the DAFNE or DESMOND programmes or would like to know more about the services offered at the Porters Avenue Integrated Diabetes Service please contact Porters Avenue on:

Tel: 020 8522 9826

E-Mail: diabetes.bdchs@nhs.net
Please tell us a little about yourself

(a) How old are you?
- Under 20
- 20 – 39
- 40 – 59
- 60 – 74
- Over 75

(c) Gender
- Male
- Female

(d) Do you consider yourself disabled?
- No
- Visual impairment
- Speech impairment
- Wheelchair user
- Mental health issues
- Hearing impairment
- Restricted mobility
- Learning difficulty
- Other hidden impairment (please specify)

(e) Are you a carer?
- Yes
- No

If Yes, do you care for...
- Disabled person in your family
- Older family member
- Child/ren under 14 years

(f) What is your sexual orientation
- Heterosexual
- Gay man
- Lesbian
- Bisexual
- Other (please specify)

(g) Do you identify, or have you ever identified, as “Transgender”?
- Yes
- No

(h) What is your religion?
- No religion
- Christian (all denominations)
- Buddhist
- Hindu
- Jewish
- Muslim
- Sikh
- Other religion (please specify)

(i) What is your postcode

<table>
<thead>
<tr>
<th>1 = Poor</th>
<th>5 = Fluent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reading</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Speaking</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

THANK YOU FOR COMPLETING THIS DIABETES SURVEY

For office use

Ref.
Appendix 3 Findings from the Patient and Carer Survey

1.1 Who Took Part in the Patient and Carer Survey?

The survey was aimed at people with Type 2 diabetes and carers of people with diabetes. Responses from LBBD staff were also accepted, but are not the main focus as they may not be residents in the Borough.

1.2 Patients

1.21 Age and gender

The age range of the respondents was between 40-59 (44%) and 60-74 (38%) which is in line with the expected age range of people most likely to develop Type 2 diabetes. There were very few respondents under 40 (12%). A majority of the respondents were female (40%).

1.22 Ethnicity

A large proportion of the respondents were White/White British (67.3%). The ethnic groups which are most likely to develop Type 2 diabetes (Black Caribbean, Black African and Asian) were not well represented among the respondents as indicated in the chart below.

![Ethnicity of Respondents Chart]
1.23  How long have you had diabetes?

The majority of the respondents have had their diabetes between 6-10 years (36%) with only a small proportion of respondents who participated in the survey being diagnose over 21 years ago (4%). It is interesting to note that during the patient perspective session many of the respondents attending had been diagnosed between 15-20 years ago and the information available to them at point of diagnosis was markedly different to those diagnosed 10 years ago or less which leads Members to conclude that the quality of information has improved over the past 10 years.

1.24  Type of Medication

87.8% of the respondents indicated that they were taking medication for their diabetes and at least 84.2% of these were taking Metformin, although some are taking a combination of diabetes drugs such as Metformin and Sitagliptin.

1.25  Annual Check ups

The responses for annual check ups among respondents was fairly good especially for retinol screening (98%). Only 71.4% had annual feet checks which was identified as an area of concern by Diabetes UK. Also very low, was the number of respondents having an annual care plan review (26.5%). Care plans was identified by Pharmacists as one of the key areas in which support could be offered to people living with Type 2 diabetes as this was one of the ways in which patients could improve self-management of their condition.
1.26 How helpful was your GP when first diagnosed?

At the patient perspective session representatives indicated that they did not receive very positive support and information from their GP. Those attending the session were generally diagnosed between 15-20 years ago. The survey indicated that this trend has now changed and that people generally feel that their GP is very helpful (38.3%) or helpful (40.4%) with only 8.5% saying that their GP was not helpful.

1.27 Who gave you information about your diabetes?

In contrast to the patient perspective session, many of the respondents 62.5% said that they got their information about diabetes from their GP. However, one of the areas of concern from service providers was that while there is good quality information available through GP surgeries, there are not enough leaflets provided to surgeries. Members suggest that commissioners may wish to review the quantity of information provided.

What is also worth noting is that GP surgeries are also working with patients on issues such as dietary information (66%), managing their condition (78.7%) and the long term health impacts of diabetes (53.2%)

1.28 Development of further health issues

41.7% of the respondents had developed further health issues, mostly relating to neuropathy and foot conditions. Only 2.1% of respondents did not realise that long-term complications were possible which indicates that a majority of patients are aware of the importance of managing their condition to prevent further health issues.
1.29 Services and Support

69.6% of the respondents had either heard and or used services at Porters Avenue, which included education programmes such as DESMOND with 52.9% of those who said they attended saying that it was very helpful. 54.3% of the respondents used the B&D Diabetes Support Group which offers support for people living with diabetes of 50+.

1.3 Carers

1.31 Support and Counselling

16.1% of the respondents cared for someone with diabetes and of that number none had received support or counselling and under half had received information about diabetes since diagnosis of the person they cared for.

1.32 Administering Medication

One of the concerns carers who attended the patient perspective session had was they did not always feel confident in administering medication because they had received little advice about doing so. The survey indicates that 28.6% of carers who responded did not feel very confident and only 57.1% feeling fairly confident.

Members suggest that some further work around information/education for carers may be required.

1.4 Conclusions from the Survey

Members found that the survey suggests that on the whole, those who responded were satisfied with the information they received at diagnosis and from their GP although commissioners may wish to consider increasing the amount of printed information available in GP surgeries.

Patients and GPs also appear to be very poor in terms of reviewing care plans annually, although it is not clear if this is because the GP did not include this as part of the review process or if patients are not aware that it should be reviewed annually.

There also needs to be a review of the information and support offered to carers. This was raised during the patient perspective session and the survey indicates that carers are receiving very little education particularly around administering medication.
Appendix 4 Overview of the National Standards Framework for diabetes

The National Service Framework for Diabetes includes standards, rationales and key interventions which should be taken into account when planning services. The standards are summarised below.

**Prevention of Type 2 diabetes**

**Standard 1**
The NHS will develop, implement and monitor strategies to reduce the risk of developing Type 2 diabetes in the population as a whole and to reduce the inequalities in the risk of developing Type 2 diabetes.

**Identification of people with diabetes**

**Standard 2**
The NHS will develop, implement and monitor strategies to identify people who do not know they have diabetes.

**Empowering people with diabetes**

**Standard 3**
All children, young people and adults with diabetes will receive a service which encourages partnership in decision-making, supports them in managing their diabetes and helps them to adopt and maintain a healthy lifestyle. This will be reflected in an agreed and shared care plan in an appropriate format and language. Where appropriate, parents and carers should be fully engaged in this process.

**Clinical care of adults with diabetes**

**Standard 4**
All adults with diabetes will receive high-quality care throughout their lifetime, including support to optimise the control of their blood glucose, blood pressure and other risk factors for developing the complications of diabetes.

**Clinical care of children and young people with diabetes**

**Standard 5**
All children and young people with diabetes will receive consistently high-quality care and they, with their families and others involved in their day-to-day care, will be supported to optimise the control of their blood glucose and their physical, psychological, intellectual, educational and social development.

**Standard 6**
All young people with diabetes will experience a smooth transition of care from paediatric diabetes services to adult diabetes services, whether hospital or community-based, either directly or via a young people’s clinic. The transition will be organised in partnership with each individual and at an age appropriate to and agreed with them.
**Management of diabetic emergencies**

**Standard 7**  
The NHS will develop, implement and monitor agreed protocols for rapid and effective treatment of diabetic emergencies by appropriately trained health care professionals. Protocols will include the management of acute complications and procedures to minimise the risk of recurrence.

**Care of people with diabetes during admission to hospital**

**Standard 8**  
All children, young people and adults with diabetes admitted to hospital, for whatever reason, will receive effective care of their diabetes. Wherever possible, they will continue to be involved in decisions concerning the management of their diabetes.

**Diabetes and pregnancy**

**Standard 9**  
The NHS will develop, implement and monitor policies that seek to empower and support women with pre-existing diabetes and those who develop diabetes during pregnancy to optimise the outcomes of their pregnancy.

**Detection and management of long-term complications**

**Standard 10**  
All young people and adults with diabetes will receive regular surveillance for the long-term complications of diabetes.

**Standard 11**  
The NHS will develop, implement and monitor agreed protocols and systems of care to ensure that all people who develop long-term complications of diabetes receive timely, appropriate and effective investigation and treatment to reduce their risk of disability and premature death.

**Standard 12**  
All people with diabetes requiring multi-agency support will receive integrated health and social care.
Overview of the National Standards Framework

Newly diagnosed patients should receive the following from their diabetes care team:
- A full medical examination.
- An agreed care plan.
- An appointment with a diabetes specialist nurse (or practice nurse) to explain what diabetes is and discuss individual treatment and the equipment needed.
- Agreed named healthcare professional to contact for support, advice or more information, if needed.
- An appointment with a state registered dietitian, to discuss usual diet, advice on how to match diet with diabetes - a follow-up meeting should be arranged for more detailed advice.
- Discuss the beneficial effects of a healthy diet, exercise and good diabetes control.
- Discuss the effects of diabetes on work, driving, insurance, prescription charges, and if the patient is a driver, whether they need to inform the DVLA and insurance company.
- Provide regular and appropriate information and education, on food and footcare for example.
- Refer to a structured education programme meeting national criteria.
- Provide information about Diabetes UK services and details of local Diabetes UK voluntary group.
- Refer to a psychologist should the person need to discuss how to cope with the diagnosis/condition.

If treated by insulin injections patient should:
- Have frequent visits demonstrating how to inject, look after insulin and syringes and dispose of sharps (needles). Also how to test blood glucose, test for ketones and be informed what the results mean and what to do about them.
- Be given supplies of, or a prescription for the medication and equipment needed.
- Discuss hypoglycaemia (hypos) when and why they may happen and how to deal with them.

If treated by tablets the patient should:
- Be given instruction on blood or urine testing and have explained what the results mean and what to do about them.
- Be given supplies of, or a prescription for the medication and equipment needed.
- Discuss hypoglycaemia (hypos): when and why they may happen and how to deal with them.

If treated by diet alone the patient should:
- Be given instruction on blood or urine testing and have explained what the results mean and what to do about them.
- Be given supplies of equipment needed.
- Be offered nutritional advice.

Once the diabetes is reasonably controlled, the person should:
- Have access to their diabetes care team at least once a year - to discuss how diabetes affects them as well as diabetes control.
- Be able to contact any member of the diabetes care team for specialist support and advice, in person or by phone.
- Have further education sessions when they are ready for them.
- Have a formal medical annual review once a year with a doctor experienced in diabetes.

On a regular basis, the diabetes care team should:
- Provide continuity of care, ideally from the same doctors and nurses.
- Work to continually review the care plan, including diabetes management goals.
- Ensure the person shares in decisions about treatment or care.
- Enable the patient to manage their own diabetes in hospital after discussion with the doctor, if they are well enough to do so and that is what you wish.
- Organise pre and post pregnancy advice, together with an obstetric hospital team, if the person is planning to become or already are pregnant.
- Encourage a carer to visit with the person, to keep them up to date on diabetes to be able to make informed judgements about diabetes care.
- Encourage the support of friends, partners and/or relatives.
- Provide educational sessions and appointments.
- Give advice on the effects of diabetes and its treatments when the person is ill or taking other medication.
## Appendix 5 - Site Visit ‘Menu of Involvement’

Site visits to the following locations were organised for Members as part of the diabetes scrutiny review.

<table>
<thead>
<tr>
<th>ORGANISATION</th>
<th>ORGANISATION DETAILS</th>
<th>DATE</th>
<th>TIME</th>
<th>LOCATION</th>
<th>EVENT</th>
<th>EVENT DETAILS</th>
<th>ATTENDING MEMBERS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>B&amp;D Diabetes Support Group</strong></td>
<td>The B&amp;D group was set up in 2003 and provides an opportunity for people with diabetes and carers of people with diabetes to meet to discuss issues relating to medication, diet and long term issues associated with diabetes. The group specifically deals with diabetics over the age of 50. There is regular attendance by health care professionals who provide advice and information.</td>
<td>11-Feb-13</td>
<td>8 to 9.45pm</td>
<td>Dagenham and Redbridge Football Club Victoria Road Dagenham RM10 7XL</td>
<td>Foot and leg ulcers – complications and impact</td>
<td>Meet with patients and carers to discuss some of the different issues faced by diabetics and carers of people with diabetes.</td>
<td>Cllr Alasia  Cllr McKenzie  Cllr Wade</td>
</tr>
<tr>
<td><strong>Integrated Diabetes Service</strong></td>
<td>The team helps patients to develop their knowledge and understanding about diabetes, controlling long-term condition. Includes patient education programme (DESMOND) and 3 clinics: Complex Care Clinic, Individual Patient Support and Intervention Clinic, diabetic Retinopathy Screening Clinic.</td>
<td>19-Feb-13</td>
<td>11:30-2pm</td>
<td>Porters Avenue</td>
<td>Complex Care Clinic  Individual Patient Support and Intervention  Diabetic Retinopathy Screening Clinic</td>
<td>Meet with service providers about the different clinics and programmes being offered to patients with diabetes.</td>
<td>Cllr McKenzie  Cllr Salam</td>
</tr>
</tbody>
</table>
This page is intentionally left blank
Title: Ideas for scrutiny reviews in 2013/14

Report of the Corporate Director of Adult and Community Services

<table>
<thead>
<tr>
<th>Open</th>
<th>For Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wards Affected: None</td>
<td>Key Decision: No</td>
</tr>
<tr>
<td>Report Author:</td>
<td>Contact Details:</td>
</tr>
</tbody>
</table>
| Mark Tyson, Group Manager Service Support & Improvement | 020 8227 2875  
  Mark.Tyson@lbbd.gov.uk |

Accountable Divisional Director:
Glynis Rogers, Divisional Director Community Safety and Public Protection

Accountable Director:
Anne Bristow, Corporate Director Adult and Community Services

Summary:
Each municipal year, as part of their annual work programme, the Council’s Select Committees aim to complete at least one investigation into an area of Member and/or public concern to make recommendations in order to improve public services.

In recent years, HASSC has completed reviews of dementia services, smoking cessation, maternity services and, most recently, of diabetes services.

Appended to this report are three topics with case studies and suggestions for what a scrutiny of these issues might look like. Members can of course select any topic under the remit of the HASSC; the proposals appended are merely suggestions.

Recommendation(s)
The Select Committee is asked to choose a proposal from the options below or decide upon a topic of their own choosing. Officers will then work with Members to draw up a project plan and collect evidence for the review.
1. Choosing a topic

1.1 When deciding which of the proposals the HASSC would like to use as a starting point for a review, Members should be mindful of the criteria that make for good scrutiny subject matter. Good review topics should:

- fall within the Select Committee’s remit;
- be timely;
- be of importance to local residents;
- be within the Council and its partners’ power to change or influence;
- add value to at least one of the Council’s key policy objectives;
- focus on areas of weaker performance;
- avoid duplicating the work of other committees, bodies or organisations.

1.2 Members will be aware that Barking and Dagenham suffers from major health inequalities because of its deprivation, the socio-economic status of residents and their associated lifestyle choices such as diet, exercise, smoking, alcohol intake and occupation.

1.3 Members will also be aware that there are a number of challenges in the provision of local health services to the communities of Barking & Dagenham, a number of which have been subject to discussion at meetings of the Committee in the 2012/13 municipal year.

1.4 2012/13 has been an unprecedented year of change for health and social care services and, in many respects, this change is set to continue over the coming 2-3 years, with the implementation of the Health & Social Care Act 2012 and the expected passage of the Care & Support Bill which will establish new structures and expectations for social care services.

2. Approaches to scrutiny

2.1 Members may wish to specifically think about the different approaches and techniques that can be used to collect evidence to inform the review, some of which are outlined below:

- desktop-based analysis and research;
- commissioning reports (or presentations) from council departments, partner organisations, or external bodies;
- organising themed workshops with stakeholders;
- surveys, site visits, walkabouts, or ‘mystery shopping’ exercises;
- inviting experts, residents, officers, partners, local rapporteurs or other relevant persons or organisations to give oral or written evidence to a Select Committee meeting.

3. Further scoping

3.1 Following the meeting once a topic has been settled on by the Select Committee, officers, in consultation with the Chair of HASSC, will return with a more detailed project plan and the review will begin in earnest over the summer. The project plan will outline:

- Further background information on the chosen issue;
• suggested terms of reference (to be agreed formally by the HASSC at a future meeting);
• suggested methodology to be followed, including the approach to evidence gathering (see para 2.1);
• the timetable with milestones and estimated date for the completion of the project;
• a list of participants and contributors to the review.

5. Outline proposals for Members’ consideration

5.1 Members will be aware that a comprehensive Joint Strategic Needs Assessment was completed in 2011, and is undergoing refresh for 2013. In addition, the Health & Wellbeing Board, as part of its initial development, has considered the outcomes frameworks published by the Department of Health, and drawn up an outcomes framework of its own, which pulls together a locally-relevant cross section of indicators that touch on local priorities.

5.2 To support Members’ thinking about scrutiny review options for the coming year, this thinking has been drawn together and three options are provided for consideration. Members may also wish to ask officers to scope other options.
<table>
<thead>
<tr>
<th>Option 1: Implementation of the Health &amp; Social Care Act 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overview</strong></td>
</tr>
<tr>
<td><strong>JSNA evidence: demography and prevalence</strong></td>
</tr>
<tr>
<td><strong>Policy and legislation issues</strong></td>
</tr>
<tr>
<td><strong>Areas of potential enquiry</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
Option 2: Emergency health care provision in the local NHS

Overview

Local emergency health care services are the subject of considerable current debate and discussion. Accident & Emergency at Queen’s Hospital has been severely criticised by the Care Quality Commission and there are changes currently being introduced to GP extended hours, out-of-hours, Walk-in and Urgent Care Centre facilities. There is concern amongst many that these proposals do not ‘fit’ consistently into an overall ‘system’ approach.

JSNA evidence: demography and prevalence

The Joint Strategic Needs Assessment doesn’t contain detailed information on urgent care activity. However, the CCG’s business case for the closure of Broad Street Walk-in Centre, profiles activity over a four-year period as follows:

<table>
<thead>
<tr>
<th>Service</th>
<th>4 Year Total</th>
<th>% Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident &amp; Emergency</td>
<td>244,700</td>
<td>40%</td>
</tr>
<tr>
<td>King George Hosp UCC</td>
<td>27,420</td>
<td>4%</td>
</tr>
<tr>
<td>Queen’s Hosp UCC</td>
<td>39,340</td>
<td>6%</td>
</tr>
<tr>
<td>Loxford Polyclinic WIC</td>
<td>5,060</td>
<td>1%</td>
</tr>
<tr>
<td>Upney Lane WIC</td>
<td>116,630</td>
<td>19%</td>
</tr>
<tr>
<td>Broad Street WIC</td>
<td>117,280</td>
<td>19%</td>
</tr>
<tr>
<td>Out of Hours</td>
<td>65,740</td>
<td>11%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>616,170</strong></td>
<td></td>
</tr>
</tbody>
</table>

Policy and legislation issues

The Care Quality Commission investigation into the quality of services at Queen’s Hospital A&E has highlighted a number of concerns, against a national backdrop of the publication of the Francis Report into the problems at Mid-Staffordshire NHS Trust. Sir Bruce Keogh, Chief Medical Officer, has also announced a national review of urgent and emergency care, to include the full range of services described above. This is very similar to the work launched by the Clinical Commissioning Group under the title ‘Urgent Care: Case for Change’, and which links to work to improve the provision of primary care as an improved option for urgent care.

Areas of potential enquiry

- Do the changes proposed for urgent care represent a balanced set of changes to the whole system, or are there issues in the way changes are being implemented that will cause problems elsewhere?
- The Committee could restrict its enquiry to A&E at Queen’s Hospital, asking whether the improvement plans are being robustly implemented and monitored: however, the Committee should be aware that this is already the focus of considerable activity and this option risks being one further avenue of scrutiny which may not assist the continued improvement of the hospital. Alternatively, the Committee may wish to ask whether the Health & Wellbeing Board has the required ‘system overview’ and is effectively driving improvement in emergency and urgent care services?
<table>
<thead>
<tr>
<th>Option 3: Mental health</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overview</strong></td>
</tr>
<tr>
<td>Mental health services are provided by the Council (social care) and the NHS. Barking &amp; Dagenham operates an integrated team, run on behalf of the Council by North East London Foundation NHS Trust. The operation is governed by a contract made under Section 75 of the National Health Service Act 2006. Mental illness encompasses a range of illnesses spanning depression, anxiety and phobia through to more serious and enduring mental illness such as psychosis and schizophrenia. Taking a wider view, the prevention of mental ill-health, and the response to low-level mental illness, is critical to the wider wellbeing of the community. MIND quote estimates predicting that by 2020 depression will be second only to heart disease as an international health problem, costing £100bn per year.</td>
</tr>
<tr>
<td><strong>JSNA evidence: demography and prevalence</strong></td>
</tr>
<tr>
<td>The 2012 JSNA estimates that approximately 5.8% of borough residents are accessing care for mental health services for a range of mental health conditions. During 2008/9, 411 adult residents of Barking and Dagenham were admitted as in-patients for mental health care, while 4,403 attended either a mental health outpatient’s appointment or had contact with a community service. It is estimated that in any given week 11% of adults in Barking and Dagenham will be experiencing depression, higher than the England average (8%) but the same as London.</td>
</tr>
<tr>
<td><strong>Policy and legislation issues</strong></td>
</tr>
<tr>
<td>The NHS Act 2006 governs the agreement between the Council and NELFT for provision of integrated mental health services. Mental health services, including the provisions for detaining those at risk of causing harm to themselves or others, are governed by a range of legislation including the Mental Health Act 2007 and Mental Capacity Act 2005.</td>
</tr>
<tr>
<td><strong>Areas of potential enquiry</strong></td>
</tr>
<tr>
<td>Given the time and resource available, Members are advised to focus in on one specific area for consideration. It is suggested that two possibilities are available:</td>
</tr>
<tr>
<td>• Firstly, to scrutinise the effectiveness of the commissioning of the joint mental health services with NELFT, their operation and the patient experience;</td>
</tr>
<tr>
<td>• Secondly, to focus on preventive mental health interventions, recognising that tackling the increases in the numbers reporting mental illness, both that have been seen and are predicted in coming years, need a concerted effort from all partners.</td>
</tr>
</tbody>
</table>
HEALTH AND ADULT SERVICES SELECT COMMITTEE
17 APRIL 2013

<table>
<thead>
<tr>
<th>Title:</th>
<th>Updated Terms of Reference for the HASSC</th>
</tr>
</thead>
</table>

Report of the Chief Executive

Open For Approval

Wards Affected: All Key Decision: No

Report Authors: Contact Details:
Glen Oldfield, Scrutiny Officer, Democratic Glen Oldfield, Scrutiny Officer, Democratic
Services Services

Telephone: 020 8227 5796 Telephone: 020 8227 5796
E-mail: glen.oldfield@lbbd.gov.uk E-mail: glen.oldfield@lbbd.gov.uk

Accountable Divisional Director:
Fiona Taylor, Head of Legal and Democratic Services

Accountable Director:
Graham Farrant, Chief Executive

Summary:
The five themed Select Committees of the Council’s scrutiny function were formally constituted in April 2009. Since that time there has been considerable change to the National Health Service through the Health and Social Care Act 2012 resulting in major structural changes which took effect from 1st April 2013. While these changes will not fundamentally change the role of HASSC, or how it conducts its business, it is important that the HASSC takes account of the relevant elements of the new NHS landscape and that the HASSC’s remit and functions have regard to the new health scrutiny powers, related legislation, and associated regulations that underpin the NHS reforms and supersede legislation and regulations previously issued by government. Attached at Appendix 1is a revised Scheme of Delegation for the HASSC to bring it up-to-date constitutionally.

Members should note that the Constitution is currently under review so the style and format of the appended Scheme of Delegation may vary as a result of maintaining consistency of presentation of information in the new version of the Constitution. All content listed will naturally still be applicable even if not explicitly written into the final version of the constitution.

LBBD’s Joint Health Scrutiny arrangements with Havering, Redbridge and Waltham Forest will be reviewed separately and reported back to the HASSC in due course.
Recommendation(s)

The HASSC is asked to:

- Approve the revised Scheme of Delegation for the HASSC so that changes to the Constitution can be presented to the Assembly for adoption, or enacted under delegated authority by the Monitoring Officer.

Background papers

- Council Constitution
- Pulling it all together: A guide to legislation covering overview and scrutiny in English local government (Centre for Public Scrutiny, May 2012)
- Health and Social Care Act 2012
- Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002
- The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

1. Relevant Aspects of the Health and Social Care Act 2012/Explanatory notes

1.1 Before asking Members to comment on constitutional changes for the HASSC, it is worth outlining the relevant aspects of the Health and Social Care Act 2012 that have a bearing on the local authority and health scrutiny to put into context the proposed amendments to the HASSC’s scheme of delegation set out in Appendix 1.

- Extending scope of scrutiny

  The health scrutiny powers have been extended and now apply to ‘relevant NHS bodies’ or ‘relevant health service providers’. This covers CCGs, the NHSCB and providers of health services (including independent sector providers). This is a landmark step in strengthening health scrutiny and ensures that any organisation commissioning or providing health services must cooperate with scrutiny by supplying information, or attendance of relevant persons, upon request.

- Localism

  As part of the localism agenda health scrutiny powers are now conferred on the local authority not on an individual Overview and Scrutiny Committee; allowing for Councils to discharge scrutiny through different models. This means that the HASSC does not directly inherit powers and functions for health scrutiny; instead these powers and functions must be delegated to the HASSC by Assembly.

- Referrals to the Secretary of State for Health

  The Department of Health’s response to the consultation on the Health Scrutiny Regulations indicated that local authorities would need to use the National Commissioning Board as an intermediary when making a referral to the
Secretary of State. However, on publishing the Regulations there was no mention of this requirement. The regulations do state that when making a referral the local authority must demonstrate it has taken all reasonable steps to resolve the dispute locally. This would include seeking advice and input from the National Commissioning Board which could work with all parties to broker an agreement. We await guidance on the exact role of the National Commissioning Board in supporting the referral process. Nevertheless a direct line to the Secretary of State remains.

It should be noted that the referral power is also extended to include other commissioners (not the CCG) proposing a substantial variation to local health services. This provision takes account of the National Commissioning Board’s role as commissioner of key health services ensuring local democratic accountability.

- **Healthwatch**

  From 1\textsuperscript{st} April 2013 Healthwatch will replace the LINk with an enhanced remit to act as a consumer champion for patients and service users. A separate paper is being presented to the HASSC to explore the functions of Healthwatch and how it might work productively with HASSC, given their overlapping remits with respect to accountability in health and social care. For the purposes of this report it is important to note that the power for LINks to make referrals to OSCs is passed onto Healthwatch, along with the obligation on the Overview and Scrutiny Committee to respond and act upon any referral in a timely fashion.

- **Health and Wellbeing Board**

  Health and Wellbeing Boards are established as statutory committees of the Council to drive integration and partnership working and to exert strategic influence over local commissioners. The Boards consist of the key leaders from across the local health and social care economy. The primary functions of the Boards are to produce the Joint Strategic Needs Assessment and Health and Wellbeing Strategy, documents that will underpin commissioning decisions and drive improvements. The HASSC will be expected to hold the local H&WBB to account for the delivery of these functions and feed concerns gathered from the scrutiny forum up to the H&WBB for action.

  Naturally, as an executive committee of the Council, the Board is subject to scrutiny in the same way as Cabinet. Therefore the power for elected members to call-in a decision of the Board applies. For simplicity where a decision owned by the H&WBB is called-in, the HASSC will respond. That said, the Call-in process will be made inclusive so that relevant Members and senior officers from other Select Committees/Directorates get the opportunity to feed into the HASSC’s response to the Call-in.

- **Public Health**

  Public Health and health improvement is now the responsibility of the local authority. Elected members will now have a direct role in decisions about the commissioning of public health initiatives and responsibility for the delivery of public health services. This will mean that when scrutinising public health issues it is the Council that will be under the microscope rather than the NHS. Public
Health comes under the portfolio of Cllr Worby with Matthew Cole (Director of Public Health) as LBBD’s accountable officer.

- **Regulatory regime**

  The Health and Social Care Act 2012 introduces a new regulatory regime to reflect new commissioning structures and a broader range of providers operating with NHS funding. As such the HASSC will need to have regard to the remits of several regulators whose roles are summarised below.

  - **Care Quality Commission (CQC)**
    
    CQC is the regulator of health and social care for England. It registers, and therefore licenses, care services if they meet essential standards of quality and safety and monitors them to ensure they continue to meet these standards. Healthwatch England will be part of the CQC.

  - **Monitor**
    
    Monitor is the regulatory body for NHS Foundation Trusts. Under the Health and Social Care Act 2012, Monitor’s key role will be to promote and protect patients’ interests. It has statutory powers in relation to co-operation and competition and will be required to support the delivery of integrated care where this would improve quality or efficiency.

  - **NHS Commissioning Board (NHSCB)**
    
    The NHSCB is a national body created under the Health and Social Care Act, whose role will include supporting, developing and holding to account the system of clinical commissioning groups, as well as being directly responsible for some specialist commissioning.

  - **National Institute for Health and Care Excellence (NICE)**
    
    NICE (formerly known as the National Institute for Health and *Clinical Excellence*) is the body responsible for providing research, evidence and guidance on what medication, treatments and interventions should be available through the NHS and, in the case of public health, through local authorities. Under the Health and Social Care Act 2012 the role of NICE has been expanded to bring high-quality guidance and standards to the social care sector. Despite the name change the acronym remains the same.

1.2 It is not necessary to cite these regulators or make reference to the regulatory regime when describing the role and functions of the HASSC. However, interaction with these bodies may prove crucial if it becomes necessary to escalate a matter to the Secretary of State. The referral process, as outlined in the regulations, demands that Local Authorities take all reasonable steps (which might include engaging with regulators) to resolve the matter before asking the Secretary of State to intervene and asks that any submission from the Local Authority explains those steps taken.

1.3 The diagram overleaf depicts the NHS landscape in the post Health and Social Care Act 2012 world showing where the local authority sits in relation to other agencies and parts of the system.
SECTION F – THE HEALTH AND ADULT SERVICES SELECT COMMITTEE

Further to the general powers of scrutiny outlined elsewhere in the Constitution the functions and powers of the HASSC are as follows:

1. Scrutinising any matter relating to the planning, provision and operation of the health service in the borough or accessed by Barking and Dagenham residents.

2. Requesting information from NHS bodies and any health service provider. Exempt from this power are requests for information that are confidential (i.e. information that identifies a living person or is prohibited under any enactment) or relate to NHS Trusts in special administration.

3. Requesting attendance from any member or employee of a relevant NHS body or health service provider to attend before it to answer any questions; provided those questions do not relate to confidential information or information that they would be entitled to refuse to provide in a court of law. The request for attendance may also be refused if reasonable notice has not been given.

4. Acting, on behalf of the Authority, as the statutory consultee where NHS bodies propose substantial developments or variations in the provision of services and thus have a duty to consult with the local authority before taking a decision. When being consulted with, the HASSC must notify the relevant NHS body of its response to the consultation and any intention to refer the matter to the Secretary of State within the timescales agreed by both parties.

5. Exercising, on behalf of the Authority, the Council’s right of referral to the Secretary of State on substantial variations to local health services. The HASSC will have regard to the criteria and process for making a referral to the Secretary of State which are prescribed in the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

6. Receiving referrals from the local Healthwatch on matters relating to the planning, provision, and operation of health services in the borough, acknowledging receipt within five working days. Further to the regulations, Healthwatch can expect a referral to be discussed at the next formal meeting of HASSC, or at a formal meeting within three months (whichever is most timely). In accordance with the regulations the HASSC is obligated to keep the referrer informed of any action taken in relation to the matter.

7. Holding to account the Health and Wellbeing Board for the delivery of its functions, and in doing so, having particular regard to the robustness of the Joint Strategic Needs Assessment and Health and Wellbeing Strategy as effective documents to ensure commissioning of health and social care services is reflective of local need.

8. Presenting recommendations arising from scrutiny investigations in accordance with the Council’s agreed processes, submitting recommendations to the relevant decision-maker as determined by Council’s Scheme of Delegation.
Where recommendations or reports are issued to NHS bodies/health service providers, that Body or provider must, if requested to do so, respond to the HASSC within 28 days.

9. Monitoring progress of implementation of recommendations in accordance with the Council’s agreed processes, ensuring that decision-makers have due regard to findings and recommendations arising from scrutiny investigations.

10. Addressing any Call-ins as allocated by the Statutory Scrutiny Officer in accordance with Article 5A. On occasions where the decision called-in is owned by the Health and Wellbeing Board the HASSC will by default be the receiving Select Committee of that Call-in regardless of the subject of the decision.

11. Addressing any Councillor Calls for Action as allocated by the Statutory Scrutiny Officer in accordance with Article 5B

12. Considering petitions in accordance with the Council’s Petition Scheme which can be found on the Council’s website. 
http://www.lbld.gov.uk/CouncilandDemocracy/Information/Pages/Petitions.aspx

13. Representing local people and bringing local concerns and feedback about health and social care services to the attention of leaders within the local health and social care economy, formally advising the Health & Wellbeing Board of any such concerns in the process.
Now that the HASSC has concluded its scrutiny of diabetes services it has reached a point where it must begin to look forward and plan its business going into the 2013/14 municipal year.

The table overleaf lists known agenda items at the time of writing and reserves slots for collecting evidence for the HASSC’s chosen review for 2013/14. The Work Programme will be reviewed once a topic area has been fully scoped and new members have been appointed following Annual Assembly (15 May). The Work Programme will be presented to the HASSC for review periodically thereafter.

To hit the ground running with the next project, the HASSC may wish to receive a scoping report and background information before its next formal meeting on 10 June 2013.

**Recommendation(s)**

The HASSC is asked to:

- Note the dates of formal meetings for 2013/14
- Note the items scheduled to be considered at future HASSC meetings
- Suggest additions to the work programme taking into account the chosen review area for 2013/14 (as presented earlier in this agenda pack)
1. Provisional work programme for 2013/14

10 June 2013
• Impact of Francis Report on Health Scrutiny
• Re-modelling of learning disability day services
• Responding to BHURT Quality Account 2013
• Scrutiny Review: Evidence Session 1

29 July 2013
• Scrutiny Review: Evidence Session 2
• Adult Social Care Local Account 2012/13

23 September 2013
• Scrutiny Review: Evidence Session 3
• Scrutiny Review: Draft Report

12 November 2013
• Scrutiny Review: Final Report

14 January 2014
• TBC

04 March 2014
• TBC