Title: 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

Open: For Information

Wards Affected: All

Key Decision: No

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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
business case contrasts this with lower rates for the Upney Lane Walk-in Centre, but doesn’t say either way whether this is due to variations in presenting need, or variations in professional judgment. Taking the 29% figure, removal of the Walk-in Centre option therefore has the potential to send an additional 1,662 patients to A&E (over and above those actually referred by the Walk-in Centre to A&E), with Queen’s Hospital being their nearest option. This would be a 3.3% increase in A&E activity based on the 50,000 attendances currently seen borough-wide. The cost of this activity, based on the business case’s estimated figures, would be £118,000 more than if they had attended the current Walk-in Centre service. It should be borne in mind that this is the clinical assessment of the appropriateness of those individuals using A&E. As noted below, the risks of attendees making their own ‘inappropriate’ decision to use A&E could be potentially greater.

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

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<td>Attendances at Upney Lane (£29 per case)</td>
<td>18%</td>
<td>3,292</td>
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<td>Other walk-in centres (£29 per case)</td>
<td>5%</td>
<td>915</td>
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<tr>
<td>Urgent Care Centre (£75 per case)</td>
<td>2%</td>
<td>366</td>
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<td>A&amp;E (£100 per case)</td>
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Scenario 2: All unregistered patients (ca. 2,000 at midpoint of estimates) divert to A&E & UCC

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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

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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 2,000m². 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