Walk-in Centres in Barking and Dagenham
A pre-consultation business case

January 2013

Version 1.0 final

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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
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”\(^2\).

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

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.\(^4\)

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\(^5\).

**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\(^6\). 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**\(^7\), 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**\(^8\), 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:

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\(^2\) [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

\(^4\) [http://www.bbc.co.uk/news/uk-politics-18503034](http://www.bbc.co.uk/news/uk-politics-18503034)

\(^5\) [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/)

\(^8\) [http://www.nelft.nhs.uk/news_publications/80](http://www.nelft.nhs.uk/news_publications/80)
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:

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<th>Table 1: Summary of current walk in services</th>
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</table>
| Opening times | Mon-Fri 7am-10pm  
Sat-Sun 10am-6pm | Mon-Fri 7am-10pm  
Sat-Sun 9am-10pm |
| Location | Morland Road, Dagenham, RM10 9HU | Barking Community Hospital  
Upney Lane, Barking IG11 9 LX |
| Provider | Care UK | NELFT |
| Contract | An APMS contract | Part of the Community Service Contract |
| Activity | Approximately 80 patients a day  
or 560 patients a week | Approximately 80 patients a day  
or 560 patients a week |
| Service type | Minor ailments and minor injuries  
Nurse led with health care assistants and a doctor available at co-located health centre. | Minor ailments and minor injuries  
Nurse led with emergency care practitioners and a doctor available |
| Service inter-dependencies | Co-located with a GP practice  
and provides complex care to Park View Care Home residents | Co-located at Barking Community Hospital |
| Diagnostic Equipment | No diagnostic equipment | X-ray equipment |
| Age Exclusions | Children under 2 years | None |
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

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d. RCGP Federated Primary Care

The Royal College of GPs has developed a toolkit\(^1\) 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\(^1\)

**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:\(^1\)

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 six to five
- To provide a 24/7 urgent care centre at King George Hospital.

b. Barking and Dagenham Health and Wellbeing Strategy 2012-15\(^2\)

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

\(^1\) [http://www.rcgp.org.uk/pdf/Toolkit_Content_Final.pdf](http://www.rcgp.org.uk/pdf/Toolkit_Content_Final.pdf)

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”.

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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:

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<th>Current State</th>
<th>Desired State</th>
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<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>
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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\(^{15}\) 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

![Diagram of current urgent care provision]

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</td>
<td>5</td>
<td>38</td>
<td>1,950</td>
<td>1%</td>
</tr>
<tr>
<td>London Ambulance Service (LAS)</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.

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</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

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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**

![Graph showing number of GPs per 100,000 population](image)

**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:

<table>
<thead>
<tr>
<th>Forecast position of the BHR health economy, 2011/12 to 2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue limit (recurrent)</td>
</tr>
<tr>
<td>Revenue limit (non recurrent)</td>
</tr>
<tr>
<td>Acute hospital care</td>
</tr>
<tr>
<td>Specialist hospital</td>
</tr>
<tr>
<td>Learning disabilities and mental health</td>
</tr>
<tr>
<td>Prescribing</td>
</tr>
<tr>
<td>Community health services</td>
</tr>
<tr>
<td>Primary medical services</td>
</tr>
<tr>
<td>Corporate and other</td>
</tr>
<tr>
<td>Surplus/(deficit)</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>TOTAL</td>
<td></td>
<td>484,100</td>
<td>49.8m</td>
</tr>
</tbody>
</table>

Barking and Dagenham walk in centre costs

Table 6: Walk in centre costs 2010-13\(^{20}\)

<table>
<thead>
<tr>
<th></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(^{21})</td>
<td>870,970</td>
<td>1,049,537</td>
<td>1,920,507</td>
</tr>
<tr>
<td>TOTAL</td>
<td>2,467,920</td>
<td>3,128,508</td>
<td>5,596,428</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)\(^{22}\).

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\(^{20}\) 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
- 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 12: Estate business case priorities**

<table>
<thead>
<tr>
<th>Factors</th>
<th>Weight</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition / flexibility of current premises</td>
<td>10</td>
<td>Ensuring the maximum use is made of existing buildings before considering new builds. This should include consideration of existing condition, compliance, capacity, flexibility and environmental performance.</td>
</tr>
<tr>
<td>Demonstrable best value and improvement in service areas</td>
<td>10</td>
<td>Support to practice merger and/or hub site as part of network way of working.</td>
</tr>
<tr>
<td>Addressing health inequalities and population health need</td>
<td>8</td>
<td>Prioritising to resources to areas of greatest health need</td>
</tr>
<tr>
<td>Addressing shortfall in current primary medical services (GP) capacity</td>
<td>8</td>
<td>Prioritising to ensure that there is capacity to meet current population needs. This may include establishing a new primary care centre without a registered list to meet current / future demand</td>
</tr>
<tr>
<td>Spread across ONEL</td>
<td>4</td>
<td>Ensuring spread of improvement 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></th>
<th>Broad Street</th>
<th>Upney Lane</th>
</tr>
</thead>
<tbody>
<tr>
<td>System</td>
<td>Broad Street uses the GP run Clinical Vision Site</td>
<td>Barking Hospital is run under contract with BHR and use the BHR PAS</td>
</tr>
<tr>
<td>Interoperability</td>
<td>Vision is used by half of all B&amp;D GP practices. The other is EMIS²³</td>
<td>To be advised</td>
</tr>
<tr>
<td>issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Future proof?</td>
<td>Future commissioning of the contract at Broad Street by the CCG and the National Commissioning Board may mean different requirements</td>
<td>To be advised</td>
</tr>
<tr>
<td>Other systems</td>
<td>The Department of Health has introduced the Summary Care Record to provide key patient information to out of hours, accident and emergency, walk in centre or urgent care centres.</td>
<td></td>
</tr>
<tr>
<td>available</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

²³ Note that it is not currently possible to share patient records between practices. This is due to information governance rather than IT systems.

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:
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>Health 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 | 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.\(^{24}\) 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>Table 10</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>Service locations</th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
<th>Option 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></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></td>
<td>2 sites Broad Street Upney Lane</td>
<td>1 site: Broad Street</td>
<td>1 site: Upney Lane</td>
<td>No sites</td>
</tr>
<tr>
<td>Service model</td>
<td>Status quo</td>
<td>Service changes</td>
<td>Service changes</td>
<td>Service change – GP led service</td>
</tr>
<tr>
<td>Commissioning consideration</td>
<td>Any Qualified Provider procurement of a new service at Broad Street (contract expires in 2013)</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>
</tr>
<tr>
<td>Estate</td>
<td>Extend lease at Upney Lane</td>
<td>Extend lease at Upney Lane</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impact / implications</td>
<td>Engagement req’d Increase investment</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>
<thead>
<tr>
<th>Building type</th>
<th>Broad Street</th>
<th>Upney Lane</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition of the building</td>
<td><strong>Status: B</strong> (of A-C): Satisfactory, minor change needed. Space is well designed and fit for purpose</td>
<td><strong>Status: Green</strong> (of Green, amber red): Good condition: unlikely major works required within the next 5 years</td>
</tr>
</tbody>
</table>
|                        | Location/layout = C in 3 out of 4 criteria (not satisfactory, major change needed):  
- Adequacy of car parking (biggest problem)  
- Access to public transport  
- Public access to stairs  
Source: CIAMS assessment | Much of the work is still under warranty. The building is purpose designed and ‘as new’  
Source: inspection Sept 2012 |
| Flexibility of the building (weighting with above = 10) | Fully utilised though some treatment rooms under-utilised (Less than 4% of total building) | 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 (weighting = 10) | Does not provide best value in terms of cost per metre (Cost in confidential Appendix G)  
**Score: 3** | Provides good value at a lower than previous cost (Cost in confidential Appendix G)  
**Score: 9** |
| Addressing health inequalities and population health need (weight = 8) | Area of health need  
**Score: 4** | Area of health need  
**Score: 4** |
| Addressing shortfall in current primary (GP) services capacity (weighting = 8) | 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** | 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(^{25}), 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></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>
<tr>
<td>Score: 3</td>
<td></td>
<td>Score: 10</td>
</tr>
</tbody>
</table>

<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>Broad Street</th>
<th>Upney Lane</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weighting</td>
<td>Weighting</td>
<td>Weighting</td>
</tr>
<tr>
<td>Condition/Flexibility</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>Best value and potential improvement</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Addresses health inequalities</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Addresses shortfall in primary care premises</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>Spread across ONEL</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total weighted score</strong></td>
<td><strong>168</strong></td>
<td><strong>326</strong></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 walk in attendances could reduce by 24% due to:
  - 12% or 7,440 of patients who attend 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>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>
<td></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\(^\text{26}\). 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 15: Effect of Option 3 on activity and net cost

<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>Activity</th>
<th>Y1</th>
<th>Y2</th>
<th>Y3</th>
<th>Y4</th>
<th>TOTAL (of years 2-4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net cost £</td>
<td>482,580</td>
<td>144,784</td>
<td>155,339</td>
<td>166,662</td>
<td>1,035,959</td>
</tr>
<tr>
<td></td>
<td>553,378</td>
<td>45,226</td>
<td>49,390</td>
<td>53,870</td>
<td>1,029,798</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1,753,565</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>108,496</td>
</tr>
</tbody>
</table>

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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 - 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

<table>
<thead>
<tr>
<th>Stage</th>
<th>Dependency</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td><strong>Understand current activity/baseline</strong></td>
<td>Developing a baseline of whole population needs for primary care access</td>
</tr>
<tr>
<td>2.</td>
<td><strong>Agreement of service model</strong></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>
</tr>
<tr>
<td>3.</td>
<td><strong>Pilot approach</strong></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>
</tr>
<tr>
<td>4.</td>
<td><strong>Agreement of business model</strong></td>
<td>To deliver agreed service model: Evaluating the model and confirming a network business case and workforce strategy</td>
</tr>
<tr>
<td>5.</td>
<td><strong>Implementation/Borough-wide diffusion</strong></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>
</tr>
<tr>
<td>6.</td>
<td><strong>Commissioning process</strong></td>
<td>Agreement of commissioning process</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>You said</th>
<th>The CCG will act:</th>
</tr>
</thead>
<tbody>
<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>
</tbody>
</table>

**Modernisation of Primary care**

The business case needs to include:

i) Explicit details on how GP primary care will be modernised to meet the challenges and ensure improved access

ii) How going to share infrastructure – particularly IT is a key enabler – sharing better patient information will lead to improved health outcomes

iii) Urgent care access to improved diagnostics – understanding was a diagnostics hub yet to be satisfied – would want this addressed in business case

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.

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

The CCG will consider all options as part of their planning

Concern about GP capacity to take on walk in centre patients when residents already struggle to get appointments with their GP.

Capacity is a problem in some GP practices and there is also a problem with managing duplication of attendance - when patients present at A&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.

Residents are being refused registration with a GP due to capacity issues.

We would like to hear from patients who experience this as there are currently no closed patient lists in Barking and Dagenham
<table>
<thead>
<tr>
<th><strong>You said</strong></th>
<th><strong>The CCG will act:</strong></th>
</tr>
</thead>
<tbody>
<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 A&amp;E 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 in the borough and what the status of London Ambulance Service funding?</strong></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>
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<td>------------------------------------------------------------------------</td>
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<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 the practice(s) concerned and explore the introduction of standard protocols</td>
</tr>
<tr>
<td>There have been allegations that Walk in Centres have begun to charge individual patients if they cannot provide a passport or valid visa and are applying secondary care rules about charging. This leaves some patients without adequate primary care provision</td>
<td>Any concerns of this nature are always raised with a provider directly. In addition, the CCG would encourage all patients to register with a GP so that they receive appropriate services within primary care</td>
</tr>
<tr>
<td><strong>Domiciliary care</strong> needs to be addressed</td>
<td>The CCG will address through integrated care and will focus on working collaboratively and improving services provided during opening hours</td>
</tr>
<tr>
<td><strong>Walk in centres should be better signposted</strong> than they are currently</td>
<td>The CCG recognises that signposting is very important and will be working with all health professionals across Barking and Dagenham to ensure there is effective signposting to urgent care services</td>
</tr>
<tr>
<td>You need to communicate with the public; <strong>lines of communication</strong> must come first be clear what it is you want to communicate.</td>
<td>The CCG and GP practices have already taken steps to communication e.g. through the campaign “A&amp;E won’t kiss it better” but plan to continue with these messages</td>
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