Executive summary

Improving urgent care services is a key strategic priority for the CCG with the aim of ensuring that patients can access high quality urgent and emergency care services that provide care in a setting that best meets their needs and represent good value for money.

There are two walk in centres (WICs) in the borough – Upney Lane walk in centre which is situated at Barking Hospital and the Broad Street walk in centre at Dagenham, which operates as a GP led health centre.

A review of walk in centres in Barking and Dagenham was undertaken between September 2012 and May 2013. The review was supported by a case for change, which reported a need to redesign the way in which services are delivered to improve the quality of services and to support people to access services in a setting that best meets their needs.

The service review identified that most people attend the walk in centres for conditions which require primary care and about a quarter of attendances represented “duplicate” activity, where patients were seeking a second opinion having already consulted with their GP or were referred back to their GP by the walk-in centre. Only 3% said they were not registered with a GP. The key reason given by patients using walk in centres was that they could not get GP appointments when they needed them.

Between February and May 2013 the CCG consulted on the governing body’s preferred option to consolidate walk in services at Barking Community Hospital and bring walk in services to an end at Broad Street – albeit retaining the other services provided from the site. Although many patients recognised the need to change urgent care provision most people were opposed to losing a walk in service in the borough. More people supported the closure of a WIC in Dagenham than in Barking. Key messages for the consultation were that patients want greater and more flexible access to GP appointments.

An equalities impact assessment was also undertaken during this period which identified a number of potentially negative and positive impacts of the proposals on people with protected characteristics and in respect of social and economic factors.

The enclosed business case proposes that services are commissioned for patients so that they are seen in the right place for their needs. This would result in:

- The walk-in centre service at Broad Street ending. The site would still provide primary care
services, blood testing services would also continue to be commissioned under appropriate contractual arrangements – not as part of urgent care services.

- The walk-in centre services at Upney Lane would continue and would be reviewed in line with the overall approach for urgent care in Barking and Dagenham.
- A reduction in urgent care activity overall, as duplicate activity will be removed from the system as pathways are more integrated with primary care.
- Patients receiving more of their care from general practice with the related health benefits this brings. The CCG has plans in place to improve access and experience of access to primary care for urgent care needs and to commission additional urgent care activity in primary care.

The key issues for consideration in making a decision on the future model of walk in centres are as follows:

- Patients in Barking and in Dagenham value the ability to get easy local access to urgent care.
- Patients want improved access to general practice. Their current experience is variable and many people are using walk in centres because they cannot believe they cannot access urgent services from their own GP.
- Current walk in centre services do not represent good value for money. Many patients who attend do not receive active treatment or management.

**Recommendations**

It is recommended that the governing body approves the proposal to:

Decommission the walk in centre service at Broad Street once its current contract comes to an end in March 2014 subject to the following:

- Commission Blood testing (phlebotomy) services currently provided under the Broad Street Walk in Centre contract to ensure this service remains available to local people.
- Work with NHSE to ensure that the general practice that is re-procured at Broad Street and the general practice providers in Locality 4 around Broad Street provide access to primary care in line with patient needs in that area and which meets predicted population growth in Dagenham
- The CCG maintains a single minor ailment and minor injuries service with X-Ray facilities at Barking Community Hospital and reviews the service model to enable better integration with primary care
- The CCG develops a robust communications plan, informed by the Patient Engagement Forum, to ensure all urgent care providers, stakeholders, patients and public are aware of proposed system change.
- The CCG works with other CCGs to evaluate and mitigate impact of changes on other walk in centres in Redbridge and Havering.

Author: Sarah D’Souza/Gemma Hughes
Date: 17 June 2013

1.0 **Purpose of report**

1.1 The purpose of the report is to provide the B&D CCG governing body with information to support a decision on the future direction of walk in services in the borough. The attached documents set out the information to support decision making:

- Consultation report
- Equalities impact assessment report and
- Business case
2.0 Background/Introduction

2.1 In Autumn 2012 Barking and Dagenham CCG published its Urgent Care Case for Change http://www.barkingdagenhamccg.nhs.uk/ONELBarking/Pages/Get-involved/Consultations/walk-in-centres-consultation.htm which set out some of the key issues and challenges relating to the commissioning of urgent care services for local people. It described an overall urgent care system where quality and access vary, that patients find confusing and struggle to navigate and which is inefficient, poor value for money and unsustainable in the future without change.

2.2 The CCG set out its belief that primary care should be the first port of call for most people with urgent care needs. Patients would benefit not only from being seen locally at their own practice but also that they would receive the associated benefits including preventative care, health promotion and continuity of care particularly for the increasing number of patients with multiple long term conditions.

3.0 Walk in centre review

3.1 A review was undertaken of the walk in centres in B&D between September 2012 and May 2013. There are two walk in centres in Barking and Dagenham:

- Broad Street Walk in Centre set up at its current location in May 2006 as a GP led Health Centre integrated with a Broad Street medical practice. The walk in service provides a minor ailments and injuries service in Dagenham for anyone over 2 years old.
- Upney Lane Walk in Centre, co-located at the Barking Community Hospital in February 2012 having moved from the former Upney Lane Clinic building, provides a minor ailments and minor injuries service in Barking. There are no age restrictions.
- Both walk in centres are nurse-led services which are open 7 days a week – 8am -10pm. Each walk in centre sees patients living in Barking and Dagenham and some who live outside the area:

3.2 The walk in centre review included: a review of the effectiveness of current services against proposed service outcomes; a clinical audit of patients and a patient survey - which explored why and when patients used the services and what sort of care was and should have been provided to them.

3.3 In January 2013 the CCG governing body considered a pre-consultation business case which set out the outcome of the walk in centre review and a number of options for addressing the issues identified as follows:

- Retain walk in centre services on two sites (do nothing)
- Consolidate walk in centre services on one site – Broad Street
- Consolidate walk in centre services on one site – Barking Hospital, Upney Lane
- Decommission both walk in centre services and reconfigure primary care

3.4 The CCG governing body agreed to engage with stakeholders on a preferred option to consolidate walk in services at Barking Community Hospital and bring walk in services to an end at Broad Street – albeit retaining the other services provided from the site – after scoring the 4 options against the following criteria.

- Accessibility and patient experience: Appropriate number of service locations
- Clinical care/safety: Clinical viability and the appropriate service model
- Affordability: Financial affordability
- Demand management: Activity analysis and modelling assumptions

4.0 Walk in centre consultation

4.1 A 12-week period of engagement and consultation took place from 27 February 2013 to 21 May 2013. During the consultation the views of a total of 481 stakeholders were gathered. Key messages from consultation are:
• Patients find it hard to get an appointment with their own GP.
• Patients value the convenience and ease of access of walk in services and consider a local service with extended opening times to be of benefit.
• Patients want greater access and more flexible access to GP appointments
• Patients were concerned about the impact of change including on GP services and A&E.
• Patients were keen to see services develop at Barking Community Hospital as well as general service improvement (customer care and waiting times)
• Although many patients recognised the need to change urgent care provision most people were opposed to losing a walk in service in the borough. More people supported the closure of a WIC in Dagenham than in Barking.

4.2 An equalities impact assessment was also undertaken during this period which identified a number of potentially negative and positive impacts of the proposals on people with protected characteristics and in respect of social and economic factors.

5.0 Walk in centre business case
5.1 The walk in centre business case describes the proposals before the governing body for decision making based on walk in centre review, consultation and equalities impact assessment and sets out the impact of implementing that proposal.

5.2 The business case notes that:
• Urgent care in Barking and Dagenham can be accessed in a range of ways. Between 2008 and 2012 there was a steady increase of 9.17% in total across urgent care services.
• Evidence from a range of stakeholder engagement sources shows that patients do not feel that they can always easily access their GP and that this is driving a significant proportion of the walk in centre activity.
• The audit of the walk-in centres in November 2012 showed that from a clinical perspective most people attend for conditions which require primary care, self care, or community pharmacy support only. About a third of attendances received advice only, no clinical treatment, management or referral on. About a quarter of attendances represented “duplicate” activity ie where patients were seeking a second opinion having already consulted with their GP or were referred back to their GP by the walk-in centre. Only 3% said they were not registered with a GP.

5.3 The business case proposes that services are commissioned for patients so that they are seen in the right place for their needs, and that the CCG fund the most appropriate clinical service. This would result in:
• The walk-in centre service at Broad Street ending. The site would still provide primary care services and engagement with local patients would be undertaken to design accessible and effective services for the local area. Blood testing services would also continue to be commissioned under appropriate contractual arrangements – not as part of urgent care services.
• The walk-in centre services at Upney Lane would continue and would be reviewed in line with the overall approach for urgent care in Barking and Dagenham.
• A reduction in urgent care activity overall, as there would be no longer be a service provided that simply refers patients back to their own GP or that provides them with no specific interventions (as currently at the WIC). This will provide a more straightforward process for patients and improved value for money for the CCG.
• Additional urgent care activity in primary care. Patients will receive more of their care from general practice with the related health benefits this brings. The CCG has plans in place to improve access and experience of access to primary care for urgent care needs.

5.4 Based on the experience of other walk-in centre closures and on the key fact that this activity is mainly primary care activity, the impact on other urgent / emergency services is expected to be
negligible.

1.0 Resources/investment
The business case sets out the financial implications of the proposal before the Governing Body.

7.0 Equalities
An equalities impact assessment has been completed and forms part of the suite of documents attached

9.0 Risk
A full risk register on project risks has been developed. This will need to be reviewed in light of the decision made by the governing body to the proposal above
Walk-in Centres in Barking and Dagenham

Business case

June 2013

Note: The business case and its appendices are available at:

Barking and Dagenham CCG
Barking Community Hospital
Upney Lane, Barking
Essex IG 11 9LX
Telephone: 020 8532 6314
http://www.barkingdagenhamccg.nhs.uk/
Amendment History

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Author</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>6 June 2013</td>
<td>Sarah Young</td>
<td>Draft outline and content from other sources organised around an agreed format</td>
</tr>
<tr>
<td>1.2</td>
<td>6 June 2013</td>
<td>Gemma Hughes</td>
<td>Comments</td>
</tr>
<tr>
<td>1.3</td>
<td>7 June 2013</td>
<td>Sarah Young</td>
<td>Further content and sections added (options and implementation sections)</td>
</tr>
<tr>
<td>1.4</td>
<td>7 June 2013</td>
<td>Gemma Hughes</td>
<td>Updates throughout</td>
</tr>
<tr>
<td>1.5</td>
<td>9 June 2013</td>
<td>Sarah Young</td>
<td>Edits throughout, formatting and appendices</td>
</tr>
<tr>
<td>1.6</td>
<td>10 June 2013</td>
<td>Sarah D’Souza</td>
<td>Updates throughout, remove appendices as separate document</td>
</tr>
<tr>
<td>1.7</td>
<td>11 June 2013</td>
<td>Sarah Young</td>
<td>Edits and formatting throughout</td>
</tr>
<tr>
<td>1.8</td>
<td>12 June 2013</td>
<td>Gemma Hughes</td>
<td>Updates throughout</td>
</tr>
<tr>
<td>1.9</td>
<td>13 June 2013</td>
<td>Gemma Hughes</td>
<td>Updates throughout</td>
</tr>
<tr>
<td>1.10</td>
<td>14 June 2013</td>
<td>Sharon Morrow</td>
<td>comments</td>
</tr>
<tr>
<td>1.11</td>
<td>14 June 2013</td>
<td>Gemma Hughes</td>
<td>Updates throughout</td>
</tr>
<tr>
<td>1.12</td>
<td>17 June 2013</td>
<td>Sharon Morrow</td>
<td>comments</td>
</tr>
</tbody>
</table>

Draft distribution list

<table>
<thead>
<tr>
<th>Name</th>
<th>(role in BC production) / position</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In draft version</strong></td>
<td></td>
</tr>
<tr>
<td>Sharon Morrow</td>
<td>(Senior responsible officer) CCG Chief Operating Officer</td>
</tr>
<tr>
<td>Gemma Hughes/Sarah D’Souza</td>
<td>(Reviewer/ editor) Senior localities lead</td>
</tr>
<tr>
<td>Sarah Young</td>
<td>(Author) project management</td>
</tr>
<tr>
<td>Rob Dickinson</td>
<td>Financial modelling</td>
</tr>
<tr>
<td>Conor Burke</td>
<td>Accountable Officer</td>
</tr>
<tr>
<td>Marie Price</td>
<td>Director of Corporate Affairs</td>
</tr>
<tr>
<td>Rob Adcock</td>
<td>Assistant Director Finance</td>
</tr>
</tbody>
</table>
## Contents

<table>
<thead>
<tr>
<th>Contents</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Summary</td>
<td></td>
</tr>
<tr>
<td><strong>A Introduction and case for change</strong></td>
<td></td>
</tr>
<tr>
<td>1 Introduction and overview</td>
<td></td>
</tr>
<tr>
<td>2 Urgent care in Barking and Dagenham</td>
<td></td>
</tr>
<tr>
<td>3 Process to consultation</td>
<td></td>
</tr>
<tr>
<td>4 The CCG agreement of a preferred option</td>
<td></td>
</tr>
<tr>
<td><strong>B Consultation responses</strong></td>
<td></td>
</tr>
<tr>
<td>1 Consultation</td>
<td></td>
</tr>
<tr>
<td>2 What did we consult on?</td>
<td></td>
</tr>
<tr>
<td>3 Key themes</td>
<td></td>
</tr>
<tr>
<td>4 Equality impact assessment</td>
<td></td>
</tr>
<tr>
<td><strong>C Decision-making</strong></td>
<td></td>
</tr>
<tr>
<td>1 Information supporting decision-making</td>
<td></td>
</tr>
<tr>
<td>2 The proposal</td>
<td></td>
</tr>
<tr>
<td>3 Impact of decision to implement the preferred option</td>
<td></td>
</tr>
<tr>
<td>4 Risks and dependencies</td>
<td></td>
</tr>
<tr>
<td>5 Implementation</td>
<td></td>
</tr>
<tr>
<td><strong>D Recommendations and next steps</strong></td>
<td></td>
</tr>
<tr>
<td>1 Recommendations</td>
<td></td>
</tr>
<tr>
<td>2 Timescales</td>
<td></td>
</tr>
</tbody>
</table>

**Appendices**

| A National and local context and policy     |      |
| B Engagement “you said, we did”            |      |
| C Urgent Care benefits map                  |      |
| D Information from other WIC closures       |      |
| E Data on City and Hackney Urgent care and A&E usage |      |
| F Planning assumptions                      |      |
| G Map of practices potentially affected     |      |
| H A&E attendance rates                      |      |

**Related reports**

- Consultation report
- Equalities impact assessment
List of tables
Table 1 Barking and Dagenham Urgent Care 2008-12
Table 2 Urgent care activity in Barking and Dagenham 11-12
Table 3 Overview of impact of proposal on activity
Table 4 Financial impact of proposal
Table 5 Clinical commissioning contractual dependencies

List of figures
Figure 1: How urgent care is accessed in Barking and Dagenham
Figure 2: Locality approach
Figure 3: Impact of proposal on activity
Figure 4: Procurement timetable for contract at Broad Street

Commonly used abbreviations
A&E Accident and Emergency
B&D Barking and Dagenham
CCG Clinical Commissioning Group
EIA Equalities Impact Assessment
GP General Practice/Practitioner
NHS National Health Service
UCC Urgent Care Centre
WIC Walk-in Centre
Executive summary

This document has been produced to support decision-making on proposed changes to the Walk-in services in Barking and Dagenham and should be read in conjunction with the other supporting documents, in particular the case for change, the consultation report and equalities impact assessment. It builds on the pre-consultation business case considered by Barking and Dagenham Clinical Commissioning Group (CCG) governing body in January 2013.

Improving urgent care services is a key strategic priority for the CCG. The CCG aims to ensure that patients can access high quality urgent and emergency care services that provide care in a setting that best meets their needs and represent good value for money.

People in Barking and Dagenham access urgent care services through a range of providers including their GP practice, GP out of hours services, two walk in centres, urgent care centres and A&E services at Queen’s Hospital and King George Hospital.

There are two walk in centres in the borough – Upney Lane walk in centre which operates from Barking Hospital and the Broad Street walk in centre in Dagenham. Broad Street walk in centre services operates as part of a GP led health centre alongside the provision of general medical services for a registered list of patients.

A review of walk in centres in Barking and Dagenham was undertaken between September 2012 and May 2013. The review is connected to a wider system programme for improving urgent and emergency care services, including the implementation of NHS 111, the emergency care improvement programme at Queen’s and King George Hospital and plans to improve access to primary care appointments.

The walk in centre review was supported by a case for change, which showed that between 2008 and 2012 there was a steady increase of 9.17% in activity across urgent care services commissioned by Barking and Dagenham CCG (excluding GP appointments). The case for change reported a need to redesign the way in which services are delivered to improve the quality of services and to support people to access services in a setting that best meets their needs. The review concluded that current system is inefficient and is not managing demand for A&E services.

The findings of the service review were reported in a pre-consultation business case which provided information on how people use the walk in centre services:

- An audit of the walk-in centres in November 2012 showed that most people attend the walk in centres for conditions which require primary care, self care, or community pharmacy support only. About a third of attendances received advice only, no clinical treatment, management or referral on and about a quarter of attendances represented “duplicate” activity, where patients were seeking a second opinion having already consulted with their GP or were referred back to their GP by the walk-in centre. Only 3% said they were not registered with a GP.

- A patient survey conducted at the time of the audit by the Local Involvement Network showed that a key reason patients gave for using walk in centres was that they could not get GP appointments when they needed them and that this is driving a significant proportion of the walk in centre activity. This view was reinforced by a more recent survey conducted by Healthwatch, which found that 85% of people surveyed said they would rather use their GP if they could get an appointment in a timely way. These findings were reflected in the responses made to the consultation on the proposed changes.
The CCG conducted a 12-week consultation between February and May on four options for the future model for walk in centres, the preferred option being to remove walk in centre services from Broad Street and retain services at Barking Community Hospital. The consultation report is attached as a separate document.

An equality impact assessment was also undertaken which provides detailed information on the potential impact on different groups of people of the proposals, and both general recommendations as well as mitigating actions. The report is attached as a separate document.

Following the development of the pre-consultation business case, further work was carried out to assess capacity in primary care and the impact of returning activity to practices should a decision be taken to close the walk in centre. There is no standard reporting in general practice used to measure GP capacity therefore a one off data collection exercise was undertaken to map GP capacity. The analysis to date suggests that capacity does vary across practices with some practices working at full capacity and others having the potential to increase capacity by flexing how they operate.

In recognition of the issues raised regarding access to primary care the CCG is responding by:

- Providing training and support to practices help manage daily demand to appointment capacity
- Piloting an urgent care surge scheme which will commission 25,000 additional appointments over period of 6-months and inform future commissioning arrangements from 2014/15

Given that walk in centres have closed in other parts of the country a literature and data review was also undertaken to assess the impact of closing a walk in centre on other parts of the urgent care system and in particular A&E. Published literature is limited but the evidence seems to suggest that there will be limited impact on A&E following the closure of a walk in centre.

This business case supports the CCG proposal to remove the walk in centre services from Broad Street, to retain and remodel the service at Barking Hospital and improve capacity in primary care for urgent care appointments. The proposal supports the CCG strategy of commissioning services for patients to be seen in the right place for their needs, and for commissioners to pay for the most appropriate clinical service. It is forecast that there will be an overall savings of between £242K and £313K p.a. in urgent care services as duplication is removed from the system by commissioning services in a more integrated way.

Walk in centre services will continue to be available for Barking and Dagenham residents at Barking Hospital and other centres in neighbouring boroughs. Blood testing services would also continue to be commissioned under appropriate contractual arrangements – not as part of urgent care services.

There will be additional activity that will return to primary care as a result of implementing this proposal. This will be additional attendances from existing patients rather than new patients as most patients attend the walk-in centres are currently registered. The CCG is currently working to secure additional urgent care capacity in primary care to deal with this increased demand, having agreed to run a pilot scheme aimed to managing surge in urgent primary care demand – in effect commissioning additional urgent care consultations in primary care at times when patients most need them.

The greatest impact will be seen in practices operating in the Broad Steet locality. The re-procurement of the general practice element of the GP led health centre service at Broad Street will ensure that patients will have access to high quality primary care services on the Broad Street site. NHS England and the CCG will also review opportunities to improve access to primary care in neighbouring practices through the better use of estate at Broad Street.
A Introduction and case for change

1. Introduction

This document has been produced to support decision-making on proposed changes to the walk-in services in Barking and Dagenham and should be read in conjunction with the other supporting documents, in particular the case for change, the consultation report and equalities impact assessment. It builds on the pre-consultation business case considered by Barking and Dagenham CCG governing body in January 2013. The governing body confirmed Option 3 in the pre-consultation business case as its preferred option for the future model of walk in centres in Barking and Dagenham – namely to decommission walk in centre services at Broad Street, to consolidate walk-in services on the Barking Community Hospital, Upney Lane site and agreed to consult on this change.

The CCG has consulted on the proposed changes and conducted an equalities impact assessment. Additional information to assess the impact of closing a walk in centre on other urgent care services is also presented in this business case.

Patients are confused by the current system and often unsure where to go to get advice or treatment. As a result there is duplication of activity as some patients attend multiple places to get their needs addressed. The preferred option:

- Supports enhanced practice to general practice, which is what patients say that they want
- Maintains a single minor ailments and minor injuries services with X-ray facilities at Barking Hospital, with the opportunity to refer to other community services on site, e.g. sexual health services
- Provides an opportunity to review the service model at Upney Lane to enable better integration with primary care services
- Support NHS England to procure high quality accessible primary care services for patients in the Broad Street locality, including the procurement of general practice services for the existing list and with the CCG explore opportunities for primary care improvement though use of the Broad Street estate
- Commission planned care services e.g. blood tests in a more cost effective way, ensuring local provision

2. Urgent care in Barking and Dagenham

2.1 The urgent care system

The pre-consultation business case focused on the role of the walk in centres in the context of the following related services in Barking and Dagenham:

- In hours, and out-of-hours general medical services
- Community pharmacies
- Community health services included integrated case management services
- NHS 111
- Urgent care centres (community and attached to A&Es)
- Accident and Emergency departments (A&Es)
- The ambulance service.

The national and local context and policy is summarised in Appendix A.
2.2 Local urgent care access

As illustrated in Figure 1 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
- The Out of Hours GP service
- Walk in centres at Broad Street, Upney Lane and other centres (some B&D patients also attend walk in services at Loxford polyclinic in Redbridge, Orchards and Harold Wood Polyclinic in Havering)
- The Urgent Care Centres at King George and Queen’s Hospitals
- Accident & Emergency at King George and Queen’s Hospitals.

![Figure 1: How urgent care is accessed in Barking and Dagenham](image)

Patients find the current system difficult to navigate which means that they often do not get their need addressed at the first service they access.
2.3 Urgent care activity

The case for change reported that between 2008 and 2012 urgent care activity increased by 9.17% across the following urgent care services commissioned by the CCG for Barking and Dagenham residents: A&E services, urgent care centres, walk in centres and GP out of hours services. The activity is not an accurate reflection of clinical need as it counts each visit or call to a service, including multiple contacts by the same person.

The introduction of new urgent care services designed to address primary urgent care needs has not managed demand. The review of urgent care activity, reported in the case for change, showed that over a four year period:

- There was no significant shift in activity from A&E to the urgent care centres at either Queen’s or King George Hospital, despite the fact that around 50% of all A&E activity is considered to be for a primary care need
- Activity in GP out of hours services decreased by 9.3% - the reasons for this need to be understood further
- Walk in centre attendances made up a combined total of 29% of all urgent care activity

The summary is in Table 1 below:

| Table 1: Barking and Dagenham Urgent Care 2008-12 |
|---------------------------------|--------|--------|
| Barking & Dagenham             | 4 Year Total | % Activity |
| Accident & Emergency           | 244,700     | 40%     |
| KGH UCC                        | 27,420      | 4%      |
| Queen’s UCC                    | 39,340      | 6%      |
| Loxford WIC                    | 5,060       | 1%      |
| Upney Lane WIC                 | 116,630     | 19%     |
| Broad Street WIC               | 117,280     | 19%     |
| Out of Hours                   | 65,740      | 11%     |
| TOTAL                          | 616,170     | 100%    |

Further information on urgent care activity for 2011-12 is in Table 2 below which breaks down attendances on a daily, weekly and annual basis and includes actual attendances for a wider range of urgent services - rapid response, the London Ambulance Service and non elective admissions), but not including urgent appointments with a GP.

---

Table 2: 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>

2.4 Primary care capacity

It is clear from the walk-in centre survey, audit and from the national GP patient survey that patients do not feel that they can always easily access their GP at the time that they need to. It seems that this perception is driving a significant proportion of the walk-in centre activity which is further underlined in the consultation responses, described in brief below and in full in the consultation report.

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 has been undertaken to map current capacity and provision of primary care including understanding variation across the borough. This is set out in more detail in section C below.

2.5 The Case for change

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

The CCG considered the challenges of commissioning urgent care and set out conclusions in the case for change document. The case for change was discussed with both the Health and Adult Services Select Committee and the Health and Wellbeing Board at their meetings in December 2012. This document is available at [http://www.barkingdagenhamccg.nhs.uk/Get-involved/Consultations/walk-in-centres-consultation.htm](http://www.barkingdagenhamccg.nhs.uk/Get-involved/Consultations/walk-in-centres-consultation.htm). The key conclusions set out in this document were that:

- There is a need to improve the quality of services, to redesign the way urgent care is delivered in the borough to ensure services are of a uniformly high standard.
- People find the current system difficult to understand and need to be helped to look after themselves, to be supported to understand and trust services and find it easy to access them.

---


3 Activity is no of patients who averaged 3 episodes, or a total of 6,100 attendances

4 Activity is a full year but from Jan 11- Dec 12
• The system is inefficient, not good value for money and will struggle with demand in future. There is an increase in urgent care activity overall and no reduction in A&E activity despite the provision of walk-in and Urgent Care Centres.

2.6 Integrated locality approach to urgent care

Barking and Dagenham CCG is working to improve urgent care as one of its main strategic priorities. The review of walk in centres in Barking and Dagenham connects to wider system work to improve urgent and emergency care pathways and performance and builds on the principle established through the Barking and Dagenham, Havering and Redbridge integrated care coalition of working in localities.

The wider system programme of work on urgent care includes:

• Implementation of the new 111 service which provides a single point of access for patients needing to access urgent care services
• An ongoing programme of improvement to urgent and emergency services at Queen’s Hospital and King George’s Hospital, including strengthening the A&E “front door” urgent care centres and redirecting activity back to primary care where it is clinically appropriate.

Barking and Dagenham CCG has been developing locality working as the delivery model for providing high quality, patient centred services. The locality model is part of an approach to provide care which is more integrated across health and social care and is a key component of the integrated care commissioning strategy.

GP practices on Barking and Dagenham are working in networks across six localities, which have been built on the existing networks for integrated case management. The locality model is being developed further by practices to impact on the management of urgent care. Primary care is the right place to manage the majority of urgent care needs - where the clinician has access to the patient’s history and is able to offer a full range of holistic care including the management of long term conditions, immunisation and health promotion and prevention advice.

The locality model encourages residents to register with and access health services through their general practice as a first point of contact, particularly for urgent primary care and supports collaboration between practices to manage demand more effectively. In this model of urgent care, patients receive the associated benefits from GP registration including preventative care and health promotion, health check services and continuity care.

A number of tools are being shared across practices to support joint working and improved access across all practices including improved demand management techniques, telephone triage and consultation, patient transfer, information sharing and shared booking systems. The CCG is employing a number of enablers to improve access to primary care, supporting practices to make full use of the range of incentives available through GMS contracts to ensure a consistent standard offer of access to urgent primary care across Barking and Dagenham. All practices are signed up to the Direct Enhanced Service for extended hours.

The primary care delivery plans managed through the locality structure and supported by Senior Locality Leads, Practice Improvement Leads, Clinical Directors and Clinical Champions is the mechanism through which this work will be aligned to overall the CCG strategy and the benefits delivered as part of the overall approach to improving urgent care as set out above.

In addition to the above, the CCG, with approval from NHS England, is commissioning a six month pilot for an urgent care surge scheme, which will deliver 25,000 additional
appointments through general practice. The aims of the scheme are to:

- Provide enhanced access to same day GP appointments in primary care that are responsive to patients urgent care needs over and above current contractual baseline;
- Flex supply to demand in order to manage A&E peaks in activity
- Improve patient confidence in availability of/access to primary care to meet urgent needs reducing need to attend alternative urgent care settings.

The evaluation of the pilot will inform future commissioning arrangements from 2014/15.

3. Process to consultation

3.1 A pre-consultation business case

A pre-consultation business case set out the rationale for a proposal to decommission the walk-in centre services at Broad Street. This relied on four separate studies, the results of which were set out in this pre-consultation business case, including evidence of:

a. Patients' reasons for using the walk-in centres through a patient survey
b. Clinical reasons for use and follow up through an audit led by clinicians
c. Patients' views on all proposals for improving urgent care services through stakeholder engagement meetings
d. Future activity modeling including financial analysis which included projected savings.

3.2 Service review process

An audit of the walk-in centres in November 2012 provided evidence of the reasons why people use them. The results showed that clinically, most people attend for conditions which require primary care, self care, and 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. About a third of attendances received advice only, no clinical treatment, management or referral on. About a quarter of attendances represented “duplicate” activity where patients were seeking a second opinion having previously consulted with their GP or were referred back to their GP by the walk-in centre. Only 3% or 22 patients said they were not registered with a GP (unregistered) in the audit.

The key findings were:

- Clinical demand for walk in services is driven by primary care need - most people (92%) attending the walk in centres require primary care, self-care or community pharmacy support and not emergency or acute services.
- 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 indicate that a fair proportion of attendances were not considered urgent i.e. requiring same day treatment. One third of attendances resulted in no active treatment, management or referral onwards, indicating no clinical intervention other than advice was given. A number of attendances were seeking a second opinion, having previously seen their GP. A further proportion was referred back to their GP by the walk-in centre.
• **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, 61% of activity is during core GP opening hours (08.00-18.30 on weekdays). There is a significant proportion of activity (30%) that is during the period that GPs are not routinely available (although other services such as out of hours GPs are).

• **Overall demand for urgent services**: the walk-in centre data and other information about activity and cost in the wider urgent care system indicates that overall 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.

3.3 **Stakeholder input**

The CCG contracted Barking and Dagenham Local Involvement Network (LINk) to undertake a patient survey which was run at the same time as a CCG-led patient audit. The approach and questionnaires were agreed by both parties and with the walk-in centre management. This survey showed that a key reason patients gave for using walk-in centres was that they could not get GP appointments when they needed them.

During the CCG consultation, Healthwatch also carried out an independent survey which involved a number of engagement sessions in various public settings with the local community. They asked for people’s views and opinions concerning proposals put forward by the CCG about urgent care services and the closure of the walk in service at Broad Street. A key finding was that 85% of people surveyed said they would rather use their GP if they could get an appointment in a timely way.

Details of how the CCG has or is intending to respond to the views expressed by stakeholders during the consultation and engagement process is provided in Appendix B.

4. **The CCG agreement of a preferred option**

Options were developed with clinical leads through the case for change to improve Barking and Dagenham’s urgent care services.

The Board of Barking and Dagenham (Shadow) CCG considered a pre-consultation business case at its meeting on 28 January. The pre-consultation business case set out four options for walk-in services at Broad Street in Dagenham and Upney Lane in Barking together with supporting evidence.

Having considered the evidence and the benefits to local people of the different options, the CCG governing body agreed to:

1. Endorse the Urgent Care Case for Change and Option 3 as the preferred option, which would remove walk in services from Broad Street and close Broad Street walk-in centre.

2. Seek the Health and Adult Services Select Committee’s (HASSC) scrutiny of the consultation process including its duration, proposed as a 6-week consultation starting in February 2013 and to consult the public on that basis.

3. Consider separately the commissioning of blood tests (phlebotomy) in the Borough in the context of planned care.

---


6 Phlebotomy Services are planned rather than urgent care and as such any recommissioning is outside the remit of this business case.
B. Consultation responses

1. Consultation

Following discussions with local community groups, clinicians and the Health and Adults Services Select Committee, the CCG proposed a six-week period of public engagement and consultation to include a variety of activities.

At the request of Barking and Dagenham’s Health and Adult Services Select Committee (“The HASSC”) 7, the consultation ran for a 12-week consultation period.

The CCG launched a consultation process on 27 February 2013 which ran to 21 May 2013.

Whilst this was an engagement process and not a formal consultation, the term “consultation” is used in public facing documents as a more known and better understood activity.

During the consultation the views of a total of 481 stakeholders were gathered:

- 474 Service users, carers, local people and NHS staff through questionnaires received at events and by post, email and the web
- 7 formal written organisational responses.

The consultation report is provided separately.

2. What did we consult on?

The proposal of the consultation was to discontinue walk in services at Broad Street Walk in Centre and consolidate services at Barking Hospital’s Upney Lane Walk in Centre and improve access to GP urgent appointments (Option 3 from the pre-consultation business case).

The consultation document also explored views on the option of closing the walk in centre at Barking Community Hospital, Upney Lane, at both sites and of the “do-nothing” option.

The consultation documents can be viewed at:
http://www.barkingdagenhamccg.nhs.uk/ONELBarking/Pages/Get-involved/Consultations/walk-in-centres-consultation.htm

3. Key themes from the consultation

The main themes from the consultation can be summarised as:

- **Theme 1: Patients find it hard to get an appointment with their own GP.** This is the strongest theme to come out of the consultation. Many patients do approach their GP as their first point of contact, but experience difficulty in getting through on the telephone and getting access to GP appointments either urgently (same day) or within a reasonable time for non-urgent matters.

- **Theme 2: People value walk in services and consider a local service with extended opening times to be of benefit.** People want a walk-in service in Barking and Dagenham. They said that this gives them the convenience of attending at times which better suit patients as well as the reassurance of access to a service when they can’t get a

---

7 [http://www.lbbd.gov.uk/CouncilandDemocracy/Scrutiny/Pages/SelectCommittees.aspx](http://www.lbbd.gov.uk/CouncilandDemocracy/Scrutiny/Pages/SelectCommittees.aspx)
GP appointment, either for urgent or less urgent reasons, as well as a local service.

- **Theme 3: Patients want more flexible access to GP appointments** – an increase in the number of appointments in core hours as well as strong support for weekend opening and later opening for bookable appointments for registered patients. There was also support for more telephone advice from local GPs who are able to access local information.

- **Theme 4: People are concerned about the impact of change** including on GP services and A&E. If proposals do go ahead, suggestions have been made about: increasing GP capacity and walk-in centre capacity, considering vulnerable patients including children and older people, considering transport and mitigating impacts on the residents of Dagenham and clear communication of changes to all patients.

- **Theme 5: People want to see services develop at Barking Community Hospital.** As well as general service improvement (customer care and waiting times), requests for new services include: more diagnostics including blood tests, more walk-in or urgent care services, a minor injury service, X-ray facilities and a fracture clinic, a GP service with extended hours and children’s services.

4. **Equality impact assessment**

A Stage Two equalities impact assessment was undertaken during April and May 2013 during the consultation period. This built upon the Stage One (desk-top) assessment developed as part of the evidence base underpinning the pre-consultation business case.

A full report is available of the assessment.

The key findings are that the proposals could have:

- A negative impact on younger people and those of working age because they are more likely to be in employment or education/training and therefore more likely to use the walk in centre.
- Both a positive and negative impact on disabled people as better access to their own GP would be beneficial but the loss of a known service could have an impact on this group.
- A negative impact on men who prefer the “drop in” nature of the walk in centre and on women as they are more likely to use the centre as patients and as carers
- Both a positive impact and a negative impact on black and minority ethnic people who would benefit from improved primary care provision based around local needs but who might be more vulnerable to the changes proposed.
- No difference was identified due to religion or belief.

The information required to assess the impact on gender reassignment, marriage or civil partnership, pregnancy or maternity and sexual orientation was not available.

An assessment of the impact of the proposals due to social and economic factors concluded that:

- A negative difference could be found for people due to their immigration status as some perceive that it is easier to access services at the walk-in centre than at a GP
- A positive and a negative difference could be found for unemployed people, as they would be disadvantaged by having to travel further on a low income, however this would be balanced by the opportunity to have a shorter distance to travel if they have improved access to their GP
- Both positive and negative impacts on employed people if they are able to benefit from improved access to their own GP outside of working hours, but taking into account that
this is the group who most use the walk-in centre (although much of this use is during working hours)

- Both positive and negative impacts on carers who could benefit from improvements to primary care more generally but who would be particularly vulnerable to changes in access to services
- A negative impact on people with low levels of education and corresponding poor levels of health literacy who might find it difficult to navigate changes to services.

The factors of quality of housing, rural/urban location were not considered relevant to this assessment.

The proposals do not appear to have any impact on human rights.

The full Equality Impact Assessment report sets out mitigating actions required for the negative impacts identified above.

C. Decision-making

1. Information supporting decision-making

As well as the public consultation, engagement and equalities assessment referred to above, additional work has been carried out since the decision to consult on the option to discontinue services at Broad Street, including:

- Analysis of primary care capacity
- Assessment of benefits of the proposals
- Assessment of other walk-in centre closures.

The main findings from this work is summarised below.

1.1 Analysis of primary care capacity

Further work has been carried out since the publication of the pre-consultation business case to understand the capacity that is available in primary care to manage urgent care appointments and the future capacity requirements.

Barking and Dagenham was considered to be an under-doctored area in the 2006 Department of Health document *Our health our care our say: a new direction for community services* – based on the number of GPs for the population being less than the national average, “a PCT is under-doctored if its number of whole time equivalent GPs (excluding GP retainers, GP registrars and locums) per 100,000 weighted population is less than the national average.” Against this context, work has been undertaken to start to quantify the capacity gap and to develop solutions to meet this.

Because GPs are contracted on a capitation basis rather than an activity basis, there is no standard reporting within general practice of the numbers of consultations, home visits, telephone consultations or interventions by other members of the primary care team. In order to assess the capacity and potential future capacity gaps that could arise from the proposed changes, a one-off data collection exercise was undertaken to map GP capacity, utilisation of capacity and provision of urgent and planned care within this. Work is now underway to create a mechanism to monitor and manage capacity using routine data collection and reporting tools.

1.1.1 Capacity in primary care
The analysis carried out to date validated some of the access issues identified by the public – 10 practices (out of a total of 40) were seeing more appointments than planned (utilisation of more than 100%). This reflects the ability of primary care to stretch their provision (see extra patients during a surgery) when the GP or practice staff identify patients that require an urgent appointment. General practices are extremely experienced in prioritising patients according to clinical need, with well-established systems in place to identify and see as urgent cases patients known to be at high clinical risk. This does however indicate the degree of “busy-ness” in these practices and aligns with the experience of patients with less urgent clinical needs finding it difficult to get to see their GP and choosing instead to attend a walk-in centre.

Capacity does vary within Barking and Dagenham, in addition to the 10 practices that at the time of data collection were effectively working over capacity, 11 practices appeared to have some spare capacity, indicating that a more even distribution of capacity could help ease pressure at busy times, e.g. by sharing/transferring patients for urgent appointments between practices.

1.1.2 Access to urgent primary care
The data collection exercise showed that practices are also working to provide a high level of urgent access with a fifth of practices currently seeing more urgent/same-day than routine appointments and more than half offering 1 urgent/same day for every 2 routine appointments.

This data was also used to test the potential impact of the closure of Broad Street on primary care capacity as described in section 3.3 below.

The analysis of the information collected about current capacity and urgent care demand is being fed back to practices and localities to assist them in planning how to better match their demand for appointments to supply. The CCG is supporting practices to improve access to urgent care by:

- Sharing tools and good practice; access to customer service training and telephone support training for practice staff, which is helping to match daily demand to appointment capacity and which will improve patient experience. Further use of telephone consultations can also enhance existing capacity as this can be a productive way to provide some patients with advice. Localities are also exploring the option of transferring patients between GPs to better match capacity and demand – to share the capacity available more evenly within a locality.
- Piloting an urgent care surge scheme, to provide an additional 25,000 appointment over a six month period

1.2 Assessment of benefits

The cost benefit assessment in the pre-consultation business case found that 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. This makes the service very attractive to some patients. The survey and audit work has focused on understanding the current use of the walk-in centres. The views of those patients who do not access the walk-in centre have not been assessed in the same way.

- Encourage frequent, local use: The accessibility of walk-in centres 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 having used the walk in centres between two and five 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 in addition to the cost of their GP registration, even if no clinical intervention is made. This additional cost is an opportunity cost lost to the health economy.

**Unnecessarily 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 better and more 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.

Additional work has been carried out to map the potential benefits of the approach proposed by the CCG to consolidate walk in services and improve primary care. The full map can be found at *Appendix C* but overall is intended to:

- Provide more urgent appointments
- Greater access to telephone advice
- Decrease patient waiting times
- Have greater clarity for where patients should go
- Mean that more patients get the right care the first time
- Patients who need advice only can use 111 or GP telephone advice
- Patients who need referral are referred quicker
- Better use of community hospital facility
- Equity of services across the borough
- Reduction in appropriate A&E attendances
- Increase dementia diagnoses of expected population
- Increased referral to integrated case management
- Reduction in outpatients and diagnostic referrals
- Reduction in admissions for people with long term conditions
- Improved patient satisfaction
- Future sustainability.

1.3 **Review of other walk in centre (WICs) closures in England**

Given that walk-in centres have been closed in other areas, efforts were made to ascertain the impact of these closures to learn lessons for Barking and Dagenham. A literature review was conducted as were telephone interviews and review of data. Overall relatively limited impact seems to have been felt by other parts of the health system where walk-in centres have closed, however there has been little fully evaluated research into this. The literature generally looks at the impact of the introduction of walk-in centres and not their removal.

In a review of literature available on the impact of walk-in centres on the workload of other local healthcare providers, it was identified that there was no statistically significant reduction in consultations at emergency departments and general practices, and that there was no impact on consultations in out of hours services as a result of the walk-in centres.

An observational study looked at the effect of an NHS walk-in centre identified that the introduction of the walk-in centre did not significantly affect the workload of local general practitioners. However, this has limitations as is an observational study of one walk-in centre.\footnote{HSU, R.T., Lambert, R.C., Dixon-Woods, M., Kurinczuk, J.J. (2003). Effect of NHS walk-in centre on local primary healthcare services: before and after observational study, BMJ, 326, 530.} Furthermore, a study on the impact of NHS WICs on primary care access times identified that no evidence existed that WICs shortened waiting times for access to primary care.

These findings seem to suggest that WICs do not reduce demand to GPs and A&E, this could be interpreted as providing supporting for the closure of walk in centres with relation to the argument that they do not appear to reduce waiting times for access to primary care.\footnote{Maheswaran, R., Pearson, T., Munro, J., Jiwa, M., Campbell, M.J., Nicholl, J.(2007). Impact of NHS walk-in centres on primary care access times: ecological study. BMJ:doi10.1136/bmj.39122.704051.55 (published 9 March 2007)} WICs may extend and at times potentially duplicate rather than offer alternatives to care provided by GPs.

The preceding evidence seems to suggest that the removal of walk in centres will have no effect as their introduction did not reduce the need for A&E and Urgent Care Centres (UCC). However this poses the question of whether the introduction of WICs improved access and where this demand will go once the WIC is closed.

The above findings were further explored by following up with data requests from other walk in centres closed in England. For more information, see Appendix D.

1.4 The experience of City and Hackney

The two walk-in centres in City and Hackney were closed at the end of October 2012, leaving only a weekend service at one site. The impact of this change has been reviewed with particular attention to the impact on use of the local A&E and Urgent Care Centre at the Homerton Hospital. Here a small increase was expected and seen in use of these other services in the month immediately after the closure, November 2012, but there appears to have been no significant longer term impact of the closure on A&E or UCC use. Data showing the use of these services is provided in Appendix E.

2. The proposal

The CCG is proposing to remove walk-in services from Broad Street, retain services at Upney Lane and improve capacity in primary care for urgent care appointments. This would:

- Provide a clearer pathway for patients seeking management of their urgent care needs; patients are confused by the current system and often unsure where to go to get advice or treatment
- Support enhanced access to general practice, which is what patients have said that they want
• Maintain a single minor ailments and minor injuries service with x-ray facilities with the opportunity to refer to other community services on site such as sexual health services

• Provide an opportunity to review the service model at Upney Lane to enable better integration with primary care services

• Support NHS England, with input from the CCG, to procure high quality accessible primary care services from the Broad street site to include the re-procurement of general medical services for the existing patient list and opportunities to improve primary care provision in the locality through the better use of the Broad street estate

• Commission planned care services e.g. blood tests in a more cost effective way from the Broad Street site

Following the review of the additional work carried out there has been no additional evidence that suggests that the previously rejected options in the pre-consultation business case should be reconsidered.

3. Impact of decision to implement preferred option

3.1 Activity modelling

In this section the impact of implementing the preferred option is considered in more detail. A range of approaches have been used to understand where patients would go if the walk-in services at Broad Street ended and the impact on other urgent care services.

This is a complicated piece of work which tries to take into account the choices patients make in light of the range of services available to them, the best place for patients to be seen given their clinical needs, other changes in the urgent care system such as NHS 111 and the experience of other areas when similar services have been closed where a level of attrition of activity has been seen.

The option that is proposed to be commissioned is for patients to be seen in the right place for their needs, and for commissioners to pay for the most appropriate clinical service.

For this option it is assumed that Broad Street will not be providing walk-in services. It will continue to provide primary care including access to urgent care with general practice in line with the developments across Barking and Dagenham. It assumes that phlebotomy services (blood tests) will be commissioned separately so this activity will not be required. A review of phlebotomy services is being instigated by the CCG (see implementation section below).

Figure 3 models the activity flow following the walk in centre closure based on the following assumptions:

• The number of attendances projected at Broad Street walk in centre for the year 2014/15 is 26,356 (these may include individual patients attending more than once).

• Of these attendances 22% will be attending for phlebotomy services not walk-in services. This activity has been deducted from total activity for the year as the intention is to commission phlebotomy services separately as it is not appropriate for this activity to be counted as urgent care activity and attract a higher tariff as a result.

• The remaining activity has been reviewed to ascertain if a service is needed. In the pre-consultation business case the assumption was that the overall WIC activity would be reduced by 24% to take into account patients who were referred on from the WIC to
their GP or were attending for a second opinion. These are duplicate activities – where the patient has to go to more than one service for the intervention they need and where the commissioner has to pay an additional cost for no additional benefit to the patient.

- The clinical audit indicated that a further 10% were attending for advice only. The amount of activity that does not require an urgent care service therefore ranges between 51% of current attendances at Broad Street (all attendances receiving no treatment, for non-urgent blood tests or duplicate activities) and 61% (adding to these the additional attendees who received advice only).

- Once the activity that is duplicate and not resulting in clinical interventions has been removed, the remainder has been allocated to the service that will best meet the needs of the patient, as follows:

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>UCC &amp; A&amp;E</td>
<td>7.21%</td>
</tr>
<tr>
<td>WIC</td>
<td>38.36%</td>
</tr>
<tr>
<td>GP</td>
<td>41.64%</td>
</tr>
<tr>
<td>OOH</td>
<td>7.21%</td>
</tr>
<tr>
<td>NHS 111</td>
<td>5.57%</td>
</tr>
</tbody>
</table>

These proportions were calculated from analysis of the walk-in-centre audit of attendances, of which those requiring clinical intervention were coded as to which service the patient would have attended if they had not been treated at the walk-in-centre. This assumes no change in the model of care for the GP and urgent care services listed.

Figure 3: Diagram of activity flow
In summary, the model proposed, in conjunction with other necessary changes in the overall urgent care system would ensure that patients are seen in the right setting to meet their needs.

Details of the assumptions used are provided in Appendix F.

3.2 Financial modeling

The financial implications of the activity changes (table 4 below) that would result from the proposal show a potential saving to the CCG of between £242,566 and £313,345 (based on the reduced activity of between 51% and 61%). This saving is based on the CCG paying for each attendance at the relevant services noted above including UCC/A&E, NHS 111 and Upney Lane walk in centre but no additional cost for attendances at GP practices as these are included in the capitation costs for registered patients. The financial assumptions are available at Appendix E.

Table 4: Financial impact of proposals

<table>
<thead>
<tr>
<th>Gross Saving</th>
<th>Reprovision Cost</th>
<th>Net Saving</th>
</tr>
</thead>
<tbody>
<tr>
<td>£602,266</td>
<td>£359,700</td>
<td>£242,566</td>
</tr>
<tr>
<td>£602,266</td>
<td>£288,921</td>
<td>£313,345</td>
</tr>
</tbody>
</table>

The potential for a penalty to be charged for loss of revenue due to rental income if the service were to be removed and leaves an unused space in the building is a potentially significant factor to take into account when assessing the financial implications of the proposal to de-commission the Walk in Centre at Broad Street. Given the recent changes to the ownership of NHS estates it is not currently clear a) if there is a penalty and b) if this penalty would apply to the CCG. Work is underway to clarify this issue; however the CCG is expecting that primary care services will continue to be provided from the estate at Broad Street which would mean that any penalty would not be applicable.

3.3 Impact on primary care

In order to determine whether urgent care activity can be appropriately managed in primary care, there has been some testing of the capacity available in general practice to manage the activity that is projected to return to primary care.

To model the impact, the proportion of all walk-in-centre attendances relating to each GP practice was calculated, and the extra activity was combined with current practice activity based on this proportion. The model identified that the impact on GP capacity would be limited with those closest to the walk-in-centre being most affected, and with most practices not being taken over 100% capacity.

People who live closest to the walk-in Centres use them most, so the impact of the closure of the walk-in service at Broad Street would have a greater impact on the practices in that locality.

The re-procurement of the general practice service at Broad Street by NHS England will ensure continued access to general medical services from Broad Street. Estates released at Broad Street by the walk-in centre will provide further opportunity to review primary care provision in the area making better use of available space.
Whilst there is no additional financial cost for CCG commissioners for the additional activity that would flow to general practice; however it is important to ensure that it is feasible for this activity to be managed within general practice.

A map of those practices most likely to be affected by this change is provided in Appendix G. This suggests that the impact of the walk-in-centre closure would not have an additional unmanageable impact on primary care.

The CCG is currently considering how to secure additional urgent care capacity in primary care, having agreed to run a pilot scheme aimed to managing surge in urgent primary care demand, as noted in the implementation section below.

3.4 Impact on A&E

There is an increasing demand for A&E services nationally and work is underway nationally and locally to address this trend. The provision of walk in centres in Barking and Dagenham has had no impact on A&E attendances locally – urgent care activity has continued to rise overall rather than activity being diverted from A&E to the walk in centres. Continuing with the current service model will not address this.

The option set out in this business case shows that between 860 and 509 additional attendances each year could be seen at the Urgent Care Centre if the Walk in centre was removed from Broad Street. The clinical needs that people present with at the Walk-in centre mean that the majority of patients should be seen in the Urgent Care Centres which are co-located with the A&Es at King George’s and Queen’s Hospital rather than attending the A&E.

As noted above, the impact of closing the Walk in Centres in Hackney on the Urgent Care and A&E services at the Homerton Hospital has been very limited.

There remains however a perceived risk by stakeholders that people will attend A&E, causing problems for an already stretched service. In order to better quantify this risk, modelling has been carried out to see what the impact could be on A&E. Gravity modelling that has been carried out demonstrates the maximum impact it could theoretically have on A&E/UCC. This model indicates that 43% of attendances who attended Broad Street Walk-in centre would attend another walk-in centre and 57% of the patients would be seen at other points of urgent care access.

Overall, based on the experience of other walk-in centre closures and on the key fact that this activity is mainly primary care activity, the impact on A&E is expected to be very limited. To ensure that this is the case the following actions are needed:

- Make primary care accessible and attractive to patients as the first port of call so they do not feel the need to attend A&E
- Clear communications to patients about where to go and when
- A robust process (including contractual mechanisms) that diverts primary care activity from A&E to UCC/general practice.

3.5 Impact on other WICs

There might be some patients who attend other walk-in centres if the Broad Street Walk-in centre closes. In order to mitigate this risk the service at Upney Lane may need flexibility to expand to provide the additional capacity that might be required.

---

13 The rates of A&E attendance for Barking and Dagenham are at Appendix H.
Further work is proposed with neighbouring boroughs to establish common protocols that integrate walk-in centres into the primary care urgent care pathway, e.g. walk-in centres being used to provide additional capacity to general practice via GP referrals rather than as solely walk in services.

3.6 Impact on patient choice

There would be no material impact on patient choice as walk-in services would still be available within the borough and primary care services would continue at the current sites.

3.7 Impact on competition

Any new walk in service at Broad Street would be openly re-procured by the CCG. The service at Upney Lane is currently under contract with NELFT and there is the opportunity to review the walk in centre service model and for contracts let in 2014/15.

4. Risks and dependencies

4.1 Risks

Managing the risks of the proposal and any implementation will be key to success. The proposed model is one that best manages patients clinical risks and balances the need to provide accessible services with the need to secure value for money for commissioners. A full assessment of risks of implementation will need to be carried out following decision on the proposed changes.

4.2 Dependencies

Dependencies relate to the commissioning of other clinical services linked to the walk in centre contracts as in Table 5 below:

| Table 5: Clinical contractual commissioning dependencies |
|-----------------------------------------------|-----------------------------------------------|
| Broad Street                                  | Upney Lane                                    |
| Process                                      |                                               |
| NHS England will commission a general medical service for the GP list and the CCG any enhanced services | The CCG will commission the walk in service through an NHS contract |
| Commissions of clinical services              |                                               |
| A decision on the proposal could affect commissioning decisions by NHS England about the service commissioned at Broad Street | Variation to the existing service will be negotiated and/or a new service model will be procured. |
| Care for residents of nursing home: would be commissioned together with the GP list above (although this could be allocated to any local GP practice) |                                               |
| Phlebotomy service currently provided within the walk in centre contract\(^\text{14}\) - a separate commissioning decision of this planned care is recommended |                                               |

\(^{14}\) 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.”
5. **Implementation**

This section outlines the main projects that will need to be implemented to realise the benefits of the proposed approach to urgent care in Barking and Dagenham.

5.1 **Development of localities model**

Implementation of locality improvement plans for urgent care services to support joint working across networks of practices and improved access across all practices including improved demand management techniques, telephon triage and consultation, patient transfer, information sharing and shared booking systems.

5.2 **The Surge Scheme pilot in Barking and Dagenham**

Barking and Dagenham CCG are commissioning additional urgent primary care for registered patients as part of a pilot scheme to deal with surges in demand. The additional activity will be over and above both current urgent care activity and booked appointments providing an additional 50,000 appointments per annum above current capacity. The scheme will be evaluated against the provision of additional activity, patient satisfaction and impact on the remainder of the urgent care system.

5.3 **An urgent care protocol across Barking and Dagenham, Redbridge and Havering**

An ongoing programme of improvement to emergency services at Queen’s Hospital and urgent care services at King George’s Hospital, including strengthen the A&E “front door” urgent care centre and redirecting activity back to primary care where this is clinically appropriate.

5.4 **Review of phlebotomy services for Barking and Dagenham**

A review of provision of blood testing (phlebotomy) services in Barking and Dagenham will be carried out to ensure that the right level of activity is commissioned to meet the needs for blood tests, this will include a review of location and timing of services in conjunction with patients and will aim to achieve a lower cost to the commissioner for phlebotomy services. Blood tests will continue to be commissioned for the Broad Street site.

5.5 **Commissioning of primary care**

**Broad Street:** NHS England will re-procure the general practice at Broad Street with input from the CCG to ensure that this delivers high quality accessible services. The Alternative Provider Medical Services contract has been extended 31 March 2014 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 5 above.

5.6 **Upney Lane:** the current service is provided as part of Community Services Contract with NELFT and is contracted until March 2014. A contract for walk-in services will need to be secured according to the appropriate processes for the next year.

D. **Conclusions and next steps**

In conclusion this business case sets out the following key points:

- Patients are confused by the current urgent care system and often unsure where to go to get advice or treatment. This results in duplication of activity as some patients attend multiple places to get their needs addressed.
• Patients want improved access to general practice. Their current experience is variable and many people are using walk in centres because they believe they cannot access urgent services from their own GP.
• Current walk in centre services do not represent good value for money. Many patients who attend do not receive active treatment or management. The introduction of new urgent care services designed to address primary care urgent care needs has not managed demand or had an impact on A&E attendances.

The proposal is that:
• The Broad Street walk-in centre service is decommissioned
• NHS England commissions a high quality accessible primary care service for the Broad street site and with the CCG looks at opportunities for primary care improvement in neighbouring practices through better use of estates.
• The CCG commissions a blood testing service, ensuring local provision for patients in the Broad street locality.
• The CCG maintains a single minor ailment and minor injuries service with x-ray facilities at Barking Community Hospital and reviews the service model to enable better integration with primary care services.

This supports the following principles:
• The CCG should commission urgent care services in the setting that best address patients’ needs in line with urgent care strategy.
• Urgent care services need to be integrated and easy for patients to navigate and access when needed.
• The CCG has a duty to commission services that represent value for money.

2. Timescales

An overview of the timescales for proposed changes is provided in figure 4 below.

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>After consideration of consultation feedback and any amendments to the proposals, a decision on the future of the services to be made in June 2013</td>
</tr>
<tr>
<td>2</td>
<td>Notify all stakeholders and the public of changes</td>
</tr>
<tr>
<td>3</td>
<td>Contract extension/variation and procurement processes to be confirmed</td>
</tr>
<tr>
<td>4</td>
<td>Any service changes could be implemented from 1 April 2013.</td>
</tr>
</tbody>
</table>

Figure 4: Procurement timetable for the APMS contract at Broad Street
Walk-in Centres in Barking and Dagenham
Business case appendices

June 2013

Note: The pre-consultation business case and its appendices are available at:

Barking and Dagenham CCG
Barking Community Hospital
Upney Lane, Barking
Essex IG 11 9LX
Telephone: 020 8532 6314
http://www.barkingdagenhamccg.nhs.uk/
Contents

Appendices

A  National and local context and policy
B  Engagement “you said, we did…”
C  Urgent care benefits map
D  Information from other walk in centre closures
E  Data on City and Hackney urgent care and A&E usage
F  Planning assumptions
G  Map of practices potentially affected
H  A&E attendance rates
Appendix A

National and local context and policy

Contents:
1 National context
2 Local context
3 National policy
4 Local policy

1 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\(^1\).

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.

**Review of walk in centre closures by Monitor**\(^6\)

On 31 May 2013, Monitor announced a review of walk in centre closures with the purpose of:

a. Examining changes to arrangements regarding the services provided by walk-in centres that have taken place over the past two to three years;

b. Assessing the impact of these changes insofar as they may affect patient choice and competition; and

c. Understanding current commissioning practices in relation to walk-in centres and possible future developments.

---

\(^1\) [http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh_129783.doc](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh_129783.doc)

\(^2\) [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)

The review is not an investigation by Monitor into possible infringements of the applicable choice and competition rules under their formal enforcement powers. The review will gather evidence from interested and relevant stakeholders by the end of June and aims to publish findings in December 2013.

2 Local context

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

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

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

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

3 National policy context

7 All travel times provided by googlemaps.co.uk
8 http://broadstreetwalkincentre.co.uk/
9 http://www.nelft.nhs.uk/news_publications/80
a. Department of Health Urgent Care

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

b. The Royal College of GPs Urgent care

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

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

c. Primary Care Foundation re urgent care

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

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

d. RCGP Federated Primary Care

The Royal College of GPs has developed a toolkit for the development of federated Primary care. This provides a useful checklist for the piloting and future development of GP localities.

4 Local policy 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

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:

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

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
• 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

---

12 See status in Section d below
13 http://www.healthfornel.nhs.uk/EasySiteWeb/GatewayLink.aspx?alId=40611
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.

e. The Urgent Care Strategy

A Case for Change sets out the CCG’s reasons for considering changes to the current Urgent Care system. It can be read in full at:
http://www.barkingdagenhamccg.nhs.uk/BarkingAndDagenhamNews/urgent_care.htm

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

The principles for an urgent care service are:

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

f. The draft Primary Care Localities Model

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

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

Key objectives:

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

End state principles: services which are:

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

Design principles:

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

g. The Surge Scheme

Barking and Dagenham CCG are planning to commission additional urgent primary care for registered patients as part of a pilot scheme to deal with surges in demand. The additional activity will be over and above both current urgent care activity and booked appointments providing an additional 50,000 appointments per annum above current capacity. The scheme will be evaluated against the provision of additional activity, patient satisfaction and impact on the remainder of the urgent care system.

The proposal for a primary care surge scheme supports the Barking, Havering and Redbridge urgent care improvement plan and is part of the B&D CCG response to ensuring that the appropriate access and capacity is provided in primary care so that fewer patients will need to access care at A&Es, Urgent Care Centres or Walk In Centres. At the moment patients are visiting these venues for what are essentially primary care needs.

A draft proposal has been discussed with NHS England who has agreed to delegate the commissioning of a service to the CCG and provide input into the development of the specification and outcomes. They have provided guidance on how the CCG can distinguish the service from core GMS services and given an opinion that, as the service is list-based, it can only be provides by general practice.

As the provider of this service will be GPs, the CCG is required to demonstrate that the service:

• meets local health needs and have been planned appropriately;
• goes beyond the scope of the GP contract; and
• follows an appropriate procurement approach.
## Engagement: “You said we did”

A summary is in **Table II** of actions arising from what stakeholders said in the engagement and consultation processes:

### Table II: Stakeholder feedback and follow up actions

<table>
<thead>
<tr>
<th>Stakeholders said</th>
<th>The CCG said…</th>
<th>Since then the CCG can update that:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme 1: Patients find it hard to get an appointment with their own GP</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Modernisation of Primary care The business case to include:  
  - Explicit details on how GP primary care will be modernised  
  - How going to share infrastructure – particularly IT | 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 has been actively looking at how GP practices can work together in localities which has included look at IT and information sharing. This is one of a number of activities the CCG is undertaking to improve Primary Care access. |
| 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 | The CCH has been actively reviewing the GP capacity baseline as referred to in the full business case. From this, it is suggested that Practices close to the Broad Street walk in centre would have capacity to accommodate additional appointments. |
| The issue of Barking and Dagenham being “under doctored” | Not applicable – this was raised by the Health and Adult Services Committee in their response to the consultation | This is covered above in the GP capacity baseline above. The number of doctors was the previous way of analysing capacity – it is more helpful to look at appointment capacity compared to national benchmarking. |
| The impact of the cessation of the extended hours access for GPs on already existing problems of primary care access | Not applicable – this was raised by the Health and Adult Services Committee in their response to the consultation | A Surge Scheme is proposed with a pilot being implemented in August 2013. More details are in **Appendix C** above. |
| **Theme 2: Patients value walk in services and consider a local service with extended opening times to be of benefit** | | |
| 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. | This is recognised as a strong theme to come out of the consultation. The CCG has undertaken detailed modelling of the likely diversion of patients to other points of access, including GPs, other |
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. walk in centres and A&E. This combined with evidence of appointment availability in Locality Four suggests there is sufficient GP capacity available. The CCG needs to work with practices to understand this better and when the best times to offer appointments are.

<table>
<thead>
<tr>
<th>A proper analysis of the likely patient flows, the make up of the practice populations immediately surrounding the walk in centre and a geographical analysis that takes account of local perceptions of the easiest place to travel to and transport routes</th>
<th>This was not commented on in the pre-consultation business case as it was raised by the Health and Adult Services Committee in their response to the consultation on 21 May 2013</th>
<th>As above</th>
</tr>
</thead>
<tbody>
<tr>
<td>A need to resolve the conflicting views of clinicians about the appropriateness of some of the activity at the WIC diverting to A&amp;E, in opposition to the business case assumptions</td>
<td>Not applicable – this was raised by the Health and Adult Services Committee in their response to the consultation</td>
<td>One of the recommendations of the business case is to develop an effective stakeholder engagement plan for the development of services in the Broad Street area, review of the Upney Lane service specification and to evaluate the impact of improved access to primary care.</td>
</tr>
<tr>
<td>Seemingly conflicting information about unmanageable demand at other locations as a result of the closure and unrealistic assumptions about diversion to A&amp;E and other urgent care settings, the latter fundamentally questioning the immediate financial basis of the change.</td>
<td>Not applicable – this was raised by the Health and Adult Services Committee in their response to the consultation</td>
<td>The potential impact of the proposed closure on other points of access has been carefully reviewed and the risks of implementation will be monitored and managed. Regular reports will be made to the HASSC on progress.</td>
</tr>
</tbody>
</table>

**Theme 3: Patients want more and more flexible access to GP appointments** in core hours as well as strong support for weekend opening and later opening for registered patients as well as more telephone advice from local GPs

| There needs to be easier access to urgent care services at GP surgeries. The CCG should look at the barriers that are faced by people in being able to contact and see their GP in a timely manner | Not applicable – this was a recommendation by Healthwatch in their response to the consultation | The CCG has looked at barriers both through the consultation as well as having undertaken an equalities impact assessment. The results of both are publicly available and provide useful information to the CCG for next steps in |
way and act to improve the situation.

**Telephone services**: A small scale assessment of the impact of the use of telephone services for the provision and support of primary care services.  
Not applicable – this was a recommendation from the equalities Impact assessment

The CCG has started to look at telephone access, telephone triage (prioritising patients according to need) as well as GP telephone advice and consultations. Training is about to take place and impacts can be evaluated and reported.

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

Didn’t hear about this in the consultation

Provision for **unregistered patients** and those whose working patterns and pressures demand on-the-day flexibility of access for minor ailments  
Not applicable – this was raised by the Health and Adult Services Committee in their response to the consultation

The CCG would like all patients to be registered with a GP and for the GP to be the first point of contact for all (non emergency) care. The CCG is looking with GP practices at when patients most need appointments to ensure patients needs at met and GP appointments don’t get wasted.

| Theme 4: Concerns about the impact of change including on GP services and A&E. If proposals do go ahead, suggestions have been made about: increasing GP capacity and walk in centre capacity, considering vulnerable patients and clear communication of changes to all patients |
|---|---|---|
| **How long will it take to deliver what is set out in the Urgent Care Case for Change?** | This is an ambitious timetable and the CCG would like to start the first pilot locality from February 2013. | The case for change will be delivered in stages and the CCG is keen for timescales to be as ambitious as possible. |
| **The Primary Care Strategy** potentially provides solutions but impossible to evaluate in the context of the WIC proposal as it remains unpublished | Not applicable – this was raised by the Health and Adult Services Committee in their response to the consultation | |
| People are going to A&E as it is open 24 hours a day and it is accessible. GP services leave much to be desired. Any decision on walk in centres should be taken whilst considering potential negative impact on A&E | A&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. We need to communicate what is appropriate to patients and explain opening hours of GP surgeries, especially when they change The CCGs in Barking and Dagenham as well as | From our review of information we have gathered, we know that the majority of people use the walk in centres for conditions which could be treated in primary care. A third of patients received only advice so could call 111 or visit a pharmacy. There are very few A&E type attendances.
General practice can never be a 24/7 service, but can become more flexible to meet patients’ needs. |
<table>
<thead>
<tr>
<th><strong>Skill mix:</strong> staff should be trained at the walk in centres to provide services such as blood tests</th>
<th>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.</th>
</tr>
</thead>
</table>

**Theme 5: Developing services at Barking Community Hospital.**

| **How will referrals be managed?** Will patients need to go to different hospitals? | 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. |
| Services should be offered to patients with a **long term condition** so that they don’t need to access A&E | As left |
| We are always told to contact the **out of hours service** even if we contact the practice at 10am | The CCG will review the nursing home enhanced service and follow up this point with the provider who raised this. |

**Communication**

<table>
<thead>
<tr>
<th>The CCG needs to actively challenge the way in which they <strong>promote all the urgent care services to the public.</strong> This includes their locations, what services they provide and when they provide them during their opening hours (e.g. the times when they hold particular clinics during opening hours), regardless of the decision about the future of Broad Street walk-in centre.</th>
<th>Not applicable – this was a recommendation by Healthwatch in their response to the consultation.</th>
</tr>
</thead>
</table>

The CCG agrees and one of the recommendations of the business case is to develop a robust communications plan, informed by the Patient Engagement Forum, to ensure all urgent care providers, stakeholders, patients and public are aware of proposed system change.
<table>
<thead>
<tr>
<th><strong>A borough wide strategy to raise health literacy:</strong> A longer term approach is required to develop community relationships and an ongoing dialogue and interest in health encouraging a more informal approach to consultations and community engagement. A greater community feel could be generated by hosting informal activity based events to convey and reiterate key simple messages about health and services to progressively raise the level of health literacy – and monitor this through provider contracts.</th>
<th>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 - This was also a recommendation from the equalities Impact assessment</th>
<th>The CCG agrees, as above, it will develop a robust communication plan.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The CCG should <strong>inform the public as soon as possible if Broad Street walk-in centre is to be closed.</strong> They should give clear information as to how the services will be placed elsewhere.</td>
<td>Not applicable – this was a recommendation by Healthwatch in their response to the consultation</td>
<td>There are two elements to communication which the CCG will deliver: 1) to communicate the outcome of the consultation and decision and 2) to deliver a communications plan leading up to and after any changes are made.</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</td>
<td>The CCG will look at this as part of its communications plan.</td>
</tr>
<tr>
<td><strong>Community participation in future community engagement and communication strategies:</strong> The wider challenge of raising the level of health literacy and general awareness of health and health services in the borough would suggest that future communication strategies require greater co ordination, community participation and creativity in both their design and the implementation.</td>
<td>Not applicable – this was a recommendation from the equalities Impact assessment</td>
<td>The CCG will look at this as part of its communications plan with a view to working with different community groups representing different parts of the community to breakdown the key messages to be communicated about future proposals.</td>
</tr>
<tr>
<td><strong>Engagement of young people:</strong> Specific work to incorporate, as part of structured programme of young</td>
<td>Not applicable – this was a recommendation from the equalities Impact assessment</td>
<td>As above</td>
</tr>
</tbody>
</table>
people’s services, engagement of young people in the health, encouraging local citizenship and involvement by developing such roles as ‘peer’ educators

| Community groups: Work with community groups to improve the signposting and explanation of types of different health services available | Not applicable – this was a recommendation from the equalities Impact assessment | As above |

The CCG should consider conducting public consultations in a way that supports and enables more people to respond to them and attracts more interest from the public. Healthwatch found it difficult initially to find the consultation document on the CCG’s website or obtain hard copies at provider sites.

Not applicable – this was a recommendation by Healthwatch in their response to the consultation

The CCG received responses from 481 people through a variety of channels. It recognises however that it needs to continue to work at ensuring different groups are all represented and would want to work in a joined up way with Healthwatch in future consultations.

Other

| The relationship between closing the walk in centres and the proposed East Dagenham health facility, which is yet to be confirmed | Not applicable – this was raised by the Health and Adult Services Committee in their response to the consultation |

Domiciliary care needs to be addressed

The CCG will address through integrated care and will focus on working collaboratively and improving services provided during opening hours

Some GPs are refusing to sign Do Not Resuscitate forms

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

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

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
| Charging. This leaves some patients without adequate primary care provision | Appropriate services within primary care |
| What is the demand for ambulances in the borough and what the status of London Ambulance Service funding? | The London Ambulance Service receives its funding at a pan London level. Demand for services is high across London. |
Appendix D

Information on other walk in centre closures

Despite the increasing number of Walk In Centre closures which have been reported in recent years there has been very little published evaluation following closure on the true impact seen by the health economy.

In order to try an understand the potential impact seen in other settings we undertook some literature and data based reviews, combined with discussion with local organisations who had undertaken closures. The outcomes of this were that:

- Anecdotally it was found that the practices that were closest to the Hounslow WIC had the highest number of people going to the UCC since closure.
- The closure of the Nottingham WIC did not negatively impact on the expected level of growth in A&E locally.
- WIC closure did not have a significant impact on A&E attendances in Hounslow or Wandsworth.

In a review of the impact of WIC’s on the workload of other local healthcare providers it was identified that there was no statistically significant reduction in consultations at emergency departments and general practices, and that there was no impact on consultations in out of hours services. (Chalder, M., Sharp, D., Moore, L., & Salisbury, C. (2003). Impact of NHS walk-in centres on the workload of other local healthcare providers: time series analysis, BMJ, 326, (7388 - 532).

Another observational study identified that the introduction of the WIC did not significantly affect the workload of local general practitioners. (HsU, R.T., Lambert, R.C., Dixon-Woods, M., Kurinczuk, J.J. (2003). Effect of NHS walk-in centre on local primary healthcare services: before and after observational study, BMJ, 326, 530)


These findings seem to suggest that WIC’s do not reduce demand to GP’s and A&E. This evidence could be interpreted as suggesting that the removal of WICs will have no effect, as their introduction did not reduce the need of A&E and ICC.

Data analysis and conversations with local commissioners suggested that in Hounslow the practices that were closest to the WIC were the ones with the highest number of people going to the UCC since closure. And, in Nottingham the PCT experienced a 4% increase in A&E attendances between 2009-10 and 2010-11 and a 2% increase between 2010-11 and 2011-12. The WIC closed in quarter 3 of 2011-12, Therefore we can extrapolate that the closure of the WIC did not negatively impact on the expected level of growth in A&E locally.

The charts below show a comparison of WIC closure dates for Hounslow, Westminster & Wandsworth with PCT A&E Activity.
Appendix E: data on urgent care and A&E usage following Hackney WIC closures (week 30)
Planning assumptions taken from the walk-in centre audit

1. Activity reductions

Activity that can be taken out of the walk in centre is as follows:

- **Phlebotomy**
  Phlebotomy accounts for 22% of Broad Street activity and 10% of all walk in activity.

- **Referrals to GP**
  Where a patient has not had any management and has been referred to their GP. This includes where patients had already consulted another clinician.

- **Advice only**
  Where a patient has not had any management and has not been referred to anyone, including their GP. This includes where patients had already consulted another clinician.

- **No treatment**
  Patients that were not managed, referred elsewhere or given any advice.

- **Patients that consulted another clinician (attended for a second opinion)**
  A proportion of this activity can be excluded. Patients that had seen a clinician before attending the walk in centre, but were referred back to their GP, or only received advice.

<table>
<thead>
<tr>
<th>Excluding</th>
<th>Activity</th>
<th>% of total activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phlebotomy</td>
<td>67</td>
<td>21.7%</td>
</tr>
<tr>
<td>No Treatment</td>
<td>19</td>
<td>6.1%</td>
</tr>
<tr>
<td>Referral to GP (no management, no 2nd opinion)</td>
<td>35</td>
<td>11.3%</td>
</tr>
<tr>
<td>Referral to GP (patients seeking 2nd opinion)</td>
<td>6</td>
<td>1.9%</td>
</tr>
<tr>
<td>Advice only (no second opinions)</td>
<td>30</td>
<td>9.7%</td>
</tr>
<tr>
<td>Advice only for patients seeking second opinion</td>
<td>4</td>
<td>1.3%</td>
</tr>
<tr>
<td>Referred to A&amp;E/required ambulance</td>
<td>26</td>
<td>8.4%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>187</strong></td>
<td><strong>60.5%</strong></td>
</tr>
</tbody>
</table>

Activity that would need to flow elsewhere is as follows:

- Patients that were managed, including those that were seeking a second opinion  (98)
- Referral on, excluding referrals to GP  (42)
- Patients that were managed and referred on, including onward referral to their own GP  (8)

Breakdown of this activity is shown below to avoid any overlap of patients

<table>
<thead>
<tr>
<th>Not excluding</th>
<th>Activity</th>
<th>% of total activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management</td>
<td>85</td>
<td>27.5%</td>
</tr>
<tr>
<td>Management and referral to other (excluding 2nd opinions)</td>
<td>3</td>
<td>1.0%</td>
</tr>
<tr>
<td>Management and referral to GP (excluding second opinion)</td>
<td>3</td>
<td>1.0%</td>
</tr>
</tbody>
</table>
Management of patients seeking second opinion

<table>
<thead>
<tr>
<th>Service</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management of patients seeking second opinion</td>
<td>13</td>
<td>4.2%</td>
</tr>
<tr>
<td>Management and referral of patients seeking 2nd opinion</td>
<td>2</td>
<td>0.6%</td>
</tr>
<tr>
<td>Patients referred to other</td>
<td>14</td>
<td>4.5%</td>
</tr>
<tr>
<td>Patients referred to other with 2nd opinion</td>
<td>2</td>
<td>0.6%</td>
</tr>
<tr>
<td>Total</td>
<td>122</td>
<td>39.5%</td>
</tr>
</tbody>
</table>

2. **Appropriate place of care for the remaining patients**

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>UCC &amp; A&amp;E</td>
<td>7.21%</td>
</tr>
<tr>
<td>WIC</td>
<td>38.36%</td>
</tr>
<tr>
<td>GP</td>
<td>41.64%</td>
</tr>
<tr>
<td>OOH</td>
<td>7.21%</td>
</tr>
<tr>
<td>NHS 111</td>
<td>5.57%</td>
</tr>
</tbody>
</table>

These proportions were calculated from analysis of the walk-in-centre audit of attendances, of which those requiring clinical intervention were coded as to which service the patient would have attended if they had not been treated at the walk-in-centre.

3. **Use of services in and out of hours**

- 61% of activity is during core GP opening hours (08.00-18.30 on weekdays).
- There is a significant proportion of activity (30%) that is during the period that GPs are not routinely available – evenings and weekends (although other services such as out of hours GPs are).

4. **Proportion of registered patients**

3% registered across both walk-in centres (walk in centres audit page 20)

BS: 4% not registered, and 4% did not specify

UL: 3% not registered, 8% did not specify

5. **Growth assumptions**

Growth of activity for 2014/15 (additional demand for services at Broad Street) 2.37%
Map showing location of practices, those circled are those expected to be most affected by the proposed closure in terms of the impact of their capacity, as indicated in the graph below.
Table III – A&E attendance rates 2009-13

<table>
<thead>
<tr>
<th>Type 1 Main A&amp;E Unit</th>
<th>Queens UCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr</td>
<td></td>
</tr>
<tr>
<td>May</td>
<td></td>
</tr>
<tr>
<td>Jun</td>
<td></td>
</tr>
<tr>
<td>Jul</td>
<td></td>
</tr>
<tr>
<td>Aug</td>
<td></td>
</tr>
<tr>
<td>Sep</td>
<td></td>
</tr>
<tr>
<td>Oct</td>
<td></td>
</tr>
<tr>
<td>Nov</td>
<td></td>
</tr>
<tr>
<td>Dec</td>
<td></td>
</tr>
<tr>
<td>Jan</td>
<td></td>
</tr>
<tr>
<td>Feb</td>
<td></td>
</tr>
<tr>
<td>Mar</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>53,279</strong></td>
</tr>
</tbody>
</table>

*Note this represents the number of attendances not attendance rate and therefore does not account for population size.*
Walk in centres in Barking and Dagenham

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

June 2013

Barking and Dagenham CCG
Barking Community Hospital
Upney Lane, Barking
Essex IG 11 9LX
Telephone: 020 8532 6314
http://www.barkingdagenhamccg.nhs.uk/
## Contents

<table>
<thead>
<tr>
<th>1</th>
<th>Executive summary</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Executive summary</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Key findings</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Themes</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2</th>
<th>Background</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urgent Care in Barking and Dagenham – the case for change</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Pre-consultation business case</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>The walk in centres</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Walk in use in Barking and Dagenham</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>The proposals</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Informal engagement</td>
<td>9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3</th>
<th>The Consultation structure</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Process</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Materials</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Activities</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Equality impact assessment</td>
<td>15</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4</th>
<th>Responses to the consultation</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Summary – in numbers</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>Responses from meetings and organisations</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>Responses by stakeholders</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>Responses – by question</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>Other suggestions</td>
<td>31</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Appendices</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Consultation documents</td>
<td>32</td>
</tr>
<tr>
<td>B</td>
<td>Healthwatch consultation response</td>
<td>32</td>
</tr>
<tr>
<td>C</td>
<td>About the respondents to the questionnaires</td>
<td>33</td>
</tr>
</tbody>
</table>
1. Summary

Executive Summary

1.1. Barking and Dagenham Clinical Commissioning Group (“The CCG”) launched a consultation in February 2013 proposing to discontinue walk in services at Broad Street Walk in Centre and consolidate services at Barking Hospital’s Upney Lane Walk in Centre and improve access to GP urgent appointments. The consultation ran for twelve weeks to 21 May 2013.

1.2. The proposal was developed as a result of a Case for Change to improve Barking and Dagenham’s urgent care services\(^1\) which was included in the the Commissioning Strategy Plan for 2012-13 and 13-14. Through this, Barking and Dagenham CCG has developed proposals to review and improve urgent primary care through the new 111 telephone service, community pharmacies, GP services (in hours) and walk in centres.

1.3. As part of this strategic development, the CCG has undertaken various activities to understand why people use the walk in centres(see Section 2.1) following a range of information (e.g. GP national survey, comments at HASSC and Health and Wellbeing meetings) which suggested that current services could better meet the health needs of local people.

1.4. The consultation documents can be viewed at: http://www.barkingdagenhamccg.nhs.uk/ONELBarking/Pages/Get-involved/Consultations/walk-in-centres-consultation.htm

1.5. During the consultation, a total of 481 stakeholders’ views were gathered:
   - 474 Service users, carers, local people and NHS staff through questionnaires received at events and by post, email and the web
   - 7 formal written organisational responses.

1.6. The results of the engagement will be presented to the CCG Governing Body meeting on 25 June 2013. The findings will be presented to The HASSC.

Key findings

1.7. Around half of the 474 people who responded by questionnaire agreed that the way of providing primary urgent care in Barking and Dagenham needs to change (49%). Around a third (31%) did not agree or supported the “do nothing” option and the remainder did not know or did not give a response.

1.8. There was little consensus as to how best to achieve change. Essential improvements in a variety of services were called for, including improvements in walk in centre services and GP services. More flexible access to GP appointments and support for maintaining or increasing health services (as opposed to perceptions of a proposed reduction) were also raised. People were concerned about capacity should proposals to close walk in services go ahead, with GP capacity and A&E seen as barriers to change.

\(^1\) The Case for change is available publicly, at http://www.barkingdagenhamccg.nhs.uk/ONELBarking/Pages/Get-involved/Consultations/walk-in-centres-consultation.htm
1.9. In terms of the question as to whether to discontinue the walk in service at Broad Street, Barking Community Hospital or both sites, most people thought that no site should be closed, with most opposition given to closing Barking Community Hospital.

Just under a fifth (19%) of responses were in support of closure of the Broad Street walk in centre compared to 5% respectively for closing the walk in centre at Barking Community Hospital and closing both sites.

Respondents were asked for their views in their own words for supporting or opposing closure The most frequent reasons given were either: the value of having walk in centres, having a local service or the response was based on the fact that respondents had only used one or other of the walk in centres. Some had concerns about the current role the walk in centres play in urgent care or the quality of the current service.

1.10. Respondents were also asked to rank the top three services they considered most likely to make a positive difference in Barking and Dagenham. These were:

- GPs to open at weekends for (same day and bookable) appointments for registered patients
- GPs to open later for bookable appointments for registered patients
- Phone advice from local GPs who are able to access local information

1.11. There were a range of views from the seven formal organisational responses. The four responses from health professional organisations were in support of proposals including Redbridge CCG and Havering CCG, the Barking and Havering Local Medical Committee and the North East London Foundation Trust (NELFT).

The CCG’s patient engagement forum made comments about service redesign but did not provide a collective view on the walk in centre closure.

Representation from The Health and Adult Services Select Committee (“The HASSC”) and Healthwatch (not an organisational view but the summary of its own survey) was not in favour of proposals. While they support improvement in primary care access, both expressed concerns about sufficient alternative urgent care capacity and choice.

Themes

1.12. The main themes from all responses by questionnaire and letter can be summarised as:

- **Theme 1: Patients find it hard to get an appointment with their own GP.** This is the strongest theme to come out of the consultation. Many patients do approach their GP as their first point of contact, but experience difficulty in getting through on the telephone and getting access to GP appointments either urgently (same day) or within a reasonable time for non-urgent matters.

- **Theme 2: Patients value walk in services and consider a local service with extended opening times to be of benefit.** People want a walk in service in Barking and Dagenham. They said that this gives them the convenience of attending at times which better suit patients as well as the reassurance of access to a service when they can’t get a GP appointment, either for urgent or less urgent reasons, as well as a local service.

- **Theme 3: Patients want more and more flexible access to GP appointments** – an increase in the number of appointments in core hours as well as strong support for weekend opening and later opening for bookable appointments for registered patients.
There was also support for more telephone advice from local GPs who are able to access local information.

- **Theme 4: Concerns about the impact of change** including on GP services and A&E. If proposals do go ahead, suggestions have been made about: increasing GP capacity and walk in centre capacity, considering vulnerable patients including children and older people, considering transport and mitigating impacts on the residents of Dagenham and clear communication of changes to all patients.

- **Theme 5: Developing services at Barking Community Hospital** as well as general service improvement (customer care and waiting times), requests for new services include: more diagnostics including blood tests, more walk in or urgent care services, a minor injury service, X-ray facilities and a fracture clinic, a GP service with extended hours and children’s services.

1.15 An equality impact assessment of the proposals has been conducted and the results of the assessment are available in the equality analysis report.

1.16 A detailed breakdown of responses to the questionnaires is set out in **Section 5** on consultation responses.

2 **Background**

Urgent Care in Barking and Dagenham

2.1 Barking and Dagenham Clinical Commissioning Group (“The CCG”) launched a consultation process on 27 February 2013 proposing to discontinue walk in services at Broad Street Walk in Centre and consolidate services at Barking Hospital’s Upney Lane Walk in Centre and improve access to GP urgent appointments. The consultation ran to 21 May 2013.

2.2 Following discussions with local community groups, clinicians and the Health and Adults Services Select Committee, the CCG proposed a six-week period of public engagement and consultation to include a variety of activities.

At the request of Barking and Dagenham’s Health and Adult Services Select Committee (“The HASSC”), the consultation ran for a 12-week consultation period.

2.3 Whilst this was an engagement process and not a formal consultation, the term “consultation” is used in public facing documents as a more known and better understood activity.

2.4 The proposals contribute to delivery of the vision and objectives of Barking and Dagenham CCG to improve urgent care services as set out in its case for change: [http://www.barkingdagenhamccg.nhs.uk/Get-involved/Consultations/walk-in-centres-consultation.htm](http://www.barkingdagenhamccg.nhs.uk/Get-involved/Consultations/walk-in-centres-consultation.htm)

2.5 As part of this strategy, it is proposed to end walk in services at Broad Street and consolidate and improve services at Upney Lane. It is felt the needs of the local people could be better met through improving access to GP practices to help ensure there is continuity of care within a team of healthcare professionals.

---

2 [http://www.lbbd.gov.uk/CouncilandDemocracy/Scrutiny/Pages/SelectCommittees.aspx](http://www.lbbd.gov.uk/CouncilandDemocracy/Scrutiny/Pages/SelectCommittees.aspx)
2.6 The proposals also align with the objectives of other key programmes for Barking and Dagenham CCG:

- Improvements to urgent care as set out in the Case for Change including alignment to the new 111 service and improved integration across all services
- Improvements to access and capacity in primary care by commissioning additional urgent care capacity in primary care and supporting general practices to work together and with other services
- An ongoing programme of improvement to emergency services at Queen’s Hospital and urgent care services at King George’s Hospital.

2.7 Combined, these proposals are expected to make it easier for people to navigate the health system when they need urgent care; improve access for all registered patients to their GP and therefore contribute to improved health outcomes through the provision of high quality primary care. Improvements in access to and capacity of primary care will also potentially make it easier for anyone not registered to do so. The CCG also has a role in demonstrating value for money in commissioning services.

Pre-consultation business case

2.8 A pre-consultation business case set out the rationale for, and sought approval of, the proposal to decommission walk in centre services at Broad Street. This relied on four separate studies, including evidence of:

a. Patients’ reasons for using the walk in centres through a patient survey
b. Clinical reasons for use and follow up through an audit led by clinicians
c. Patients’ views on all proposals for improving urgent care services through stakeholder engagement meetings
d. Future activity modelling including financial analysis which included projected savings.

2.9 The focus of the pre-consultation 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.

The walk in centres

2.10 Walk in centres provide access to urgent primary healthcare services for anyone, including patients not registered with a GP or who are not in their local area.

There are around 92 centres nationally dealing with minor illnesses and injuries, treating around 3 million patients a year.
Walk in centres are not, however, a "nationally mandated" policy by the Department of Health. They are rapidly closing across the country, with figures recently suggesting a quarter have closed in the past year.

Walk in centres were established under two national programmes:

In 1999 the Department of Health authorised funding for a pilot scheme of 40 NHS walk in centres in 30 towns and cities across England. The overall aim of walk in centres was to improve access to high quality health care in a manner that is both efficient and supportive of other local NHS providers. It was hoped that the centres will complement other primary care initiatives such as NHS Direct, playing a major part in the government's commitment to modernise the NHS. There is no national evaluation or indeed limited literature about the role or effectiveness of walk in centres.

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.

Walk in centre usage in Barking and Dagenham

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

Broad Street Walk in Centre, set up at its current location in May 2006, as a GP-led health centre integrated with a medical practice. The walk in service is nurse-led and provides a minor ailments and injuries service (excluding fractures) in Dagenham. Upney Lane Walk in Centre, co-located at the Barking Community Hospital in February 2012 having moved from the former Upney Lane Clinic building, provides a minor ailments and minor injuries service (including X-ray / fractures) in Barking.

2.12 The two walk in centres in Barking and Dagenham had approximately 58,000 attendances in total last year (2011-12).

2.13 The CCG and walk in centres carried out an audit to understand patients’ use and health needs. The key findings showed that:

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 the ethnicity of patients reflected the general population.

Patient use: 61% of patients attend the walk in centres during core GP opening hours (08.30 – 18.30 on weekdays) and 13% during extended GP hours (these vary according to the practice and include early appointments from 08.00, evening appointments after 18.30 and weekends). 30% of patients attended outside these hours when general practices were not open – either in core or extended hours.

Clinical evidence: A large majority (92%) of the attendances were for issues that could be addressed in primary care (GP and pharmacy) and only a small proportion (8%) needed referral on to A&E for emergency care. The majority of the attendances were during core

---

3 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC65536/#B1
4 All travel times provided by googlemaps.co.uk
GP hours. This means that the service sought by patients during these times is already available from general practice – so in effect this is a duplication of an existing 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 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, given any clinical intervention/treatment or referred elsewhere. A greater percentage of patients who attended Broad Street were actively managed or referred compared to those attending Upney Lane:

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. It 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. In these cases, commissioners are paying for a service but patients are not receiving medical treatment.

**Second opinions:** Another factor to consider about the issue of 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 already sought advice from a GP.

**Best place to manage patients:** Clinicians were asked their 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 about patients attending with minor injuries. In the clinicians’ view, 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. This is different to the diagnoses made by the clinicians in the audit – 10% of patients seen at Broad Street and 8% of Upney Lane patients were referred to A&E.

**Where patients lived:** 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 highest proportion of people attending Broad Street and Upney Lane are those that live the nearest to the centres.
Where patients were 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 those unregistered patients, 8 were from out of the borough.

For more information see the audit report, survey and full decision-making business case5.

The proposals

3.1 The pre-consultation business case set out four options for walk in services at Broad Street in Dagenham and Upney Lane in Barking:

<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>Close Broad Street and 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>

3.2 The benefits to local people of the different options were assessed. Consideration included:

- 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 NHS England.

3.3 As a result of this assessment, the CCG Governing Body identified a preferred option, **Option 3**. This was put forward as the proposal for the consultation, to close the walk in service at Broad Street which would continue to house a GP practice, to:

- Encourage people to use their GP as a first point of contact
- Help to achieve savings known to be needed to protect other health services
- Improve the likelihood of patients registering with a GP and accessing health services
- Make the system more efficient by removing duplication.

Informal engagement

3.4 In one week in November 2012, Barking and Dagenham CCG commissioned The LINKS to do a patient survey at the walk in centres to understand their use better. The CCG also undertook a patient audit at the same time. This involved asking questions of patients and the clinicians they saw. Out of the 1,025 patients surveyed, 640 also gave their consent to have their clinical attendance audited.

3.5 Engagement meetings were held prior to the consultation to understand service users, carers and stakeholders’ views and use of services to help shape proposals. Meetings were held with the following patient and patient and health representatives:

- The CCG Patient Engagement Forum
- A CCG stakeholder event for its strategic plan in January

---

5 The audit report and survey can be seen at: [http://www.barkingdagenhamccg.nhs.uk/ONELBarking/Pages/Get-involved/Consultations/walk-in-centres-consultation.htm](http://www.barkingdagenhamccg.nhs.uk/ONELBarking/Pages/Get-involved/Consultations/walk-in-centres-consultation.htm)
• 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 CCG Stakeholder event on 16 January

3.6 The Local Involvement Network (LINK) was also invited to be involved in meetings. A summary of what stakeholders said and the CCG responses is set out in an Appendix B to the pre-consultation business case with the exception of the stakeholder event which is summarised below.

3.7 The stakeholder engagement event on 16 January focused on gathering views around the wider commissioning strategy of the CCG and focused particularly on the benefits and potential for developing the locality model where services were designed around clusters of GP practices and patients were managed as close to home as possible reducing reliance on hospital based care wherever this improve patient experience, integration and outcomes. The early output of bottom-up design work on urgent care undertaken with one locality within Barking and Dagenham was shared.

The output of this workshop helped to further shape the locality and urgent care programme of work. Further stakeholder views around the direction of travel for urgent care have been gathered from a range of sources including monthly Patient Engagement Forum meetings and more formally through the walk in centre consultation. An urgent care surge scheme is being developed based in part on support expressed by patients for getting more of their urgent care needs met by their GP and addressing concerns about availability and access. This is due to be piloted from August 2013. The scheme is designed to provide additional same day appointments in primary care above contract baseline, distributed according to expressed patient preference/demand with clear outcomes around demonstrating improved patient confidence in access arrangements.

Most recently a session with the patient engagement forum workshop on urgent care has identified some of the key elements of the service specification needed with general practice providers under the scheme.

3.8 A case for change was developed with clinical leads and discussed with both the HASSC and the Health and Wellbeing Board at meetings on 10 and 12 December.

3.9 From December 2012 to March 2013, meetings were held with the Chair and members of both the Health and Adult Services Select Committee and the Shadow Health and Wellbeing Board to seek their comments on the case for change, the pre-consultation business case and consultation documents, as follows:

<table>
<thead>
<tr>
<th>Date:</th>
<th>HASSC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autumn 2012</td>
<td>Briefing meeting with the chair and vice-chair of the HASSC</td>
</tr>
<tr>
<td>Autumn 2012</td>
<td>Briefing meeting with the chair of the HWBB</td>
</tr>
<tr>
<td>10 December</td>
<td>HWBB considered the Urgent Care case for change</td>
</tr>
<tr>
<td>12 December</td>
<td>HASSC considered the Urgent Care case for change</td>
</tr>
<tr>
<td>13 February 2013</td>
<td>HASSC considered the pre-consultation business case</td>
</tr>
<tr>
<td>12 March</td>
<td>The HWBB considered the pre-consultation business case</td>
</tr>
<tr>
<td>(17 April)</td>
<td>(The HASSC considered its formal response as part of the consultation)</td>
</tr>
</tbody>
</table>
3.10 A sensitivity analysis of the options was conducted with the London Borough of Barking and Dagenham’s Public Health team, the LINK and two CCG clinical leads. The outcome of this analysis was confirmation that the CCG’s preferred option best met the criteria for decision-making, having agreed combined scores against these, being:

- Accessibility and patient experience: Appropriate number of service locations
- Clinical care/safety: Clinical viability and the appropriate service model
- Affordability: Financial affordability
- Demand management: Activity analysis and modelling assumptions.

3 The Consultation structure

Process

4.1 The proposal was the subject of a consultation from 27 February to 21 May 2013. The CCG had proposed a six-week period of engagement, and agreed to a 12-week period following discussions with Barking and Dagenham’s Health and Adult Services Select Committee at its meeting on 13 February date.

Policy overview

4.2 NHS bodies have two overarching legal duties to involve and consult:

Duty to promote public involvement and consultation under section 242, NHS Act 2006, as amended

The duty applies specifically where there are changes proposed in the way in which services are delivered, or in the range of services available. The duty applies to all NHS providers, including foundation trusts and any independent providers, profit making or social enterprises, which are commissioned by the NHS.

Duty to consult with local authority under section 244, NHS Act 2006, as amended

The duty requires NHS bodies to consult with the local authority on proposed changes which are considered to constitute a substantial variation or development to a health service. This is additional to the duty to involve or consult under section 242. (Note: the Act has been amended so that it no longer specifies it must be the overview and scrutiny committee, sometimes known as the health scrutiny committee or HSC, as the particular part of the local authority that must be consulted).

In addition to the statutory duties outlined above, the NHS must also have regard to the guidance published by the Secretary of State, including the four tests for reconfiguration introduced in 2010:

- GP commissioning support
- Patient and public engagement
- Clinical evidence base
- Choice and competition

Evidence of how the service changes meets the four tests is required ahead of any consultation on reconfiguring services.
Materials

4.3 The following documents were produced to promote awareness of the consultation:
- Media advertisements
- Press releases
- Printed consultation documents (A total of 5000)
- An easy-read version of the consultation document
- Posters
- Letters to key stakeholders
- Consultation information on the CCG website.

4.4 The consultation document went live on the website on 27 February to 21 May 2013. The following documents were produced on the CCG website with a news item link to:
http://www.barkingdagenhamccg.nhs.uk/ONELBarking/Pages/Get-involved/Consultations/walk-in-centres-consultation.htm
- The consultation document which included a questionnaire
- An easy read version of the consultation document and questionnaire
- A consultation questionnaire in an on-line version
- The pre-consultation business case together with the following of its appendices:
  - A patient audit report (Appendix A)
  - And a patient survey report (Appendix B).

4.5 The consultation document and questionnaire were printed and widely distributed:

Media:
- Media release sent to local press on launch date (27/2).
- Advertisement placed in the Barking and Dagenham Post for 6/3.
- Media release sent out on 15/4 advertising the drop-in session in Dagenham on 23/4.
- Advertisement published in the Barking and Dagenham Post for 8 May (quarter page) trailing the end of the consultation on 21 May.
- Media release sent out to local press on 13/5 encouraging responses before the consultation end. This resulted in a note in the Barking and Dagenham Post on 15/5.

Consultation documents:
- Consultation documents were published on launch date (27/2) on a dedicated consultation page on the CCG website and linked to the homepage as a news item.
- Around 350 consultation documents were distributed to councillors, MPs, libraries, GPs and voluntary organisations in the borough, as well as both the affected walk in centres.
- Easy-read consultation document was produced and sent to libraries, The umbrella organisation for the voluntary and community sector (CVS), Healthwatch, the patient engagement forum and the Osborne Partnership (a charitable organisation strives to offer the best possible training and work opportunities for people with learning difficulties)
- Second mailshot of 350 consultation documents to GPs and libraries, with easy-read documents included in a mail out to GPs.
- Online questionnaire set up via Survey Monkey and linked to consultation page on the CCG website, and report on responses created.
- All consultation responses received and logged.
- The CCG ordered a further 4,000 copies of the consultation document and distributed these via urgent care and GP sites as well as at events, as follows:
  - Display at walk in centres – 1,125
  - Hand delivery to GP surgeries with posters and to explain consultation -1,000
• Mail out with agreed letter from the Local Pharmacy Committee to display in all community pharmacies - 800
• Barking, Havering and Redbridge University Trust in their urgent care centres A&E departments and outpatients - 225
• Supported patient completion at GP surgeries and walk in centres – 200.
• Event in Barking Market on Thursday 2 May - 110
• Event in Dagenham Heathway on Saturday 11 May - 215

Activities

Stakeholders:

• Email sent on launch date (27/2) to a list of 80 key stakeholders (including all Barking and Dagenham councillors) with a link to the consultation website.
• Barking and Dagenham councillors in the wards nearest the affected walk in centres, Upney Lane and Broad Street have been emailed with an offer of more detailed briefings by the CCG on the launch date and on 10/4, with no take up by councillors.
• CSU communications team attendance at LBBD HASSC meeting on 17/4 to monitor the HASSC discussion of the consultation and report back to CSU/CCG team.
• Item in BHR CCG staff newsletter on 17/4 encouraging staff to contribute to consultation.
• Meeting with Jon Cruddas MP on 19/4 where an update on proposals was given
• Margaret Hodge’s office were in contact to ask for details of Patient Participation Groups in Barking and Dagenham
• Margaret Hodge’s office received a briefing on 14/5 on the consultation proposals and background for them.

4.6 Two drop-in sessions and a further two events in shopping areas were arranged so that local people could find out more and have their say. The sessions were held on:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Details</th>
</tr>
</thead>
</table>
| **Drop-in session 19 March at Barking Learning Centre** | • 10 questionnaires filled in  
• CCG staff spoke to approximately 30 people  
• It was a fairly quiet event, many of the members of public attending had not used the Broad Street WIC due to location (ie it was not in Barking). |
| **Drop-in session 23rd April at Dagenham Library** | • 15 questionnaires filled in  
• CCG staff/clinicians spoke to approximately 50 people – many of them were interested to hear about the proposals and there was a general feeling that people would be disappointed to see the Broad Street WIC close. (Note that this was the first good weather day of the year). |
| **Event at shopping centre on Thursday 2 May - Barking Market** | • 110 surveys distributed  
• 52 questionnaires filled in  
• CCG staff spoke to approximately 200 people – many of the members of public attending had not used the Broad Street WIC due to location. People’s views were captured in the questionnaire feedback. |
| **Event at shopping centre on Saturday 11 May - Dagenham Heathway** | • 215 surveys distributed  
• 79 questionnaires filled in  
• CCG staff spoke to approximately 350 people – many of them were interested to hear about the proposals. People’s views were captured in the questionnaire feedback. |
| **Total** | **630 people spoken to, 156 questionnaires completed** |
### 4.7 Meetings at which service users and carers were the predominant audience:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CCG presence at GP surgeries and the walk in centres</strong></td>
<td>The CCG’s three practice improvement leads were present in GP surgeries and at the walk in centres to consult with patients while they were in waiting rooms. In addition, some practices also collected completed questionnaires from patients. This resulted in 188 questionnaires being completed in total.</td>
</tr>
</tbody>
</table>
| **Patient Engagement Forum Working Sub Group on urgent care** | This session specifically sought feedback from 6 patient representatives on how urgent care could be improved, the suggestions made at the group follow:  
- **Opening times**: 8am-8pm throughout the week  
- **Telephone contact**: No premium numbers. A good telephone system that you can get through on and a good response time; We need to make sure that the GP practice has someone at the end of the phone even out of opening hours. This is to answer the phone and help guide people; telephone advice with a GP who can access your records was also a suggestion. This could provide reassurance to someone without a visit. Members felt that this would work better if it was your own GP.  
- **Specialists**: It would be good to have specialists available for people who have long term conditions. People with long term conditions are more likely to go to A&E and walk in centres.  
- **Nurses**: Suggestions of using nurses as well, who can prescribe.  
- **Quality assurance**: Mystery Shopping; GPs tendering must demonstrate that they receive regular training  
- **Communication and Publicity**: Part of the budget needs to be committed to communication and publicity; GPS need to have regular communications with their patient list; We need posters explaining costs of A&E, walk in centres etc. and clarification of what these services are for. Clarification on what is being offered to the patient.  
- **Capacity**: There were some concerns about the capacity of GPs. They cannot cope right now, so we need to bring in extra support for the extra sessions. Some surgeries are down a GP and hours have been cut in places e.g. evening sessions. But it was also felt that GPs who were contracted between 8.30am-6.30pm were not always accessible and sometimes closed during those hours.  
- **Seeing the same GP**: It was agreed that in some cases such as mental health, it would be good to aim to see the same GP who is familiar with you. Relationships were very important in these cases.  
- **Follow up**: GPs need to follow up A&E attendance and educate patients  
- **Model**: Could be a shared service with other surgeries; One GP taking lead for a particular day; All having access to your records; Good administration; Good communications; Good Publicity; GP peer support |
| **Other Patient Engagement Forum meetings** | The Forum received a presentation on the walk in centre consultation at their meeting on 12 March 2013 and made the following comments:  
- Concern regarding whether the closure of walk in centres will increase demand at A&E  
- If the Broad Street walk in centre closes the space should be used to provide another service to the people of Barking and Dagenham  
Suggested that the general public need to be educated as to how these proposals link in with wider proposals for improving urgent care. |

**Total** | 204 people spoken to, 188 questionnaires completed |
4.8 Meetings at which professionals were the predominant audience:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 April 2013</td>
<td>Barking and Dagenham Local Medical Committee (LMC). A copy of the consultation document was circulated and the LMC invited to respond.</td>
</tr>
</tbody>
</table>

Equality impact assessment

In parallel to the consultation activities, a Stage Two equalities impact assessment was developed as part of the evidence base of findings. It was informed by a Stage One (desk-top) equalities impact assessment produced by the CCG. The scope of the Stage Two assessment was to undertake:

- 1 locality community stakeholder event
- Target 3-5 community and local forums and/or face to face consultations

The period of the equality impact assessment consultation ran between 10 April and 20 May 2013 and engaged a total of 96 stakeholders. These were as follows:

- B&D Equality and Diversity Officer at the London Borough of Barking and Dagenham – 10 April 2013 (1)
- Healthwatch Barking and Dagenham Consultation - 15 April 2013 (4)
- Lay member CCG - 18 April 2013 (1)
- EQIA Upney Lane WIC consultation including local businesses around Upney Lane - 25 April, 16 and 21 May 2013 (22)
- Community based consultations at the B&D CVS Volunteer and Community sector open day – 25 April 2013 inclusive of voluntary group representatives and local residents (34):
  - Carers of Barking and Dagenham
  - Citizen advice Bureau
  - Council for Voluntary Service B&D
  - Diabetes UK
  - Faith forum B&D
  - Sickle Cell/Thalassaemia Support Group of BDH
  - East Thames
  - Translating & Interpreting Service
- Consultation B&D LGBT forum - 29 April 2013 (2)
- Race Equality Council consultation - 2 May 2013 (5)
- Rwandan, Kosovan, Albanian, Turkish and Kurdish women’s groups
- Broad Street Walk in Centre Consultation including local businesses around Broad Street - 29 April, 7 and 16 May 2013 (27)

The findings of the equalities impact assessment are available in a separate, full report.
4 Consultation responses

Summary

4.9 The consultation document and easy read version are both at Appendix A.

4.10 This section summarises all responses following the above activities, including:

- Responses to the consultation questionnaire
- Two public drop-in sessions
- Meetings at which service users and carers were the predominant audience
- Meetings at which professionals were the predominant audience
- Written responses from organisations.

481 individual responses were received as summarised in the chart below which included:

- 10 (2%) questionnaires using an easy-read format produced
- 12 (2%) letters by email and post
- 79 (17%) and 52 (11%) questionnaires completed respectively with members of the public at a CCG event in Dagenham Heathway Shopping Centre and Barking Market
- 2 questionnaires downloaded and emailed
- 91 (19%) questionnaires handwritten sent by post
- 188 (39%) questionnaires completed by patients at GP practices and the walk in centres, some with support of practice or CCG staff
- 47 (10%) responses using the questionnaire on the web page (Survey Monkey).

One letter was disregarded as it was a duplicate of an email. 9 questionnaires were received after the closing date and were therefore not included in the consideration below:
4.11 A summary of responses from the questionnaires is in Section 5. Please also refer to Appendix C for detailed analysis of the profile of respondents to the questionnaire.

4.12 Healthwatch Barking and Dagenham also carried out a number of engagement sessions in various public settings with the local community. They asked for people’s views and opinions concerning proposals put forward by the CCG about urgent care services and the closure of the walk in service at Broad Street. Healthwatch provided this collective public response of 200 people surveyed and that:

- 85% would rather use their GP if they could get an appointment in a timely way.
- Almost 70% of people did not always get an appointment with their GP quickly enough.
- There was a source of constant frustration in not being able to do so and of lengthy delays in getting calls answered via the GP practice telephone answering services.
- Almost 70% of people said they did not want Broad Street walk in service to be closed.
- There is fear and concern that sufficient alternative urgent care services would not be in place.
- Over 50% of respondents did not know of any other urgent care services apart from those at Broad Street walk in centre.
- The public are unaware and confused about what urgent care is available and when it should be used; terms such as A&E, urgent care, minor injury, polyclinic, walk in centre and ‘out of hours’ services are a source of confusion in the public’s mind as these all seem interchangeable and vary in the services they provide.

4.13 Healthwatch’s letter setting out its findings are at Appendix C.

4.14 Written responses were received from the following seven organisations:

- The HASSC
- Havering CCG
- Healthwatch
- The LMC
- NELFT
- The Patient Engagement Forum (of the CCG)
- Redbridge CCG

4.15 A summary of feedback from meetings and written responses are summarised in the tables below.
<table>
<thead>
<tr>
<th>Date</th>
<th>Who</th>
<th>Type</th>
<th>Support</th>
<th>Comments and risks</th>
<th>Questions</th>
<th>Suggestions</th>
</tr>
</thead>
</table>
| 17 April   | The HASSC Local authority scrutiny committee | x                                         |         | Fundamentally opposed to any measures which reduce the range of choice and flexibility for local residents  
Opposes the closure of Broad Street walk in centre  
Supports pursuit of appointments for patients within their localities  
Recognises efforts made by the CCG to engage with the HASSC on proposals  
A paper was appended which set out range of risks including access, capacity & patient choice | A number of questions raised in section 6.2 of the report about analysis, next steps, GP and other capacity, 111, impact of removal of a walk in centre. | Support the pursuit of more GP access through GP localities.  
A number of other comments in their letter as set out below |
| 19 April   | Jon Cruddas MP           | MP                                        | -       | The Barking and Dagenham CCG Chair assured Jon Cruddas that there would continue to be a GP practice on site at Broad Street even if it is decided to go ahead with closing the walk in centre |                                                                                                                                                                                                  |                                                                                                                                                                                                  |
| 21 May 2013 | Havering CCG            | NHS Clinical Commissioning Group          | ✓       | Endorses proposals to prioritise urgent care for re-design and agrees that improving access to general practice is central to managing urgent care more effectively and providing care for patients.  
Agrees with proposal to maintain a service at Upney Lane – a service that will remain accessible to Havering patients, albeit for a small percentage  
Understands that there is limited impact on our registered population from the closure of Broad Street | Wishes to work collaboratively with Barking and Dagenham (and Havering) to improve the management of cross-border patient flows and support general practice in providing first-line service for their patients  
Would like to develop a consistent approach across the remaining walk in centres in Barking and Dagenham, Havering and Redbridge  
Remains receptive to learning from your experience and in working collaboratively wherever possible. |
<table>
<thead>
<tr>
<th>Date</th>
<th>Who</th>
<th>Type</th>
<th>Support</th>
<th>Comments and risks</th>
<th>Questions</th>
<th>Suggestions</th>
</tr>
</thead>
</table>
| 21 May 2013 | Healthwatch                        | Independent consumer champion for health and social care             | x       | Provided a collective public response of 200 people surveyed and confirmed it has no organisational view but 70% of people it surveyed does not want Broad Street walk in centre to close |                                                                                                                                                                                                          | The CCG to consider:  
  • Actively challenge the way in which urgent care is promoted  
  • Easier access to urgent care at GP surgeries  
  • Inform the public of a decision about the WIC promptly  
  • Consider conducting consultations in ways which support and enable more people to respond |
| 9 May      | NELFT (of Barking Community Hospital WIC) | NHS provider                                                        | ✓       | Supports the idea of closing one of the current walk in centres, but retaining one within the borough. Supports the proposed location Welcome the opportunity to work with primary care colleagues to improve access to primary care services, which may include other options not referred to in this consultation, e.g. wound dressing management out of hours and at weekends and more health screening interventions | What plans will be in place to provide primary care appointments out of hours that cannot access practices during the day?  
 Will there be sufficient premises space to see patients from other practices in the locality, under the arrangements proposed?  
 Is the CCG confident that NHS 111 will know where to direct patients to at any point? | Has the impact of the closure of the Broad Street service been worked through, and if so, what are the contingency plans relating to the rise in minor injury demand?  
 What plans will be in place to ensure that primary care can flex capacity to meet pressure surges for acute services at peak periods?  
 Should work be done to dissuade patients going to A&E out of hours, to prevent the rise in demand that has been witnessed in recent years?  
 What action will be taken to discourage patients from visiting the urgent care centre when primary care service open? |
<table>
<thead>
<tr>
<th>Date</th>
<th>Who</th>
<th>Type</th>
<th>Support</th>
<th>Comments and risks</th>
<th>Questions</th>
<th>Suggestions</th>
</tr>
</thead>
<tbody>
<tr>
<td>17 May</td>
<td>CCG Patient Engagement Forum</td>
<td>Patient representation Group</td>
<td>✓</td>
<td>Concern about GP capacity - see feedback from design workshop in section 4.6 above</td>
<td></td>
<td>See feedback from design workshop in section 4.6 above</td>
</tr>
<tr>
<td>21 May</td>
<td>Redbridge CCG</td>
<td>NHS Clinical Commissioning Group</td>
<td>✓</td>
<td>Endorses proposals to prioritise urgent care for re-design and agrees that improving access to general practice is central to managing urgent care more effectively and providing care for patients. Agrees with proposal to maintain a service at Upney Lane – a service that will remain accessible to Redbridge registered patients, albeit for a small percentage Understands that there is limited impact on our registered population from the closure of Broad Street</td>
<td></td>
<td>Wishes to work collaboratively with Barking and Dagenham (and Havering) to improve the management of cross-border patient flows and support general practice in providing first-line service for their patients Would like to develop a consistent approach across the remaining walk in centres in BHR Remains receptive to learning from this experience and in working collaboratively wherever possible.</td>
</tr>
<tr>
<td>9 April</td>
<td>The LMC</td>
<td>GP professional body</td>
<td>✓</td>
<td>Proper resourcing of the practices will be needed if GPs are expected to take on additional work</td>
<td></td>
<td>CCG to work more closely with the GP practices to see that a high quality service is available to the population</td>
</tr>
</tbody>
</table>
Responses by stakeholders

4.16 A demographic summary of those people who responded by questionnaire to the consultation is given at Appendix C. The headlines are:

- Most responses by questionnaire (92%) were made by individuals giving their own views
- Most people who responded were from Barking and Dagenham (73%)
- Two thirds of responses were from women (66%) and just over a quarter (26%) from men
- The ethnicity profile of respondents (predominately White British) was not representative of Barking and Dagenham or the local wards around both walk in centres
- In terms of age, most were 41-65 years (40%) with the next highest 26-40 years (26%). This is not representative of the local population which is relatively young
- Nearly three-quarters (72%) said they were responding as a local resident or service user
- Nearly three-quarters (75%) were not employed by the NHS and 11% were
- In terms of identifying with a religion or belief, most people said Christianity (42%)
- 14% of people said they had a disability.

Responses by question

4.17 The questionnaire asked eight questions and provided space for additional comments:

Question 1. Are you providing this response: In a personal capacity or as a representative of a group?

Question 2. Do you think we need to change the current way of providing urgent primary care services?

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

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

Question 5. Are there new services that should be developed at Barking Community Hospital?

Question 6. We are proposing to close the walk in service at Broad Street. Do you think we should discontinue the walk in service at:
- Broad Street
- Barking Community Hospital
- Both Broad St and Barking Community Hospital

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

Question 8. If we go ahead with our proposals, what else should we consider? Please use this box for any other comments you have.
4.18 The responses were as follows:

**Question 1:** “Are you providing this response: In a personal capacity or as a representative of a group?”

Most responses by questionnaire (92%) were made by individuals giving their own views:

![Question 1: Type of response](image)

**Question 2:** “Do you think we need to change the current way of providing urgent primary care services?”

About half of responses (49%) thought the way of providing urgent care did need to change. About a third (31%) did not, and another 20% did not know or didn’t give a response.

The reasons for these responses are on page 23 below:

![Question 2: Respondents' views on whether we to change the current way urgent care is provided](image)
Respondents were asked to give their views on why urgent care needs to change. A summary is in the chart on the right.

Most people did not give a reason (45%). Of those that did, the most frequent were:

Some reinforced the value of the walk in centres or having a local service (13%).

Others wanted to see more flexible access to GP appointments (9%) increases in health services (4%, as opposed to a perceived reduction in services). 2% of people expressed satisfaction with or benefits of being registered with a GP.

Concerns were expressed about the value or quality of services. Most called for improvements in a variety of services (9%), with 4% specifically about walk in centres and (2%) about GPs.

Concerns about capacity were raised should proposals to close walk in services go ahead, with most people raising GP capacity (7%) and A&E (2%) as barriers to change. A small number of comments were about personal experiences (3%).
Question 3: “What do you think about our plans for urgent primary care? For instance more appointments at GP surgeries – especially in the evenings and weekends; more telephone advice; and more services being made available in local GP surgeries.”

Respondents were asked to give their views on the CCG plans for urgent care.

Most people did not give a reason (23%). Of those that did, most people supported the plans, with general support (23%) and 3% in favour as working people or parents and 3% supportive with some reservation.

On the other hand, 7% of people did not support the plans to close the walk in centres.

Others used this as an opportunity to make comments about access to services they want to see, including support for general increase in the number of appointments (including during the day, or core hours, 13%) and weekends and evenings (8%).

Concerns were expressed about the value or quality of services. Again 9% were about improvements desired in a variety of services (9%), with 5% specifically about walk in centres and (2%) about GPs.

There were positive and negative comments about telephone advice (3%).
Question 4: “Tick the three services shown below that you think would most improve care in the borough.”

Respondents were asked to chose 3 services from a list of 8, with no need to rank services if they didn’t think they would make a positive difference.

The order of preference was as follows:

- GPs to open at weekends for bookable appointments for registered patients – 19%
- GPs to open later for bookable appointments for registered patients – 16%
- Phone advice from local GPs who are able to access local information – 13%
- GPs to open earlier for bookable appointments for registered patients – 12%
- Access to urgent appointments with a neighbouring GP – 9%
- A wider range of services in community pharmacies – 7%
- Improve GP premises – 3%
- Increase the number of urgent appointments at GP surgeries – 16%.

**Question 4 - Respondents' views on services which would most improve care in the borough**
Question 5: “Are there new services that should be developed at Barking Community Hospital?”

Respondents were asked to give their views on new services they would like developed at Barking Community Hospital.

57% of people didn’t give a view, with another 15% saying none or they did not know.

Points made about specific services were:

- More diagnostics including blood tests – 2%
- More walk in or urgent care services – 4%
- Minor injury, X-ray facilities and a fracture clinic – 2%
- A GP service with extended hours – 3%
- Children’s services – 1%

Some wanted an improvement in services overall, including better customer care and reduced waiting times (2%) whereas another 2% commended current services. 3% commented on other locations.
Question 6: “We are proposing to close the walk in service at Broad Street. Do you think we should discontinue the walk in service at Broad Street, Barking Community Hospital or both sites?”

People were asked to respond to each of the three suggestions with a yes / no / don’t know response. The charts below show that most people did not think any site should be closed, with most opposition to closing the walk in centre at Barking Community Hospital (67%).

For Broad Street, a fifth of responses (19%) were in support of closure compared to 5% each for Barking Community Hospital and both sites. People also gave their reasons which are summarised on page 28.

This analysis of the responses to the questionnaire show that fewer people were against closing both sites. This is because fewer people answered this question, perhaps as they felt that they had already answered by giving their views on the closure of Broad Street or Upney Lane. Out of the 481 questionnaires returned, 443 answered the question about the closure of Broad Street, 414 answered the question about the closure of Upney Lane and 356 answered the question about closing both sites.
Respondents were asked to give their views on discontinuing the walk in services. A summary is in the chart on the right.

Most people did not give a reason (24%).

Of those that did, most people reinforced the value of walk in centres (19%) or of a local service (13%). Another 6% said their response was based on the fact that they had used the walk in centre or only knew about of the walk in centres.

Concern were also raised about the role the walk in centres play in urgent care or the quality of the current service (6%).

Concerns about the effect changes could have on capacity were raised about GP capacity (9%) and other services including A&E (6%).

Some people wanted an increase in services – rather than a reduction, including more access and a wider range of services (5% in total).
Question 7: “Are there other any suggestions you have to improve urgent care in the borough?”

Respondents were asked to suggest ways of improving urgent care.

Nearly two-third of people did not make suggestions (64%).

Suggestions made in order of frequency were:

- Increase GP capacity and range of opening hours
- Increase walk in centre capacity
- Increase capacity somewhere
- Consider vulnerable patients including home visits
- Improve GP communication, inc telephone access & advice
- Better integration of services
- Improve arrangements for booking appointments
- More X-ray facilities
- Increase capacity - A&E
- Communicate changes so people know where to go
- Better sharing of patient records
- Improve quality of services
- Increase use of pharmacies.
Question 8: “If we go ahead with our proposals, what else should we consider? Please use this box for any other comments you have.”

Respondents were asked what else should be considered if proposals go ahead.

Nearly two-third of people did not make suggestions (63%). Those made in order of frequency were:

- Increase GP capacity and range of opening hours
- Other suggestions - various
- Keep the walk in centres as they are
- Consider vulnerable patients including children and older people
- Increase walk in centre capacity
- Reduce impact on Dagenham residents - improve public transport
- Communicate changes so people know where to go
- Increase capacity somewhere
- Consider impact on A&E capacity
- More GPs in Dagenham
- Patient-centred care
- Increase capacity in urgent care (centres).
Other suggestions

4.19 The proposal has generated a wide range of feedback and suggestions as to how services in Barking and Dagenham could be improved. This wealth of information will continue to be analysed and will be used to influence the recommendations that are developed to ensure that commissioning decisions reflect the findings as outlined in the key themes. It includes suggestions about:

In response to Question 7: “Are there other any suggestions you have to improve urgent care in the borough?”

Suggestions not made elsewhere by (one or two people) included (in no particular order):

- 24/7 access to urgent care in Barking and Dagenham
- A GP at the walk in centre
- Female (nursing) staff as they are easier for women to talk to
- Health Education introduced to the community, regarding food and nutrition
- Introduce fines for people who misuse A&E
- A minor injuries unit
- More mental health drop in provision in Barking and Dagenham
- Translation of health materials into different languages.

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

Suggestions not made elsewhere by (one or two people) included (in no particular order):

- Access to medicines at the walk in centres
- Health education and promotion
- Improve quality of referrals between services
- Increased physiotherapy or a hydrotherapy centre instead of a walk in centre
- Make better use of buildings
- Make it easier for people to register with a GP
- More mental health drop in provision (in Dagenham).
Consultation documents

The consultation document and Easy-read formats are below. Right click on the icon to open the documents:

The consultation document

The Easy-read document

APPENDIX B

Healthwatch consultation response
APPENDIX C

About the respondents to the questionnaires

This summary is about those people who responded by questionnaire to the consultation – (474 people in total) and information where given by letter.

Most people who responded were from Barking and Dagenham (73%) with over a fifth (22%) not giving a response. Less than 5% were from other boroughs.

Two thirds of responses were from women (66%) and a quarter (25%) from men.

About the respondents : The borough they live in

![Borough Distribution Bar Chart]

About the respondents: Their gender

![Gender Pie Chart]
Most respondents said they were White British (including respondents who said they were “British English”) (59% in total) with the next highest responses from people who said they were Black African (9%), Black African, Asian British or Indian (3% in each case). This is not representative of the ethnicity of Barking and Dagenham – the proportion of Black and Minority Ethnic residents who responded to the consultation was smaller than expected compared to the population profile of the local wards in which the walk in centres are located.

**About the respondents: Their ethnicity**

![Bar chart showing the distribution of respondents by ethnicity.](chart_url)
Respondents were asked in what capacity they were responding.

Nearly three-quarters (72%) said they were responding as a local resident or service user. The responses given in order of frequency were:

- Local resident
- Service user
- Other
- Service user and Local Resident
- Carer
- Prefer not to say
- Carer and Local Resident
- Service user and other

14% of people did not respond or preferred not to say.

In terms of 4.2% of responses from carers, this is an under-representation of the proportion of carers in Barking and Dagenham, estimated at 1 in 10 by Carers UK.
Respondents were asked if they were employed by the NHS. Nearly three-quarters (73%) said they were not, with 11% confirming they did work for the NHS.

In terms of age, most people said they were 41-65 years (40%) with the next highest 26-40 years (26%). This was not representative of the local population as Barking and Dagenham has a relatively young population compared with the UK average with a higher proportion of people aged 0-14 and 25-39 years.
Respondents were asked the religion or belief they most identify with. Most people said Christianity (42%) with Islam the next highest at 7.5%. A third (33%) of people did not respond or preferred not to say.

Finally, respondents were asked if they considered themselves to have a disability. 13% of people said they have a disability.

About the respondents: The religion or belief with which they most identify

About the respondents: If they consider that they have a disability
Equality analysis of proposals to close the walk-in service at Broad Street, Dagenham, and improve urgent primary care services in the borough

June 2013
### Summary

<table>
<thead>
<tr>
<th>Contents</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part 1: Contact details</td>
<td>5</td>
</tr>
<tr>
<td>Part 2: About the piece of work</td>
<td>6</td>
</tr>
<tr>
<td>Part 3: Existing knowledge</td>
<td>11</td>
</tr>
<tr>
<td>Part 4: Consultation and engagement</td>
<td>14</td>
</tr>
<tr>
<td>Part 5: Assessing impact on diversity</td>
<td>18</td>
</tr>
<tr>
<td>Part 6: Social and economic factors</td>
<td>25</td>
</tr>
<tr>
<td>Part 7: Human Rights</td>
<td>28</td>
</tr>
<tr>
<td>Part 8: Mitigating actions</td>
<td>28</td>
</tr>
<tr>
<td>Part 9: General recommendations</td>
<td>32</td>
</tr>
<tr>
<td>Part 10: Checklist and sign off</td>
<td>33</td>
</tr>
</tbody>
</table>

Appendix A: Equality analysis guidance  
Appendix B: References/evidence sources
Summary

An equalities impact assessment was carried out of Barking and Dagenham CCG’s proposals to close the walk in service at Broad Street, Dagenham and to review and improve primary care services in the borough. An equalities specialist was engaged to carry out this assessment (which ran concurrently with the CCG consultation process) and to produce this report.

The assessment included stakeholder engagement, listening to the views of different people and groups as well as analysis of the information available about the specific services under review and demographic information available about Barking and Dagenham. The perceptions of people about the walk in centre and their concerns about its possible removal are included in this report.

The proposals to improve primary care services are being made to benefit the local population and to improve health outcomes, in the main by improving access to primary care and to ensure that all people can receive the benefits of seeing their registered GP. This is of particular importance to more vulnerable people and groups. However, it is often these more vulnerable people, who though may be a small minority of the users of the Walk in centre service, use the Walk in centre because of the factors that make them vulnerable. For example women from minority cultural groups might now be accustomed to using walk in services because they have found them easy to access. Although these people would be better served by accessing a registered GP, the removal of the service they have grown accustomed to using could have a negative impact that will need to be mitigated.

The overall impact of the proposals on the protected characteristics of age, disability, gender, gender reassignment, ethnic background, marriage or civil partnership, pregnancy or maternity, religion or belief and sexual orientation has been assessed.

The key findings are that the proposals could have:

- A negative impact on younger people and those of working age because they are more likely to be in employment or education/training and therefore more likely to use the walk in centre.
- Both a positive and negative impact on disabled people as better access to their own GP would be beneficial but the loss of a known service could have an impact on this group.
- A negative impact on men who prefer the “drop in” nature of the walk in centre and on women as they are more likely to use the centre as patients and as carers.
- Both a positive impact and a negative impact on black and minority ethnic people who would benefit from improved primary care provision based around local needs but who might be more vulnerable to the changes proposed.
- No difference was identified due to religion or belief.

The information required to assess the impact on gender reassignment, marriage or civil partnership, pregnancy or maternity and sexual orientation was not available.

An assessment of the impact of the proposals due to social and economic factors concluded that:

- A negative difference could be found for people due to their immigration status as some perceive that it is easier to access services at the Walk in centre than at a GP.
A positive and a negative difference could be found for unemployed people, as they would be disadvantaged by having to travel further on a low income, however this would be balanced by the opportunity to have a shorter distance to travel if they have improved access to their GP.

Both positive and negative impacts on employed people if they are able to benefit from improved access to their own GP outside of working hours, but taking into account that this is the group who most use the Walk in centre (although much of this use is during working hours).

Both positive and negative impacts on carers who could benefit from improvements to primary care more generally but who would be particularly vulnerable to changes in access to services.

A negative impact on people with low levels of education and corresponding poor levels of health literacy who might find it difficult to navigate changes to services.

The factors of quality of housing, rural/urban location were not considered relevant to this assessment.

The proposals do not appear to have any impact on human rights.

Mitigating actions have been identified for the negative impacts identified above.

Despite extensive engagement efforts, there is an ongoing engagement challenge in Barking and Dagenham in particular to engage with some of the smaller minority groups and newly arrived people.
Equality Impact Assessment – Walk-in centres in Barking and Dagenham

Equality Analysis form

Part 1: contact details

Name and job title of person leading on this piece of work:

Gemma Hughes/Sarah D’Souza, Senior Locality Lead, Barking and Dagenham CCG

Directorate and Team:

Barking and Dagenham CCG

Email address and telephone number:

B&D tel: 0203 644 2383
Email: gemma.hughes@barkingdagenhamccg.nhs.uk
sarah.d’souza@barkingdagenhamccg.nhs.uk
Barking and Dagenham CCG
Barking Community Hospital
Upney Lane
Barking
IG11 9LX

Names and job titles of all people working on this equality analysis:

Sarah Young – Programme Manager Urgent Care Barking and Dagenham CCG
Sola Afuape – Equality Specialist Local Borough of Barking and Dagenham (Lead and Author)
Amy Burgess – Patient and Public Engagement Adviser Barking and Dagenham CCG
Contributors
Gemma Hughes – Senior Locality Lead, Barking and Dagenham CCG
Sarah D’Souza – Senior Locality Lead, Barking and Dagenham CCG
Equality Impact Assessment – Walk-in centres in Barking and Dagenham

Part 2: about the piece of work

Name of policy/project/service or function:

Review of Walk-in service at Broad Street, Dagenham and urgent primary care services within Barking and Dagenham. Barking and Dagenham CCG is reviewing existing services at Broad Street and in primary care across the borough. An engagement process ran from February to May 2013. An equality impact assessment (EQIA) has been undertaken alongside this process consultation. The outcome of the EQIA will contribute to the wider review.

Definition of Urgent care: “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.”

Department of Health

Background

In April 2013 Barking and Dagenham CCG assumed responsibility for commissioning local acute and community healthcare services for the borough. In the CCG’s most recent Commissioning Strategic Plan, a review of access to urgent care services had been identified as a key priority for 2012-2015.

The Service

There are two walk-in centres that provide nurse-led minor ailments and minor injuries services in Barking and Dagenham. One is situated in Broad Street in Dagenham and the other at Barking Community Hospital, Upney Lane in Barking. Both are open 7 days a week, till 10pm weekday evenings and from 7am til 6pm (Broad Street) and 9am - 10pm (Upney Lane) at the weekends. There is similar patient activity at both centres with an average of 80 patients a day attending each centre. Children aged 2 years and under are excluded from Broad Street but there are no restrictions at Upney Lane.

Broad Street Walk-in centre is co-located with a Medical Practice 10 minutes from local transport whilst Upney Lane is located in Barking Community Hospital next to the local tube station. The walk-in services at the two centres are provided by Care UK and North East London Foundation NHS Trust respectively. Whilst Upney Lane provides some diagnostic services there are none at Broad Street.

Walk-in centres were established following national programmes to fund NHS walk-in centre to improve access to high quality health care and to establish GP-led health centres.

What is the final product or intended outcome?

It is intended that the EQIA will inform the review of the walk-in centre and in particular decisions about the future of Broad Street and to inform the CCG’s plans to improve urgent primary care across the borough. The walk-in service at Broad Street is provided by Care UK under a contract which has been extended to March 2014. This contract includes general medical services (GP) services also at this site. At this point the contract must terminate and all services under it will have to be re-procured, if they are to continue. The intention is that GP services will be re-procured. Alongside wider considerations for system change a decision, therefore, is to be made whether to continue the contract for the Walk-in service or to seek alternative provisions of care. As part of the review a proposal has been made to
close the Broad Street Walk-in Centre and redesign existing primary care provision to provide suitable urgent care services for the borough.

Initial analysis suggests that patients are using the walk-in centres at times and for treatments that might otherwise be served through their GP or through self care. It is proposed that in future the CCG should commission a service model that:

- encourages a greater uptake of GP services as first point of contact
- supports greater GP registration and access to appropriate urgent care services
- reduces duplication of services
- achieves savings that can be deployed to protect other key services

The consultation report, outcome of the EQIA and business case will be presented to the CCG Governing Body on 25 June 2013 for consideration to inform the service decision.

Who is the target audience?

The current proposals to changes to the Walk-in Centres will impact on the population of Barking and Dagenham as a whole as they are part of a wider strategy to introduce measures that will improve urgent care services for the borough.

The communication strategy for the consultation identified a number of key target groups to be consulted with as follows:

- Patients and carers
- Health and related partners
- Community
- NHS staff and internal stakeholders

Borough profile

The borough of Barking and Dagenham is noted for its high levels of deprivation and has a growing and increasingly diverse population projected to continue growing between now and 2020. The biggest growth rate is between the ages of 0-4 years with the number of young people under 14 years of age and people between 25 and 40 years of age projected to grow as a proportion of the whole population.

Barking and Dagenham currently has a lower proportion of elderly people as compared to the population in England which will continue particularly with the decline in numbers from the older white British ethnic group and growth of younger black and minority ethnic (BME) groups. The number of men over the age of 75 is expected to increase but only in very small numbers and numbers of women of a similar age to decline also in very small numbers. This overall plateau in growth suggests that issues associated with an increase in an ageing population will be less of an issue in the borough compared to the rest of the nation and that services will need to respond to a younger population.

The Walk-in centres were introduced to improve access to high quality care in a manner that is both efficient and supportive of the wider local health economy. Typically it was considered an appropriate provision for local residents new to the borough or who were not registered with their GP and/or as an intermediary facility outside of surgery hours.
The Department of Health commissioned a national evaluation of NHS Walk-in Centre services\(^1\) in 2002, however since then there has been no further national evaluation against which to benchmark local Walk-in centres.

Local analysis of recent use of the Walk-in centres has provided some data that would suggest that the centres are being used by significant numbers of people who are already registered.

A breakdown of the Experian Mosaic\(^2\) customer profiling information that provides a deeper understanding of the characteristics, activities and behaviours of local populations in the electoral wards around both Walk-in centres suggest a high proportion of established adults of working age, younger married couples and a greater degree of diversity of ethnicity than the national average.

In addition to the local population proposed changes will also impact on the healthcare providers who currently provide the services, who may or may not be included in future plans. As a consequence of this the healthcare professionals who support these services and/or refer patients to the service will also be affected.

Local businesses in the Broad Street area have indicated that their principle interest in the proposals has centred around the impact the Centre has had on limiting their car park provision in the area and the role they play in signposting people to the Centre who struggle to locate it.

**What are the benefits of this piece of work?**

This piece of work is part of a review of urgent primary care services and plans to improve access to and experience of these services. It is proposed that supporting patients to obtain and have better and/or increased access to their GP will encourage better holistic and preventative care, e.g. with an increasing number of people supported to better manage their health. It is also proposed that it will be a simpler and more cost effective system which will reduce the number of entries into the healthcare system for advice or care. It is proposed that the closure of the Walk-in Centre in Broad Street will release funds to redesign primary care services to support greater engagement with GP services and to relieve pressure on A&E services.

**How will you promote the work to your target audience?**

A communication strategy and action plan was agreed in advance of the consultation. This involved a number of communication approaches to the following groups:

- Patients and carers
- Health and related partners
- Community
- NHS staff and internal stakeholders

---


A consultation document setting out the key points to be considered was produced and circulated as a hard copy extensively throughout the borough and an electronic version was available on the CCG website. An Easy Read version of the consultation document was also produced to support greater access to a broader range of residents. This was also circulated and posted on the website. Consultation documents were distributed to both walk-in centres. A number of consultation events were undertaken in March through to May 2013 in both the Barking and Dagenham area. CCG practice improvement leads provided outreach support to the consultation. Working from within each of the Walk-in Centres, they provided individual assistance to residents by talking them through the consultation document to answer any questions and support residents to complete the consultation form, particularly those for whom English may not be their first language.

Part 2a: for Services

Where do people go to use your service? Select all that apply

<table>
<thead>
<tr>
<th>NHS Facility (e.g. GP Surgery; Hospital; health centre; specialised clinic; children’s centre)</th>
<th>NHS Facilities:</th>
</tr>
</thead>
<tbody>
<tr>
<td>NELFT at BCH</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Walk in services are provided by: NELFT at BCH

| Independent Sector Treatment Centre | Care UK at Broad Street where there is also a GP lead health centre provided by the same provider | Yes |

At home

Other – please specify

<table>
<thead>
<tr>
<th>How are people referred to your service? Select all that apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional referral (e.g. medical professional; social care professional; educational referral)</td>
</tr>
<tr>
<td>Legal/criminal justice system</td>
</tr>
<tr>
<td>Self referral</td>
</tr>
</tbody>
</table>

Do patients have to be assessed before using your service?

| Yes | N/A |
| No | No |

Do you collect any of the following data about your service users?

Information is not uniformly collected across both the walk in centres, as they operate under different contractual arrangements. Only some equality information is routinely gathered, processed and monitored, as set out below

| Age | Yes | No |
| Disability | | |
| Ethnic background | Yes | |
| Gender | Yes | |

Page 9 of 40
Equality Impact Assessment – Walk-in centres in Barking and Dagenham

<table>
<thead>
<tr>
<th>Gender reassignment</th>
<th>√</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married or Civil Partnership</td>
<td>√</td>
</tr>
<tr>
<td>Pregnancy or maternity</td>
<td>√</td>
</tr>
<tr>
<td>Religion or Belief</td>
<td>√</td>
</tr>
<tr>
<td>Sexual orientation</td>
<td>√</td>
</tr>
</tbody>
</table>

If you have answered yes to any of the above, please describe how you use the information:

Services provided by both Walk-in centres are contracted out to two providers.

Care UK has an APMS contract for the Broad Street Walk-in Centre and collects data as indicated above. Patients are asked a number of questions about their status through a patient experience questionnaire on arrival at the walk-in centre. North East London Foundation Trust (NELFT) provides the walk-in service at Upney Lane as part of the Community Service contract and collects similar equality data recorded on the Patient Administration System (PAS) managed by Barking, Havering and Redbridge University Hospitals NHS Trust.

This information can be used by providers to report to commissioners, however commissioners do not currently have in place a process for routinely monitoring and analysing the equality data that is collected. There is also not a requirement to provide commissioners with routine equality data within either contract.

In November 2012, as part of the wider review of Urgent Care services, the CCG and Walk-in centres conducted a patient audit to investigate the key reasons for use of the Walk-in Centres. This included some equality breakdown of the sample population audited namely by age, gender and ethnicity.

During this time Barking and Dagenham Local Involvement Network (LINK) was also commissioned by the CCG to undertake a patient survey to collate patient’s views about their use of these services and their patient experiences. This also included some equality analysis.

Further extrapolation of the patient audit data as a one-off exercise, with appropriate Calidcott Guardian approval could extract additional equality information as patient consent was sought for use of participants’ NHS numbers for further analysis.

For the EQIA equality information from the following sources was used to inform the assessment:

- B&D CCG Walk-in Centres in Barking and Dagenham: A consultation on proposals February 2013
- B&D CCG Desk top EQIA Review of Walk-in Services based in Barking and Dagenham January 2013
- B&D CCG Urgent Care: The Case for Change
- LBBD EIA JSNA 2012
- LBBD Community Mapping 2011
- Patient Survey of Walk-in Services: Report by Barking and Dagenham Links December 2012
Part 3: existing knowledge

Are you aware of any existing inequalities relating this policy/project/policy or service?

<table>
<thead>
<tr>
<th>Yes</th>
<th>Please give brief details</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Analysis from available data</strong></td>
</tr>
<tr>
<td></td>
<td>Intelligence from the National Commissioning Board (NCB) Outcomes Benchmarking support pack: CCG level(^3) provides a detailed comparative analysis of the position of Barking and Dagenham residents for some NHS health outcomes and other associated indicators. It provides an initial cut of data that informs the Barking and Dagenham Commissioning Strategy Plan 2012/3-2013/4 and reports poor outcomes in relation to reported patient experience of GP services and GP out of hours services. Routine reporting and analysis of equalities indicators from the providers of both walk-in centres is not currently carried out. An analysis therefore of existing inequalities is not available from this data.</td>
</tr>
<tr>
<td></td>
<td>An initial desktop equality analysis was conducted on the Walk-in Centre proposals in advance of the consultation in January 2013. This provided an early indication of existing and potential inequalities for the following residents:</td>
</tr>
<tr>
<td></td>
<td>• Unregistered patients</td>
</tr>
<tr>
<td></td>
<td>• Carers</td>
</tr>
<tr>
<td></td>
<td>• Vulnerable people</td>
</tr>
<tr>
<td></td>
<td>• Homeless people</td>
</tr>
<tr>
<td></td>
<td>• Some migrant communities</td>
</tr>
</tbody>
</table>

**Services**

Broad Street WIC has a smaller range of services, which may disadvantage Dagenham residents. Upney Lane WIC has extended opening hours at the weekend that may favour working people.

In the white paper ‘Our Health Our Care Our Say’ 2006 \(^4\) Barking and Dagenham PCT was highlighted as one of the bottom 10 per cent of PCTs with the fewest doctors and therefore identified as under doctored area.

---


Since the 2006 report there has been national and local commitment to addressing the issue of GP numbers across the country and a number of approaches used to explore and implement ways to address access and capacity issues.

However, there is still a perception that the borough is under resourced in terms of GP provision which would suggest the need for robust collation and analysis of current GP and primary care capacity within the borough. There are complexities associated with this as models of provision of primary care have evolved to include a broader range of health professionals and providers.

Many of those attending the walk-in centre have been identified as of working age. The CQC national health survey\(^5\) of local health services found that 38% of young people aged 16-35 years stated that they found GP practice times inconvenient. Also when attempting to access their GP surgery by telephone, 50% reported experiencing difficulties some or all of the time. This correlates to similar evidence collected from the recent CCG patient audit and LINKs patient survey.

Transport
There are better public transport links and access to the Upney Lane site for Barking Residents. Dagenham residents have further to travel with less immediate access to the Broad Street site and would have even further to travel if redirected to other walk-in centres. However if they were able to access their own GP for urgent care, this could mean reduced travel. There are low rates of car ownership in Barking and Dagenham (JSNA 2013) so public transport links are important.

Equality and Diversity
Data from the Joint Strategic Needs Assessment (JSNA 2013)\(^6\) and Community Mapping of Barking and Dagenham (2011)\(^7\) highlight the increasing diversity of the borough. As new and more diverse communities enter the borough they bring new challenges to the provision of equitable healthcare. Within these new groups are many different migrant communities. Many of these people will be young and relatively healthy however often their overall health compared to established communities may be poorer with some significant health needs.

It was noted in the Equalities Impact Assessment of the London Borough of Barking & Dagenham (LBBD) Health and Wellbeing strategy 2012-2015 that race, ethnicity and English as a second language influences a patient’s perspectives, beliefs, values and behaviour towards health and wellbeing. These factors give rise to variations in interpretation of symptoms, thresholds of seeking care, comprehension of management strategies, expectations of care and adherence to preventative measures and medication.

Of the national reports of marked differences in satisfaction with primary care services, people from BME groups often report significantly poorer access to services often as a result of language barriers, poor service links with new communities and communication of changes to services and practices that do not

---

\(^5\) Care Quality Commission PCT Survey Results 2008 [http://www.nhssurveys.org/survey/697](http://www.nhssurveys.org/survey/697)

\(^6\) Barking and Dagenham Joint Strategic Needs Assessment (JSNA) 2011 [http://lbbdstaff/sites/PublicHealth/JSNA/SitePages/Home.aspx](http://lbbdstaff/sites/PublicHealth/JSNA/SitePages/Home.aspx)

reach or are sufficiently well understood by parts of the community.

Health Literacy

According to the American Medical Association report *Health Literacy and Patient Safety: Help Patients understand*\(^8\) states ‘poor health literacy is a stronger predictor of a person’s health than age, income, employment status, education level and ethnicity’.

However typically poor health literacy is often associated with poor education levels, unemployment status, low incomes and prevalent within some BME groups for which a number of these factors occur. Barking and Dagenham’s socioeconomic position includes a lower percentage of its population across all ethnic groups in employment, a higher than national average of residents of working age without qualifications and education attainment and low household incomes.

Health literacy requires more than the ability to read, which for those whom English is not the first language is already a barrier to access to services. In addition it requires a combination of reading, listening, analytical and decision-making skills and an ability to apply these skills appropriately to each health situation. For example it includes the ability to correctly read and understand medical information literature, appointment slips, instructions on prescription bottles, GP instructions and consent forms, and navigate healthcare systems.

The ability to effectively communicate is also relevant as those who are best able to articulate their health needs invariably receive the most effective treatment. Some groups, the elderly, vulnerable and those with particular communication needs find some environments better suited to allowing them time to give their best account of their health needs.

The level of health literacy within the borough can also provide an indication of how residents respond to changes within the local services and explain why some consultation efforts struggle to raise the required level of understanding of proposed change.

Low levels of health literacy are also linked to more emergency visits and hospitalisation according to the Agency for Healthcare Research and Quality report.

| No | N/A |

---

\(^8\) American Medical Association report Health Literacy and Patient Safety: https://www.ama-assn.org/go/amafoundation-healthliteracy
Part 4: consultation and engagement

Has your target audience been involved or informed about this piece of work or service?

<table>
<thead>
<tr>
<th>Yes</th>
<th>Please give brief details</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A comprehensive strategy and plan was produced setting out the required steps for effective engagement across the borough. The target audience was categorised broadly into the following groups:</td>
</tr>
<tr>
<td></td>
<td>- Patients and carers</td>
</tr>
<tr>
<td></td>
<td>- Health and related partners</td>
</tr>
<tr>
<td></td>
<td>- Community</td>
</tr>
<tr>
<td></td>
<td>- NHS staff and internal stakeholders</td>
</tr>
</tbody>
</table>

The consultation was undertaken by the CCG team and involved the following:

- Programme Manager Urgent Care B&D CCG
- Patient and Public Engagement Adviser B&D CCG
- Senior Locality Leads, B&D CCG
- Practice Improvement Leads, B&D CCG
- North East London and the City’s Commissioning Support Unit Communications Team

The consultation ran from 27 February to 21 May 2013 and was preceded by a number of internal and external discussions with key stakeholders within the local health economy, including local community groups and clinicians. A dedicated email account was also set up (WIC.consultation@onel.co.uk)

Stakeholder involvement and communication:

Through media

- Media release sent to local press on launch date (27/2).
- Advertisement placed in the Barking and Dagenham Post (6/3).
- Media release sent out advertising the drop-in session in Dagenham on 23rd April (15/4)
- A quarter page advertisement published in the Barking and Dagenham Post trailing the end of the consultation on 21 May (8/5)
- Media release sent out to local press encouraging responses before the consultation end (13/5), resulting in a note in the Barking and Dagenham Post (15/5)

A number of engagement opportunities were created through consultation documentation:

- Consultation documents were published on launch date (27/2) on a dedicated consultation page on the CCG website and linked to the homepage as a news item.
- Around 350 consultation documents were distributed to councillors, MPs, libraries, GPs and voluntary organisations in the borough, as well as both the affected walk-in centres.
- Easy Read consultation document was produced and sent for redistribution to libraries, CVS, HealthWatch, the patient engagement forum and the
Osborne Partnership.
• Second mailshot of 350 consultation documents were sent to GPs and libraries, with Easy Read documents included in the mailout to GPs.
• Online questionnaire was set up via Survey Monkey and linked to consultation page on the CCG website, and report on responses created.
• Total of 481 consultation responses received and logged in a spreadsheet.

Through stakeholder engagement:
• Email sent on the consultation launch date to a list of 80 key stakeholders (including all Barking and Dagenham councillors) with a link to the consultation website (27/2)
• Barking and Dagenham councillors in the wards nearest the affected walk-in centres, Upney Lane and Broad Street were invited to receive a more detailed briefings by the CCG on the launch date (10/4)
• Health & Scrutiny Committee (HSC) discussion of the consultation at LBBD HSC meeting on 17/4 was fed back to CCG team by CSU comms team to improve process.
• Item in BHR CCG staff newsletter encouraging staff to contribute to consultation (17/4)
• CCG Chair meeting with Dagenham MP Jon Cruddas (19/4)
• Briefing provided to Barking MP Margaret Hodge’s office (14/5)

Through local events
• Drop-in event held at Barking Learning Centre, around 30 attended and 10 questionnaire completed (19/3)
• Drop-in session held at Dagenham Library, approximately 50 attendees and 15 questionnaires completed (23/4)

The results of the consultation will be published alongside the EQIA.

In addition the following specific activities were conducted to inform the EQIA:

**EQIA assessment consultations**

The scope of the consultations was to undertake:
• 1 locality community stakeholder event
• Target 3-5 community and local forums and/or face to face consultations

The period of the consultation ran between 10th April and 20th May 2013 and engaged a total of 96 stakeholders. These were as follows:

• London Borough B&D Equality and Diversity Officer – 10 April 2013 (1)
• HealthWatch Barking and Dagenham Consultation - 15 April 2013 (4)
• Public and patient involvement lay member CCG - 18 April 2013 (1)
• EQIA Upney Lane WIC consultation including local businesses around Upney Lane - 25 April, 16 and 21 May 2013 (22)

Community based consultations at the B&D CVS Volunteer and Community sector open day – 25 April 2013 inclusive of voluntary group representatives and local
residents (34)

- Carers of Barking and Dagenham
- Citizen advice Bureau
- Council for Voluntary Service B&D
- Diabetes UK
- Faith forum B&D
- Sickle Cell/Thalassaemia Support Group of BDH
- East Thames
- Translating & Interpreting Service

- Consultation B&D LGBT forum - 29th April 2013 (2)
- Race Equality Council consultation - 2 May 2013 (5)
- Rwandan, Kosovan, Albanian, Turkish and Kurdish women’s groups
- Broad Street Walk-in Centre Consultation including local businesses around Broad Street - 29th April, 7 and 16th May 2013 (27)

Feedback on consultation process

Despite the comprehensive nature of the consultation exercise undertaken a number of small local community groups and local residents during the EQIA consultation indicated they were either not aware of the proposed changes or could only vaguely reference it.

It was noted that it was particularly so for the smaller interest community groups, such as the Rwandan, Kosovan, Turkish, and Albanian local women’s groups which was in contrast to larger established interest groups such as Diabetes UK, who were well informed and had a strong grasp of the full proposal.

Of the 26 local residents engaged at the B&D CVS Volunteer and Community sector open day only 7 were fully aware of the consultation having picked up a consultation document at either their Gp surgery (2) or the Broad Street Walk-in centre (1) or during the event from one of the stands (4). On further discussion it was clear that whilst some acknowledged they had seen the consultation documents they had not either understood that it was relevant to them or else were not confident enough to seek out further information.

Others had only digested part of the proposals and were formulating decisions based on partial information i.e. had understood that Broad Street walk in centre was closing and had seen it as a proposal for or against its closure but had not taken on board the proposal for improved GP services. Others had seen it as part of national rationalisation of public services and therefore had not investigated further. Many were sceptical that any feedback they gave would influence the final decision. Only a very few were aware of the statutory responsibility for public bodies to consult and involve local people in all decision-making processes of changes to services that affected them.

Of those that had a comprehensive understanding of the proposals were local people who were either involved in local voluntary and public involvement groups or
had attended a presentation e.g. Barking branch of Diabetes UK. The majority were older white British residents and well established within the local community. Conversely many of the local BME community groups consulted during the EQIA were unaware or were only engaged through consultations run by the Race Equality Council and HealthWatch. This is potentially also reflected by the proportion of BME residents who responded to the consultation. They were a much smaller number than expected compared to the population profile described in the Experian customer insight information of the local wards around both walk-in centres.

A number of younger people, 25 years and below, approached through the EQIA consultation indicated they did not feel that they had been targeted and some suggested that this was a common experience of local public consultations and that they often felt excluded, indicating that they felt the issues were not packaged in a way that would specifically engage their interest or attention.

This highlights the more general issue of the ongoing challenge of engaging Barking and Dagenham residents in local consultations about changes in health services. There are a number of levels of engagement required; through local voluntary sector groups who represent specific interests within the community, local business and workers in the borough and local residents more generally.

The distribution of the consultation material was extensive and an excellent attempt was made to make the documents widely available, however some groups still found it difficult to engage.

| No | N/A |
**Part 5: Assessing impact on diversity**

Could people be affected differently based on their protected characteristics? Summary of impact follows in the table below, further details are provided in the commentary.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Positive difference</th>
<th>Negative difference</th>
<th>No difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td>Yes for younger people and those of working age</td>
<td></td>
</tr>
<tr>
<td>Disability</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td>Yes for women as main users of the service</td>
<td>Yes for men that benefit from the kind of service offered</td>
</tr>
<tr>
<td>Gender reassignment</td>
<td>Data not available for analysis although some commentary provided</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethnic background</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Marriage or Civil Partnership</td>
<td>Data not available for analysis although some commentary provided</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy or Maternity</td>
<td>Data not available for analysis although some commentary provided</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religion or Belief</td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Sexual orientation</td>
<td>Data not available for analysis although some commentary provided</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Commentary: Impact on Age**

**Information from services**

Routine data is collected by both providers of the Walk-in centres for age for all attendees, however a process is not in place to collate this data as part of a wider monitoring process. A more recent audit conducted by the CCG and patient survey undertaken by the local LINKs indicate that there is potentially an over-representation of patients of working age residents 26-40 years attending both Walk-in centres. This is linked to their working status but also correlates with their age. Broad Street does not provide services for children under the age of 2 years.

**EQIA engagement activities**

The EQIA consultation indicates that walk-in centres are favoured by working people who are unable to obtain appointments that fit in with their working life and/or who value the convenience and flexibility of the immediate and extended access of Walk-in centres. This is also a matter that affects young people in work, training and education and is referred to in the employment section below.

Some young people indicated they preferred the anonymity of their local walk-in centre as it could not be determined why they were seeking treatment. This is also particularly relevant for some BME groups as referred to in the ethnicity section below. Some young people
indicated they had used the walk-in centre to seek advice about other services where they felt uncomfortable asking a family doctor.

Some mothers and carers indicated that the walk-in centres provided them with a safer less stressful environment than attendance at A&E for their children or the elderly.

Elderly residents in Dagenham expressed concern about the cost and difficulty getting to the other walk-in centres proposed and some indicated, by experience or reputation, that they would be very reluctant to go to Queen’s or King George’s.

Some care workers indicated concern about the suitability of telephone advice and support as part of the provision of urgent care particularly for the frail and vulnerable.

**General information**
Barking and Dagenham has a relatively young population compared with the UK average with a higher proportion of people aged 0-14 and 25-39. This reflects current and predicted future migration patterns into the borough. Overall it is estimated that there will be a substantial increase in the total population between 2013 and 2021. A fall in the older population, namely the over 65 of 20% is predicted with the decline in older people expected to continue to 2025.

**Conclusion**
The proposal to close Broad Street Walk-in centre could have a negative impact in terms of age on people of working age and younger people because of their employment/education commitments, however it should be noted that much of the Walk-in centre activity is during core GP hours (8am-6.30pm) or usual working hours so the negative impact here is restricted to those people in these age groups who use the services outside of core GP hours. Younger people who prefer the anonymity of a Walk-in service could also be negatively impacted. Very young children (under 2s) will not be affected by the proposals as they are excluded from the service at Broad Street. Children over the age of 2, like other patients, would benefit from receiving services at their registered GP to ensure they are included in the full range of health services, screening, immunisation and preventative services available to registered patients but not to A&E attendees or Walk-in centre attendees. The small proportion of older people who might use the walk-in service could be affected but it should be noted that they would not be expected to use A&E services as an alternative but their GP, which is much more suitable to meet their ongoing needs. As such there will be very little negative impact on the very young or the older population.

**Commentary: Impact on Disability**

**Information from services**
Disability data is currently not routinely collected by either of the walk-in services and opportunities therefore to understand the differential impact for this group and further segment down into sub disability categories is limited. Both the Walk-in centres and all GP practices in Barking and Dagenham are Disability Discrimination Act (DDA) compliant.

**EQIA engagement activities**
Some carers and voluntary groups expressed concern that a focus on increased primary care services and the increased pressure on GPs may reduce access and time allocated to disabled people overall particularly for single handed GPs.

One carer spoke of her concern that frequent minor ailments and injuries can indicate for some groups, i.e. disabled people, the elderly, those suffering from poor mental health, that they are not coping particularly if they are living independent lives and adequate time was needed to ensure that such signs were readily picked up. In addition another within the same consultation group queried whether some of these vulnerable people living independently may lose a vital access point into health services that supports them manage their health and maintain their independence.

It was noted that deaf people often experience difficulty booking GP appointments due to the increased use of automated telephone booking systems and that the proposal of telephone advice services as part of the urgent care proposals could potentially present a barrier to equitable access for this group.

Broad Street WIC is a new building built recently to include the necessary DDA access requirements whereas there is a perception that a number of the local GP practices are in older buildings and do not provide adequate or appropriate access. For some residents who were born overseas their expectation of urgent care services will often be that of newly built facilities and rather less so than of some of the smaller GP premises in residential buildings, as there are association with safer, functioning services with the former in their countries of origin.

**General information**
Populations are increasing in complexity and their needs. There is heterogeneity amongst disabled people arising from variations in impairment and from variations in socio-demographic characteristics. Disabled people can often present with a number of complexities even when presenting with minor ailments or injuries and in addition people with learning disabilities or difficulties may require additional time to communicate both the nature of the injury and the cause.

**Conclusion**
The proposed changes could have both positive and negative impacts on disabled people.

**Commentary: Impact on Gender**

**Information from services**
Data is collected routinely by gender at both Walk-in centres but a mechanism to monitor this is currently not in place. A recent patient survey of access to both walk-in centres by the local LINKs indicates that a slightly greater number of women use the walk-in centre services as compared with men or the local population average. In addition the survey also identified a number of carers who also used the centres and it is likely that these are predominantly women (see general information below). Both Walk-in centres provide contraceptive services and, whilst at Upney Lane there is a sexual health centre very nearby, Broad Street is the only facility in that immediate area providing that service.

**EQIA engagement activities**
Some women indicated that they preferred to use the walk-in centre because it allowed them to navigate a number of responsibilities and was a ‘calmer’ and safer alternative to A&E. One female carer spoke of bringing in both her daughter and her elderly mother to the walk-in centre at Broad Street as both required minor treatment. This she felt would not have been...
possible had she tried to co ordinate this at her GP practice. This was also significant as she was a single parent just new into the area with limited support and would have struggled to find someone to look after either her daughter or mother.

In addition some voluntary sector groups have indicated that most young girls and women may not go to their family GP due to concerns of levels of confidentiality amongst some GPs in their community and sharing of information with other members of the extended family. Whilst there is not current data to confirm this is the case Walk-in centres, because of their anonymity, potentially may offer an access point into health services and support for these women.

Some women pointed to the behaviour of their male partners and the difficulties they had encouraging them to visit their GP but having more success going with them or sending them to the Walk-in centre. Some men indicated they preferred the drop in nature of the Walk-in centre so they could go as the problem arose. Many indicated that they wouldn’t bother addressing the issue if they had to wait for an appointment with the GP. Also going to Walk-in centre felt like getting a ‘quick check up and nothing to worry about’ where as going to the GP felt a bit more formal and serious.

**General information**

The population in Barking and Dagenham is currently 49% men to 51% women with the gap predicted to reduce slightly by 2021. In general women outnumber men in all age categories and this becomes more pronounced with the older population. In relation to carers, national data indicates that a higher percentage of carers are often female.

There are increasing incidences of domestic abuse in some communities within Barking and Dagenham with sexual violence and exploitation of young girls. Improved data collection of the walk-in centres may help to better understand whether young women experiencing these problems access these services. Consultations as part of the EQiA of the Health and Wellbeing strategy 2012-2015 indicated that the issues these young women experience can remain hidden within communities which can make it very difficult for some women to seek treatment for their injuries and potentially feel safe enough to explore and access support and appropriate care. This is linked to ethnicity issues as noted below.

**Conclusion**

As more women than men use the services at Broad Street, for a range of reasons described in brief above, the changes would have an impact on women. However men who benefit from the “drop-in” nature of the service would also be affected. Work to improve access to primary care provides an opportunity to address some of the specific issues faced by women to access services and to find new ways of making services accessible to men.

**Gender reassignment**

JSNA 2011 data estimate there are approximately 15 people in the borough who are transgender. The transgender community is a particularly vulnerable group. The lack of knowledge and stigma amongst healthcare professionals, the lack of available medical information and the high incidence of hate crimes in the borough is an ongoing concern for some residents. A lack of data about this community means there is little to no evidence available about their health needs and whether they are disproportionately impacted by changes in local services. A review of equality data collection is required to collate information that supports the consideration of how services can be shaped to best meet their health needs.
Commentary: Impact on Ethnicity

Information from services

Equality data for both walk-in centres is collected for ethnicity but is currently not monitored and therefore the outcomes not referenced here.

The more recent LINKs patient survey of the walk-in centres shows Asian groups collectively the highest attendees at the Upney Lane Walk-in centre after the majority white British group. Black African groups appear as the next largest attendees after the majority white British group at the Broad Street Walk-in centre in the same LINKs patient survey. The equality profile of attendees as identified in the LINKs patient survey at each of the walk-in centres broadly reflects the local population in and around the respective walk-in centres and would suggest that those attending are people living in the local vicinity.

EQIA engagement activities

Although some Asian communities are well established in Barking and Dagenham language barriers still remain for those whom English is not their first language and for some west African nationals they report difficulty in being understood despite a good grasp of spoken English.

EQIA consultations with both groups indicated that they have difficulty expressing themselves to some GPs particularly if it is not their regular GP. Some indicated that this had been some of the reason why they had used the walk-in centre as, for one resident, their problem had escalated whilst they had waited sometime for a free appointment with their regular GPs. Some had indicated that some GPs did not allow them sufficient time to express their issue and that in fact in one case an older west African woman spoke of being hurried out of the surgery because the GP was running late. She later attended and received treatment at the Broad Street Walk-in centre having been taken there the following day by her grandson.

Consultations with Rwandan, Kosovan, Albanian, Turkish and Kurdish women’s groups through the Race Equality Council indicated their support for both walk-in centres. Many felt more confident navigating services they were familiar with in their local area having taken some time to establish a mechanism for doing so and that travelling outside the area for those who required an interpreter or struggled with English was very difficult as they felt it would be difficult to obtain the local support they currently received attending appointments from friends, family and community members. It was felt that urgent care provision therefore needed to be made in each local area as a 3 miles difference meant many would feel less confident travelling to alternative services. This was felt to be equally the case for the proposed increased use of telephone advice. Some welcomed the introduction and felt it may give them more time to talk through their concerns whilst others felt that it would exacerbate the language difficulties and would leave many frustrated.

Local voluntary sector groups indicate there are significant numbers of asylum seekers, refugees and undocumented migrants in the borough who use walk-in services. They report local people with no fixed address, often young people forced to leave a family home or relocating because of domestic abuse. Many struggle to register with GPs and when presenting at the local walk-in centres will often present as if they have a permanent residency when often they do not.

As noted above, some young people indicated they preferred the anonymity of their local walk-in centre as it could not be determined why they were seeking treatment. This is also
particularly relevant for some BME groups as they indicated that they were not always confident that patient confidentiality was maintained particularly where the GP surgery was part of their community.

The issue of anonymity for women to access services safely and privately outside of their communities is particularly relevant for some women from new BME communities entering the borough where there are imbalances of power within their family structures which restrict their rights to certain healthcare. In these instances small community organisations who try and support these women increasing speak of the need to use or refer women to the Walk-in Centres or A&E.

**General information**

The population profile in Barking and Dagenham has changed considerably over the last ten years with a notable increase in younger BME communities moving into the area. Data from the LBBD community mapping (2011) indicates that the increase in ethnic diversity is predicted to continue.

The borough has historically experienced a relatively high rate of migration from Indian and Pakistani nationals and this is apparent in wards in and around the Upney Walk-in centre. In more recently years, however, the trends have favoured a more significant increase in West African and Eastern European nationals moving into the area. These groups, Black African in particular, are well represented in the wards around the Broad Street Walk-in Centre.

A more informed understanding of the impact of the increase in European nationals into the area is difficult to determine within the broad dataset of White Other. A further subdivision of these groups will increasingly be required as the report from the LBBD Health and Social Care Needs Assessment of Eastern Europeans suggest that there is a level of distrust of some services and some groups such as the Roma community can struggle to register or retain their registration as often those that register are deregistered as they move sites.

It is important to note that ethnic data does not currently record gypsies and travellers and there are still issues of stigma associated with this group that can prevent self-identification. In addition this group continues to experience discrimination which can be a barrier to accessing primary care services through the appropriate route. Often travellers present to health services when the issue is ‘urgent’ or at the point of crisis. Traveller communities traditionally report more accessible, friendlier services at A&E or ‘drop-in’ (Walk-in services) with a more thorough examination often given reflective of the practitioner’s understanding of their health needs resulting from their traveller lifestyle.

Previous experiences of ill-treatment at any services are quickly communicated throughout their community and families and whole traveller communities will avoid services through word of mouth. Lack of access to primary services can occur at registration stage with some administration and reception staff providing barriers often through misunderstandings. Some traveller communities have a strong gender divide and will not disclose their personal details or health concerns to a receptionist. A lack of understanding of the cultural context for traveller communities and the required protocols for NHS staff are often unresolved barriers at registration stage that continues to exclude traveller communities from accessing effective primary care.
Conclusion

The proposals to close Broad Street and improve urgent primary care could have both positive and negative impacts in relation to ethnicity. The work the CCG is doing to develop urgent primary care GP services around local communities or “localities” within Barking and Dagenham could potentially offer greater understanding of needs of BME communities if this was built into each locality model. There are opportunities to also address the specific issues that BME groups, as well as women and younger people face in this work.

Closing the Broad Street walk-in centre could have an adverse impact people living closest to the centre, given that there is a high proportion of black African groups living in wards surrounding the Broad Street walk-in Centre, this may impact on these groups as well as on the majority White British users of the service. However additional more extensive information about their preference and/or ability to travel to alternative centres or access their local GP is required to fully assess the potential for negative impacts and to identify mitigating actions.

The relatively anonymous nature of the service at the Walk-in centre, as perceived by some people, means that groups who wish to avoid contact with their family doctor for a range of reasons would potentially be disadvantaged by the proposed closure.

Marriage or Civil Partnership

Data is collected at both walk-in centres however a monitoring system is not currently in place. Some national reports, however, indicate that work is still required across all health professions for greater recognition and understanding of civil partnerships and rights between same sex couples.

Pregnancy or Maternity

Data is not collected for this protected characteristic for either walk-in centre. Consultation from the EQIA of the Health and Wellbeing strategy 2102-2015 highlighted the issue of lack of access to services for pregnant women from traveller communities. Walk-in centres potentially offer a point of entry for some flexible care for women from traveller communities who may not be registered with a GP. Currently there are limited services to address this issue. (see ethnicity section for additional adverse impacts experienced by traveller communities)

Religion or belief

Data is routinely collected by both walk-in centres but a monitoring system is not currently in place. Some religious groups may not be able to take advantage of some of proposed extended hours i.e. residents from the Jewish community who observe a holy day from Friday to Saturday. Walk-in centre opening times which include Sunday may be more accessible. However there was no evidence of this having an adverse impact on those communities for this reason in the borough from the consultation.

Sexual orientation

Data is not routinely collected for either walk-in centre. Walk-in centres could potentially provide a certain degree of anonymity for those in society that feel they experience persecution and isolation within their communities relating to their sexual orientation. This is increasingly reported by new communities who arrive from countries where same sex relationships are against the law.
Part 6: social and economic factors:

Could people be affected differently based on the following social and economic factors?

<table>
<thead>
<tr>
<th>Social/economic factor</th>
<th>Positive difference</th>
<th>Negative difference</th>
<th>No difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immigration status</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployed people</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed people</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carers</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Quality of housing</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rural location</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban location</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level or type of education</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

Commentary: Impact on Immigration

Information from services

EQIA engagement activities

UK immigrants can often experience difficulty registering with a GP over the widespread confusion of the difference between the primary care rules on eligibility and the secondary care rules on entitlement for overseas visitor.

GPs have complete discretion to register whomever they wish and can refuse to register on reasonable grounds as long as they don’t discriminate. Voluntary sector migrant groups report that some practices mistakenly ask for immigration status before they register some patients. It does not appear universally understood or implemented in practice that immigration status does not affect eligibility to primary care services and hence such checks not required.

Confusion can occur by both immigrants and general practice staff, with some immigrants not clear they can register with a GP. Some voluntary sector groups report increasing concern in relation to the impact of this on some Eastern European groups, in addition to other groups. These issues are particularly concerning for refugees and asylum seekers who may be extremely vulnerable.

Conclusion

Greater clarity is required not just for GPs but for their staff who inadvertently may present barriers to registration not just by refusing to register but also through the questions they ask. Training for all GPs and practice staff in addition to clearly displayed posters setting out registration eligibility particularly highlighting the principle of primary care access to all should be introduced.

Commentary: Impact on employed people
The EQIA consultation indicates that walk-in centres are favoured by working people who are unable to obtain appointments that fit in with their working life and/or who value the convenience and flexibility of the immediate and extended access of Walk-in centres.

Local people in the Dagenham expressed concern about the waiting time to access a GP appointment or delays in making appointments and indicated these as some of the reasons why they favoured the walk-in service. Many indicated that they worked in jobs that were longer hours than GP opening times and were often not autonomous in those roles to be able to influence their availability when trying to make appointments which made securing a GP appointment even harder or timely.

A number of young people expressed concern that even when they were able to secure appointments they often had difficulty obtaining appointments either side of the day and often had to take a day or half day off work or further education. One resident had indicated that although unemployed he was participating in an apprenticeship scheme and there was pressure to not take time off during his ‘working hours’ for a GP appointment as could compromise his benefits.

**Conclusion**
The availability of the extended hours and days currently available at both Walk-in Centres may benefit working people and fit in with their lifestyle particularly where working people work long extended hours.

**Commentary: Impact on Carers**

**EQIA engagement activities**

Carers require fast, accessible, flexible effective treatment either for themselves or the person they care for. Carers report that they can feel acknowledged as carers at Walk-in centres and partners in the cared for person’s care as often the walk-in centre practitioner will look to them, the carer, for additional health information and guidance.

Some carers indicated that they strongly supported increased ‘resources’ in GP surgeries to support single handed GPs as they felt this would alleviate the ‘pressure’ on those GPs and improve time required by carers of residents with complex needs. The early stage of the development locality model presents an opportunity to introduce an increased focus on carers and their health.

**General information**

At the time of the 2001 Census, there was a population of 162,713 people living in Barking and Dagenham. That census, for the first time, asked a question about the provision of help or support to family members, friends or neighbours with long term physical or mental ill-health or disability or problems relating to old age. Census data counted 15,899 carers in Barking and Dagenham, or about 1 in 10 of the total population. Building on the 2001 Census figures, Carers UK estimate that in 2011 there are 16,758 carers in Barking and Dagenham, and that the value of care they provide is £352 million[3]. These figures will continue to grow as the overall size of the population increases. A priority for the national strategy for carers is

---

Equality Impact Assessment – Walk-in centres in Barking and Dagenham

to support those with caring responsibilities to recognise themselves as carers. The importance of this is demonstrated by the fact that our partner voluntary organisations currently have only approximately 2,600 local carers registered for support and advice. This suggests that a potentially large number of carers are not known to the local authority or any carer support services.

Evaluation of the 2001 census data relating to carers in the borough shows most carers (96%) are adults. About half (8,229) were aged between 18 and 49, and 44% (7,047) were over the age of 50. More than 600 people under the age of 18 said they were carers. The 2001 Census identified that there were 623 (4% of carers) under 18 years of age who are carers in Barking and Dagenham. However in contrast 97 young carers aged under 18 received packages of funding in the borough in 2009/10. There may well be a substantial level of unmet need that may exist within the borough in respect of young carers.

The ethnic profile of the borough’s 2,662 registered carers shows that 60% are of white British or white Irish backgrounds, slightly lower than the 67% of the population from those backgrounds. However, the ethnic profile of the borough’s known carers overall roughly mirrors the ethnic profile of the borough, suggesting that carers of all different ethnicities are aware of the support available.

Of the 15,899 carers in the borough recorded by the 2001 census, more than half provided fewer than 19 hours of care a week:

- 9,356 (59%) stated that they provided up to 19 hours of care per week
- 2,136 (13%) provided care of between 20 and 49 hours per week and
- 4,397 (28%) provided weekly care totalling 50 hours or more\[4\]

**Conclusion**
The proposed changes could have both positive and negative impacts on carers.

**Impact on Level or Type of education**

Low levels of education have been associated with poor levels of health literacy, which are crucial for navigating health services. Barking and Dagenham has below average level of educational attainment and potentially low levels of health literacy. This may have a significant impact on some local people navigating the changes proposed and therefore successful implementation of the proposed model.

\[4\] Following the census results in the summer, an exercise will be completed to map the age breakdown with the hours of care activity data.
Part 7: Human Rights

Could your piece of work or delivery of your service have an impact on any of the following human rights?

<table>
<thead>
<tr>
<th>Human Right</th>
<th>Positive impact</th>
<th>Negative impact</th>
<th>No impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>The right not to be tortured or treated in an inhuman or degrading way</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>The Right to life</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>The Right to liberty</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>The Right to a fair trial</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>The Right to respect for private and family life, home and correspondence</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>The Right not to be discriminated against</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

Part 8: Mitigating Actions

This section lists the negative impacts that have been identified, assess whether these will be of high, medium or low impact and sets out the key actions required to mitigate against the negative impacts.
<table>
<thead>
<tr>
<th>Negative impact identified</th>
<th>High/Medium/Low impact</th>
<th>Mitigating actions</th>
<th>Lead body</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of system for monitoring equalities data within provision of services</td>
<td>High</td>
<td>Establish routine equality monitoring. Retrospective review of equality data collected for baseline analysis and to inform new specification for equality reporting within provider contracts. Commissioners to introduce monitoring protocol of equalities data based on statutory requirement and health inequalities identified. This should include a record of any barriers to monitoring or data collection on a risk register.</td>
<td>NHSE CCG</td>
</tr>
<tr>
<td>Data collection in place for some but not all equality areas in particular sexual orientation, disabilities and maternity.</td>
<td>Medium</td>
<td>Improve evidence and data collection across all equality areas. Through the use of Health Care Analytics, the Open Exeter patient list and practice based data. This can provide read codes for some of the gaps in data i.e. learning disability, maternity.</td>
<td>NHSE CCG</td>
</tr>
<tr>
<td>Diversity of groups 'hidden' within broad categories of data collected which do not provide a clear indication of the changing demographic. In particular further subdivisions of white other to reflect increase in European populations, gypsy and traveller communities, transient and migrant communities and those with no registered abode.</td>
<td>Medium</td>
<td>Improve data quality. Through commissioning requirement for data quality, accuracy and completeness. Including in contract specifications further subdivisions within main ethnic groups and inclusion of gypsy &amp; traveller.</td>
<td>NHSE CCG</td>
</tr>
<tr>
<td>Lack of data available to consider needs across the broad disability spectrum i.e. for people with sensory impairments in addition to people with physical disabilities, particularly with proposal for telephone triage. Opportunity to extend specification to include dementia, mental health,</td>
<td>Medium</td>
<td>Improve monitoring of equality data by the inclusion of subdivision of disability groups as well as for dementia, mental health service users, carers and those with HIV with some facilitate to collate data on complex and multiple disabilities and people with drug and alcohol problems.</td>
<td>NHSE CCG</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>HIV and carers all of which are increasingly featured in JSNA data.</td>
<td>Poor engagement from under represented groups. Need for ongoing patient scrutiny of urgent care patient satisfaction data broken down across the equality characteristics.</td>
<td>High</td>
<td>Engagement &amp; involvement Role for HealthWatch to work with CCG engagement team to co ordinate efforts to encourage membership to local patient engagement forum targeting under represented groups to address gap in broader community representation.</td>
</tr>
<tr>
<td>Gaps in quantitative equality data. Need to supplement with qualitative information from under represented groups as identified above.</td>
<td>High</td>
<td>See above</td>
<td></td>
</tr>
<tr>
<td>Lack of data monitoring impact on Gp services with change in demographic and increase in numbers from particular groups.</td>
<td>High</td>
<td>Analysis of equality profile of patient lists in practices in relation to local ward profile and regular monitoring and reporting of trends, working with representative patient groups to interpret data and recommend actions.</td>
<td></td>
</tr>
<tr>
<td>Patient involvement and co design of services happening but greater diversity and more active patient involvement required. Process required to happening at community level to better engage wider population in the changes.</td>
<td>High</td>
<td>Introduce Peer researchers. Local residents with personal experience of local services trained to carry out research for service improvement, used to review services within Locality model. Reaching into communities to interview, explore issues, research experiences of primary and urgent care services, which could be fed into redesign of locality model. Supports co production model and engagement of local people in service redesign. (could potentially recruit from Patient forum groups/Healthwatch?)</td>
<td></td>
</tr>
<tr>
<td>Differential experiences of satisfaction with primary care services by different groups</td>
<td>High</td>
<td>Monitor levels of patient complaints of primary care services and assess against equality characteristics. Feed into review of Locality model.</td>
<td></td>
</tr>
<tr>
<td>Poor levels of health literacy of the borough.</td>
<td>High</td>
<td>Joint working required between CCG and LBBD public health team to collaborate across agendas. Link to Public Health Community Health Champions programme.</td>
<td></td>
</tr>
<tr>
<td>Lack of awareness of GP choice among some groups</td>
<td>Medium</td>
<td>Partnership work with local CVS, Healthwatch and practice engagement leads working with residents to develop</td>
<td></td>
</tr>
</tbody>
</table>
and distribute appropriate literature which explores the choices available to residents.

| Barriers to GP registration for local residents | High | Practices to be offered training setting out the barriers to registration to include legislative requirements, immigration status and perceptions by local residents. Training to be co designed and potentially delivered with local residents from groups identified within the EQIA | NHSE CCG |
| GP access and capacity issues significant barrier to locality model | High | Joint working required across teams within LBBBD public health team, CCG and NHSE | CCG NHSE LBBBD |
Part 9: General Recommendations:

The consultation through the EQIA process has highlighted a number of opportunities to improve primary care services to local residents in addition to the specific service recommendations outlined above. These recommendations will also help to maximise the potential positive impacts of the proposals identified during this analysis.

The 5 general recommendations are listed below for consideration:

1. **A cross-agency, borough wide strategy to raise health literacy:**
   A longer term approach is required to develop community relationships and an ongoing dialogue and interest in health. Involve’s *‘Not another consultation: Making consultations fun and informal’* publication encourages a more informal approach to consultations and community engagement in support of increasing understanding of key health messages. A greater community feel could be generated around the health agenda by hosting a number of informal activity based events where conversation could take place during ‘socials’ such as ‘cook and talk’ events. Opportunities should also be identified to use existing borough and local events to convey and reiterate key simple messages about health and services to progressively raise the level of health literacy throughout the borough. Commissioners could seek to monitor the level of health literacy through provider contracts. The wider responsibilities for health across the local authority, providers and commissioners would require cross-agency work to respond to this recommendation and additional resources and capacity to engage would be required.

2. **Community participation in future community engagement and communication strategies:**
   The wider challenge of raising the level of health literacy and general awareness of health and health services in the borough would suggest that future communication strategies require greater coordination, community participation and creativity in both their design and the implementation. Engagement teams could work with different community groups representing different parts of the community to breakdown the key messages to be communicated about future proposals and work with them to coordinate a community wide strategy for identifying and engaging key groups i.e. small community groups, faith establishments, local businesses etc. As for the first recommendation this would require cross-agency commitment and dedicated resources.

3. **Engagement of young people**
   Specific work to incorporate, as part of structured programme of young people’s services, engagement of young people in the health, encouraging local citizenship and involvement by developing such roles as ‘peer’ educators.

4. **Telephone services**
   A small scale assessment of the impact of the use of telephone services for the provision and support of primary care services.

---

9 Not another consultation! Making community engagement informal and fun. Involve as part of Local Government and Improvement Development  
5. **Community groups**
   Work with community groups to improve the signposting and explanation of types of different health services available

### Part 10 Checklist and sign-off

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive impact identified</td>
<td>yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative impact identified</td>
<td>yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultation/engagement or research taken place</td>
<td>Yes consultation taken place as described as well as desktop EQIA exercise</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comments received from Equality lead</td>
<td>Incorporated into EQIA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EIA signed off by Senior Manager</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date submitted for publication</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Equality analysis – Walk-in centres in Barking and Dagenham
Appendix A: Equality analysis guidance

Introduction

Public sector organisations have a legal duty to promote equality and have respect for equality and human rights by treating people with dignity and respect. This applies to how services are commissioned, implementation of policies and duties as an employer.

Equality analyses can help demonstrate different needs are taken into account in planning and delivery of services and implementation of policies. They are a method of ensuring services are inclusive and of equal benefit to different groups.

An equality analysis is required when:

- developing a new piece of work
- amending or reviewing an existing piece of work
- commissioning a new service
- reviewing delivery of a new service.

The intended outcome is to maximise the positive and minimise the negative impact for all groups.

This guidance provides information on each part of the equality analyses template.

Part 1: contact details

Provide details about who is leading on the piece of work and all people that will contribute to the equality analysis. Wherever possible, have at least two people working on the equality analysis; this will help bring a wider perspective and knowledge.

Part 2: about the piece of work

Provide information about the piece of work or service being assessed. Think about:

- **Is it a new or existing piece of work or service**: equality analyses should be completed at the beginning of a piece of work. This will help ensure all groups benefit equally. If an equality analysis is completed after a piece of work is in progress, it may be difficult to make changes, and could lead to some people being excluded.

- **The final product or intended outcome**: For example, a final product could be to publish a report or leaflet; an outcome could be to publish and implement a new policy or to introduce a new service.

- **Benefits of the piece of work**: Think about what improvements will be made as a result of your piece of work being completed. Stating the intended benefits will help focus on what you are doing, why it is being done, and who it is being done for. Some benefits may happen quickly, whereas others may become apparent over a period of time.

- **The target audience**: this could be a variety of audiences or a limited group, but you should state all groups that may have even a passing interest. For example, a consultation regarding service change may impact healthcare providers, community and...
voluntary organisations, members of staff and the general public. An organisational policy, would be aimed at staff, but may also attract interest from unions, or staff networks. Some services may be aimed at a specific group and others will be available to anyone.

- **Promoting the piece of work to the target audience:** This is really about communication, for example publishing a report or policy; sending an email bulletin; designing a leaflet for patients; producing an information pack; sending out letters; or a radio or poster advertising campaigns. Thinking about these questions will influence how your piece of work is designed and delivered, including the tone of language and type of images used.

### Part 2a: services

If you are assessing a **new or existing service** you will have to complete Part 2a. This gathers information on:

- where the service is delivered
- processes for referring and assessing service users
- diversity monitoring information

This will help identify unintentional barriers to the service among different groups and help identify good practice.

### Part 3: existing knowledge

This will gather information on any existing inequalities relating to this area. This could be evidence or research completed by external organisations or internally. A useful starting point could be Annual Public Health Reports, Commissioning Strategic Plans or JSNAs which should provide information on priorities specific to your borough and recent local population data.

For internal policies, you could access information on NHS Annual Staff Survey; internal staff surveys and HR employment monitoring data.

For services, research or evidence regarding access to, satisfaction with, or uptake of the same or similar a similar services could be useful.

### Part 4: consultation and engagement

Involving the target audience is an important part of delivering high quality services. This will help ensure their views have been heard and wherever possible, can be taken into account. If any consultation or engagement activities have taken place, the details should be completed.

If no consultation or engagement has taken place, you should start to think about whether some activities should be planned. This could be workshops, focus groups, consultation events, panel meetings or any other method used to gather the views of people in your target audience.

If there is no information for Parts 3 or 4 it will be difficult to complete the remainder of the form. You should at this stage, either conduct some research, such as internet searches,
Part 5: assessing impact on protected characteristics

In considering diversity, we are legally required to consider the following characteristics: age, disability, gender, gender reassignment, ethnic background, marriage or civil partnership, pregnancy or maternity, religion or belief and sexual orientation. These are referred to as protected characteristics.

The same piece of work may affect people differently. Individuals have different language needs, may have physical or mental health impairments; have different needs, perceptions and experiences based on their sex, age, religion or belief or sexual orientation.

Considering diversity involves thinking about the range of different characteristics that may affect or influence individual experiences and, whether their characteristics may contribute to them having a different experience. Dual characteristics are where the specific needs of an individual are affected by more than one protected characteristic; for example a black older person may have specific needs relating to their ethnicity and their age.

Differences may be positive or negative; the same piece of work could have elements of both. If a difference unintentionally excludes a group it will be considered negative.

For example, publishing a report and not having arrangements in place to provide it in alternative languages or formats would be negative impact on some ethnic groups and on some disabled people.

Arranging a meeting and making sure there is an equal mix of vegetarian and non-vegetarian food would have positive impact on people from some religious groups or, individuals that may have a particular belief.

Services that target specific group e.g. children’s services, will not automatically be seen as discriminating against adults. However, a children’s service would still have to demonstrate it is equally accessible to, for example, disabled children; children from different ethnic groups and children in different age groups.

Think about whether the differences you have identified are positive or negative.

This should be based on whether a diverse selection of your target audience has equal opportunity to gain access, gain information or, participate.

Part 6: assessing impact on social and economic factors

Health and the ability to access services are often affected and influenced by a combination of different social and economic factors, which individuals may experience from childhood and may be beyond their individual control.
Think about whether the piece of work or delivery of the service may impact people differently based on their lifestyle, environment or level of income. For example:

- Lower income families, regardless of ethnic background, generally experience poorer health.
- Refugees or asylum seekers, people from travelling communities and homeless people, will have specific health care needs, but lack of permanence or stability will impact their ability or opportunity to benefit from services.
- Poor quality housing, unstable education or unemployment can also affect an individual’s immediate and long term health and how they engage with health care providers.
- People with caring responsibilities have unique needs. They may require additional support, if they want to access services for themselves or their dependant. They may put the needs of their dependant first. They may also need access to specific services such as specialist support groups or support services to help cope with stress.

Think about whether the design, delivery and communication of the piece of work take these wider social factors into account. People that experience social disadvantage are often referred to as ‘hard to reach’. However, they are often excluded because specific consideration is not given to different circumstances.

For example, providing a drop-in health centre could have a positive impact on people without a permanent address that are unable to register with a GP. A proposal to implement a computerised self-book appointment system may exclude people on low incomes or unemployed people as they may find it difficult to access a computer. Providing information on healthy lifestyles in a long complicated report may exclude people with low levels of literacy.

Ignoring social factors will reinforce existing difficulties and have a negative impact. Considering the impact of social factors will have a positive impact.

### Part 7: assessing impact on human rights

Human Rights apply to all people regardless of whether individuals are identified with, or consider they belong to, any of the groups protected by equality legislation. Human Rights are underpinned by the principles referred to as FREDA. This means we should all be treated with fairness, respect, equality, dignity, autonomy.

In considering human rights impact, think about where and how the service is delivered and whether it impacts an individual’s privacy, dignity or respect. Human rights should be balanced. One person having the benefit of their human rights should not limit or prevent another person having theirs.

Assessing the human rights impact has important implications for healthcare and employment. For example:
Organising an MMR vaccination programme, would impact the right to autonomy (choosing whether or not to use the service); but it would also have to be balanced against the rights of protecting other individuals in wider society. This will influence how the benefits of the vaccination programme are targeted and promoted.

The right to respect for family life could be applicable in a clinic or hospital setting, and also in an employment setting in relation to flexible working practices. Think about whether your piece of work takes the needs of individual circumstances into account. Does your service give equal consideration to different types of family structures, including people in same-sex relationships?

The right to life could be applicable to decisions made about the availability of drugs or other medical treatment or procedures. Think about whether processes for commissioning and decision making are transparent. Are specific criteria involved, does it apply equally to all people eligible to use your service?

**Part 8: rating negative impact**

Negative impact is an action or process that may exclude some of the target audience or prevents different groups from having equal access or benefits from a service and may be intentional or unintentional.

If negative impact has been identified, actions will have to be put in place to address this. If it is not possible to remove the negative impact, you will have to state why. You should list the details of the negative impact, including the groups/areas affected on the form.

You are asked to rate negative impact as High; Medium or Low. Rating negative impact will help prioritise implementation of actions.

The following prompts will help decide on the rating:

**High:**
- Individuals from at least one group will be disadvantaged or excluded unless immediate changes are implemented.
- Organisation would find it difficult to defend a claim of discrimination
- Organisation would find it difficult to demonstrate any steps have been taken to comply with equality legislation

**Medium**
- Individuals from at least one group will be disadvantaged or excluded but this can be rectified if new policies or processes are implemented or amended within, for example, 6 – 12 months
- Organisation would be at risk of claims of discrimination or, at risk of breaching equality legislation unless actions can be identified and implemented.

**Low**
- Possible negative impact on a specific group or individual, which can be dealt with on a case by case basis
- Organisation meets legal duties but recognises improvements could be made
If negative impact has been identified actions will have to be put in place to remove or lessen it; some impacts may be more complicated than others to address.

In some circumstances, it may be possible to completely remove negative impact, and in others it may only be possible to lessen, rather than completely remove the negative impact.

For example, an action to provide documents in alternative languages and formats, would remove negative impact on some groups of disabled people; people from different ethnic groups and people with poor literacy.

A more complicated action would be one required to improve attendance rates among, for example, gay women for cervical screening appointments. Addressing this may require detailed analysis of systems and processes, as well as engaging with the specific groups. However, if the impact has been identified, we have a legal duty to take action to make improvements.

As well as identifying what has to be done, you will also have to specify who will lead on it and when it will be done.

Arrangements to review or monitor the effectiveness of actions are also required. This helps ensure the actions have the intended outcome to either completely remove or lessen negative impact.

If you have identified negative impact you will have to complete the rest of the form. If no negative impact has been identified go straight to Part 10.

**Part 10: checklist and sign-off for publication**

This is the final part of the form. It summarises the outcome of the equality analysis and indicates whether any further action will be taken. It is also a method of ensuring all relevant people have been involved. Once the form has been completed it should be published on the CCG website.
Appendix B: Evidence sources

- B&D CCG Walk-in Centres in Barking and Dagenham: A consultation on proposals
  February 2013
- B&D CCG Desk top EQIA Review of Walk-in Services based in Barking and
  Dagenham January 2013
- B&D CCG Urgent Care: The Case for Change
- LBBD EIA JSNA 2012
- LBBD Community Mapping 2011
- Patient Survey of Walk-in Services: Report by Barking and Dagenham Links
  December 2012
- Walk-in centres in Barking and Dagenham: A Patient Audit January 2013
- ‘A response from the Public’: HealthWatch Barking and Dagenham May 2013
- Health and Social Care LGBT Needs Assessment 2009 for LBBD and NHS B&D
- LBBD Health and Social Care Needs of Eastern Europeans
- Experian Mosaic customer profiling information
- National Commissioning Board (NCB) Information packs at CCG level
- CQC national health survey
- American Medical Association report Health Literacy and Patient Safety
  Bristol; 2002 Jul [cited 2003 Mar 12]. Available from: URL:
- Involve’s ‘Not another consultation: Making consultations fun and informal
- B&D JSNA 2013