

Monitor

Making the health sector
work for patients

Walk-in centre review: final report and recommendations



About Monitor

Monitor is the sector regulator for health services in England. Our job is to protect and promote the interests of patients by ensuring that the whole sector works for their benefit.

For example, we make sure foundation hospitals, ambulance trusts and mental health and community care organisations are well led and are run efficiently, so they can continue delivering good quality services for patients in the future. To do this, we work particularly closely with the Care Quality Commission, the quality and safety regulator. When it establishes that a foundation trust is failing to provide good quality care, we take remedial action to ensure the problem is fixed.

We also set prices for NHS-funded services, tackle anti-competitive practices that are against the interests of patients, help commissioners ensure essential local services continue if providers get into serious difficulty, and enable better integration of care so services are less fragmented and easier to access.

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Contents

Executive summary	4
1. Introduction	10
1.1. What are walk-in centres?	10
1.2. Why did Monitor review walk-in centres?	10
1.3. Our key pieces of research	11
1.4. Topics covered in this report	12
2. Walk-in centres were introduced to improve access to primary care, 13 modernise the NHS, and offer patients more choice	
2.1. 1999-2004: Nurse-led walk-in centres	14
2.2. 2005-2007: Commuter walk-in centres	15
2.3. 2007-2010: The Next Stage Review and the emergence of GP-led health centres	16
3. Since 2010, policy objectives have evolved to focus on improving access to 24/7 care and better managing demand	19
4. Walk-in centres today: service features vary by locality	21
4.1. Numbers and locations of walk-in centres in England	21
4.2. Overview of services provided	26
4.3. Alternative service options to walk-in centres	28
4.4. Providers of walk-in centres	31
4.5. Links and relationships with other providers	33
4.6. Pricing for walk-in centre services	35
5. Demand for walk-in centres is strong	39
5.1. Who uses walk-in centres?	39
5.2. Numbers of walk-in attendances	40
5.3. Registration with GP-led health centres	42
6. There is a trend to close walk-in centres	45
7. Analysis and findings	51
7.1. In some cases, walk-in centre closures may adversely affect patients' access to primary care for some patients	51
7.2. The split in commissioning responsibilities for walk-in centres is causing confusion and could lead to decisions that do not take a system-wide view of the potential impact of changes to walk-in centre provision	59

7.3. Walk-in centres would work better for patients if payment mechanisms are reformed	63
8. Factors for commissioners to consider when deciding whether to continue to procure walk-in centre services	67
8.1. Assessing patients' needs	68
8.2. Choosing a service model and provider	70
8.3. Improving services by providing them in a more integrated way	73
8.4. Managing conflicts of interest	74
8.5. Acting transparently	76
9. Our recommendations	78
10. Long-term work to make services work better for patients	83
Annex 1: Alternatives to walk-in centres	86
Annex 2: List of current walk-in centres	95
Annex 3: List of closed walk-in centres	106

Executive summary

In the decade from 2000-2010, the NHS opened more than 230 walk-in centres across England. The aim was to improve patients' access to primary care, modernise the NHS to be more responsive to patients' busy lifestyles, and offer patients more choice.

The centres delivered primary care differently from the traditional way in which general practitioners (GPs) provide primary care services to patients who register with their practice. The walk-in centres allowed patients to access care from a GP or a nurse with no need to register or to pre-book an appointment. The centres were open for longer hours than the typical GP practice, including after normal working hours and on weekends.

Walk-in centres proved to be popular with the public. Attendances at many centres have exceeded expected levels.

However, from the start, the centres have stirred debate. Proponents say that walk-in centres are important in providing easy access to primary care, particularly when some patients have difficulties getting timely or convenient appointments with a GP practice or accessing primary care more generally. Others believe that walk-in centres create demand for care for self-limiting, minor conditions. They say that the resources used to provide walk-in centres would be better spent on other priorities.

Since the start of 2010, local commissioners have closed more than 50 walk-in centres across England. About one-third of these closures were part of service reconfigurations that replaced a walk-in centre with an urgent care centre co-located with an A&E department or with primary care staff within an A&E department.

In many localities where walk-in centres still operate, commissioners are reviewing contractual arrangements and are considering closing the centres or making changes to services or locations.

Following reports of walk-in centre closures, Monitor decided to review the provision of walk-in centre services in England. As the sector regulator for health services in England, our primary duty is to protect and promote the interests of patients. We aim to enable providers and commissioners of NHS-funded care to deliver the best possible outcomes for patients today and tomorrow by creating the right incentives, providing information they need, and enforcing rules where necessary. The questions about walk-in centres that we sought to understand are:

- Why are walk-in centres closing?
- What is the potential impact of closures on patients?
- Are commissioning arrangements and practices related to walk-in centres working in patients' interests?

- Are the payment mechanisms for walk-in centres and GP services generating benefits for patients?

How we conducted our review

In May 2013, Monitor launched this review with a call for submissions seeking information and views about walk-in centre provision in England. We received 65 responses from patients, walk-in centre providers, GPs, commissioners and other stakeholders in the sector. In addition to the call for submissions, we undertook a broad range of research, including a survey of almost 2,000 patients using 20 walk-in centres across England. We also gathered evidence from walk-in centre providers and commissioning bodies and spoke to more than 25 stakeholders about their experiences and views of walk-in centres.

In November 2013, we published a preliminary report setting out our initial findings and the results of our patient survey. In our preliminary report, we invited stakeholders to respond to a number of specific questions related to our findings and to submit any additional information and views about walk-in centre provision. We received 36 responses, and we gathered more feedback from stakeholders, which we took into account in preparing this final report. The submissions are published on our website.¹

This document represents the final stage of our walk-in centre review. The factual background and key findings are largely unchanged from the preliminary report. We have noted where we have made changes or additions based on stakeholders' responses to our preliminary report. Also in this final report, we have:

- updated the section describing the factors for commissioners to consider when deciding whether to continue to procure walk-in centre services with examples of best practice and links to relevant guidance (Section 8);
- added our recommendations for commissioners that aim to address, in the short-term, some of the findings of our review (Section 9); and
- highlighted the long-term work going on in the sector that is also likely to address some of the findings of our review, emphasising the need for this work to be well co-ordinated (Section 10).

Our findings

We found that the provision of walk-in centre services varies greatly by location. The range of services on offer, the settings where the centres are located, the skill mix of clinicians, opening hours, the degree to which they are integrated with other

¹ <http://www.monitor.gov.uk/WIC>

providers, the types of patients attending – all of these factors can vary from centre to centre, reflecting local health economies and populations. Likewise, the reasons for a particular closure and its impact on patients largely depend on local circumstances.

Despite the variation, our review revealed some common themes in the key areas that we examined.

As to why walk-in centres are closing, commissioners who have closed centres often cited concerns that the centres were generating unwarranted demand for services; that they led to duplication because some patients used them in addition to other services for the same problems; and that they caused confusion among patients about where to go for care. Commissioners also commonly said they felt they were “paying twice” for patients who attend walk-in centres. This was because most patients attending a walk-in centre are registered with a GP practice elsewhere that is already being paid to provide their primary care under the current list-based remuneration mechanism for primary care.

We also identified some common issues in the other key areas that we explored: the potential impact on patients of walk-in centre closures; whether commissioning practices are working in patients’ interests; and whether payment mechanisms for walk-in centres and GP services are generating benefits for patients. Our examination of these areas has led us to the following findings:

- **In some cases, walk-in centre closures may adversely affect patients’ access to primary care for some patients**

Our research indicates that closures may adversely affect some patients by:

- making it more difficult for them to access primary care services where there are problems with access to local GP practices; and
- limiting the ability of primary care to reach particular groups of people who find it difficult to engage with the traditional model of GP services or whose uptake and interaction with primary care has traditionally been poor.

- **The division of commissioning responsibilities for walk-in centres is causing confusion and could lead to decisions that do not take a system-wide view of the potential impact of changes to walk-in centre provision**

Walk-in centres play a role in both primary and urgent care provision. The split in commissioning responsibilities between NHS England and clinical commissioning groups (CCGs), with NHS England broadly responsible for primary care and CCGs for urgent care, has led to confusion about which commissioning body is chiefly responsible for overseeing walk-in centre provision. This is particularly true where a walk-in centre offers both a

registered-list GP practice and walk-in services for non-registered patients. The absence of clarity can lead to some drawbacks for patients, including a lack of clear accountability for decision-making and a lack of transparency as to which commissioners are making key decisions. In addition, the split in responsibilities has created a risk that commissioners' decisions about walk-in centres do not take a local system-wide view of patients' needs and the potential impact of changes to walk-in centre services across primary and secondary care services in the local health system.

- **Walk-in centres would work better for patients if payment mechanisms were reformed**

Current payment mechanisms for GP practices and walk-in centres discourage commissioners from offering walk-in centres, even where these may represent a high quality, cost-effective model for delivering services. In addition, the payment mechanisms do not strengthen incentives for GP practices to improve the quality and efficiency of their services so that their patients are more likely to choose the GP's services rather than a walk-in centre.

Increasing demand for services and finite resources create significant challenges for the NHS. In taking decisions about whether to continue to procure walk-in centre services, commissioners will want to assess the benefits of walk-in centres and of other models of care in areas including ease of access, quality of care, efficiency and affordability. It is for local commissioners to decide what is best for patients in their areas, having engaged with relevant stakeholders, including people in their communities.

Factors for commissioners to consider when deciding whether to continue to procure walk-in centre services

Taking the challenges described above into account, and recognising commissioners' independence, in Section 8 of this report we set out some factors for commissioners to consider when deciding whether to continue to procure walk-in centre services. We have highlighted those factors that are most likely to be relevant to commissioners making decisions about walk-in centres, including:

- assessing patients' needs in the local area and understanding what role the walk-in centre may play in meeting them;
- deciding what services to procure and from whom when a contract for a walk-in centre is due to expire;
- considering whether services can be delivered in a more integrated way;
- managing conflicts of interest; and

- ensuring transparency in decision making.

We have also included some relevant examples of best practice and links to further resources for commissioners. Assessing walk-in centres in this way should ensure that local patients' needs are met as well as they can be.

Recommendations and future work

While Section 8 describes the factors commissioners will need to consider when deciding whether to continue to procure walk-in centre services generally, Section 9 sets out recommendations for commissioners to address some of the specific findings of our review. We recommend that:

- commissioners take steps now to clarify and bring transparency to commissioning responsibilities by publishing certain information about the contracts for each walk-in centre in their area, including which commissioning bodies are managing them and which are responsible for decisions about whether to continue to procure them;
- NHS England and CCGs work together to make decisions about walk-in centres, both with and without a registered list, to ensure that they take into account the effect on patients across primary and secondary care of any changes in services;
- local Healthwatch organisations and health and wellbeing boards should play a role in the decision process;
- commissioners work with any GP practices that have a high number of their patients using a walk-in centre to identify and correct any access or other problems; and
- commissioners follow up their decisions related to walk-in centres with a review to ensure that any changes are working in patients' interests.

Our recommendations aim to support commissioners' decision-making processes related to walk-in centres in the short-term. However, long-term solutions are needed to address the difficulties that some patients have in accessing primary care, and the difficulties some GP practices have in responding to increasing demand. Likewise, it will be necessary to ensure that the division in responsibilities for commissioning is working in patients' interests across NHS services and that payment mechanisms are creating the right incentives to benefit patients.

In Section 10, we describe some of the work currently taking place across the sector that is likely to address these issues in the long-term, including:

- NHS England, the commissioner of primary medical services and specialist services, is leading the development of a strategic framework to strengthen primary care.
- NHS England also has set out its vision for urgent care, which features an enhanced NHS 111 service to help people get the right advice or service to meet their needs. It also envisions providing a more standardised, less confusing, offer of urgent care services outside of hospital so that people without emergency needs will no longer seek treatment at A&E departments.
- In addition to supporting NHS England in its work to improve general practice and urgent care, Monitor has proposed doing further research into demand for and supply of GP services to gain a better understanding of the variations in access and quality across England and how these may be addressed.

It is important that all of the organisations working to promote change – NHS England, Monitor, the Department of Health, the Care Quality Commission, and others – co-ordinate their work so that NHS services, including walk-in centres, work better for patients.

1. Introduction

1.1. What are walk-in centres?

There is no standard definition of an NHS walk-in centre.² We define an NHS walk-in centre as a site that provides routine and urgent primary care for minor ailments and injuries with no requirement for patients to pre-book an appointment or to be registered at the centre or with any GP practice.

Our definition includes “GP-led health centres”. These treat minor illness and injury with no requirement for patients to pre-book an appointment or be registered at the centre, but which also offer patients the option to register with the GP practice at the centre if they wish. We describe the different types of walk-in centres that fall within our definition in more detail in Section 2.

While all walk-in centres provide basic advice and treatment for minor conditions, the full range of services on offer vary greatly by location. In Section 4, we discuss in more detail the services that walk-in centres provide and alternatives for those services that may be available to patients.

1.2. Why did Monitor review walk-in centres?

Our decision to review walk-in centre provision was grounded in our main duty as health care sector regulator: to protect and promote the interests of patients by promoting the provision of health care services that is effective, efficient and economic and that maintains and improves the quality of services.

We have a range of functions to enable us to carry out our duty. This review was based on our functions of ensuring that the commissioning of services, choice and competition are working in the best interests of patients.³

² For purposes of setting out commissioning responsibilities, regulations define a walk-in centre as “a centre at which information and treatment for minor conditions is provided to the public under arrangement made by a relevant body.” National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012.

³ To carry out these functions, Monitor has the power to: enforce the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013; enforce the provider licence; enforce provisions of the Competition Act 1998; make market investigation references to the Competition Commission; review mergers between NHS trusts; and provide advice on merger benefits to the Office of Fair Trading for mergers involving foundation trusts. From April 2014, the functions of the Competition Commission and the Office of Fair Trading will transfer to the Competition & Markets Authority.

We launched this review, following reports of walk-in centre closures, to understand the nature of walk-in centre provision in England⁴ as well as to understand:

- Why are walk-in centres closing?
- What is the potential impact of closures on patients?
- Are commissioning arrangements and practices related to walk-in centres working in patients' interests?
- Are the payment mechanisms for walk-in centres and GP services generating benefits for patients?

Some issues related to walk-in centre provision fell outside the scope of our review. We did not investigate, for example, how the quality of care at walk-in centres compares to other primary care services. We also did not assess the underlying costs of providing care in walk-in centres compared to the costs in other settings.⁵ Commissioners are best placed to consider these issues locally when evaluating which models of care are best to meet the needs of their patients.

Further, some of the issues we identified in our review of walk-in centres relate more broadly to the provision of GP services. We published a discussion document in February 2014 summarising the issues raised in our call for evidence on GP services, which set out to understand how well arrangements for commissioning and providing GP services are working for patients. The document also proposes further work by Monitor in this area.⁶

1.3. Our key pieces of research

- **Call for submissions:** we issued a call for submissions and received 65 responses from service users, commissioners, walk-in centre providers (both independent and public), GPs, nurses, and several local and national organisations. We also invited stakeholders to respond to our subsequent preliminary report, published in November 2013. We received 36 submissions, which are published on our website.⁷

⁴ See *Review by Monitor of the provision of walk-in centre services in England*, Scope of review, 31 May 2013, www.monitor.gov.uk/sites/default/files/publications/ToPublishReviewWalkinCentreServicesMay2013.pdf.

⁵ Comparing costs to deliver services in different settings is complex and subject to the reliability of underlying data. Monitor is working to improve costing as part of its role in setting prices for NHS-funded services. See www.monitor-nhsft.gov.uk/home/news-events-publications/our-publications/browse-category/guidance-health-care-providers-and-co-10.

⁶ Available at www.monitor.gov.uk/node/5942.

⁷ <http://www.monitor.gov.uk/WIC>

- **Patient survey:** to better understand who uses walk-in centres and why, we commissioned a survey of 1,886 patients at 20 centres across England. The patient survey report was published alongside the preliminary report.⁸
- **Stakeholder meetings:** we met with more than 25 stakeholders, including walk-in centre providers, commissioners, local health and wellbeing board members, Healthwatch representatives, local authority councillors, and academics who have studied walk-in centres.
- **Information and data from providers and commissioners:** in addition to gathering publicly available information, we sought information and data from walk-in centre providers and commissioning bodies.

1.4. Topics covered in this report

Section 2:	The history and policies behind walk-in centres
Section 3:	The policy context today
Section 4:	Overview of walk-in centre provision today: locations, services, providers, and pricing
Section 5:	Demand for walk-in centre services
Section 6:	Reasons for the trend to close walk-in centres
Section 7:	Our analysis and findings related to the key areas that we examined
Section 8:	Factors for commissioners to consider when deciding whether to continue to procure walk-in centre services
Section 9:	Our recommendations
Section 10:	Long-term work to make services work better for patients

⁸ See Accent, *Patients' use of walk-in centres*, Report, October 2013 [Monitor's patient survey report], available at www.monitor-nhsft.gov.uk/home/news-events-publications/our-publications/browse-category/guidance-health-care-providers-and-co-40.

2. Walk-in centres were introduced to improve access to primary care, modernise the NHS, and offer patients more choice

Between 2000 and 2010, the government launched initiatives to establish NHS walk-in centres throughout England as part of efforts to achieve three major health care policy goals:

1. Improving access to primary care

The government wanted to improve access to primary care because of concerns that people sometimes found it difficult to access health care quickly from general practice. The requirement to register with a GP practice close to home, in particular, was thought to present barriers to access for certain groups, including commuters, the homeless, tourists and travellers.⁹ Later in the decade, the Department of Health's public consultations raised concerns that:

*“many people are seeking the opportunity to access routine primary care from a GP in the evenings or at weekends. And a quarter of patients still report that they cannot book advance appointments at their GP practice. It is also significant that young working males and black and ethnic minority communities are more likely to report difficulties in accessing GP services.”*¹⁰

The walk-in centre model was introduced to lower the barriers to accessing primary care.

2. Modernising the NHS to make it more responsive to patients' lifestyles

The government wanted to modernise the NHS to meet the needs of people with busy schedules, such as parents and workers who have difficulty taking time off work to visit their GP.¹¹ Walk-in centres were to offer conveniently located services with extended hours including weekends, and fast access to an appointment. Many centres were expected to keep waiting-times to within 15-30 minutes for a triage assessment or a full consultation.¹²

⁹ C. Salisbury, M. Chalder, et al, [The National Evaluation of NHS Walk-in Centres](#), Final Report, July 2002, p.1.

¹⁰ Department of Health, [NHS Next Stage Review Interim report](#), October 2007, p.25.

¹¹ See press release, 1999/0226, [Up to £30 million to develop 20 NHS fast access walk-in centres](#), 13 April 1999.

¹² L. Mountford, R. Rosen, [NHS Walk-in Centres in London: An initial assessment](#), The King's Fund, 2001; Department of Health, [Contract for Primary Medical Care Services](#) [for use with health centres as per EAPMC criteria], 11 July 2008, Schedule 2, p.13, available at: http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Aboutus/Procurementandproposals/Procurement/ProcurementatPCTs/DH_086657.

3. Offering more choice to patients

The government has sought to expand choice in both primary and secondary care to give patients more control over their care and to strengthen incentives for providers to improve services in order to attract patients. Walk-in centres, particularly those introduced later in the decade, were intended to give people greater choice from a range of primary care services.¹³

While walk-in centres were established primarily to provide and improve access to primary care, our conversations with stakeholders and other evidence suggests that many in the sector view the main purpose of walk-in centres as reducing pressures on A&E departments.¹⁴

Most walk-in centres in England were established through the three national initiatives described below. The centres reflected local commissioners' decisions about where, how, and what services were to be provided.¹⁵

2.1. 1999-2004: Nurse-led walk-in centres

In April 1999, Prime Minister Tony Blair announced plans to establish a number of nurse-led walk-in centres that would provide information and treatment for minor conditions.¹⁶ Services were to be provided without the need for a pre-booked appointment for extended hours (typically 7am to 10pm), 365 days a year. The centres were to be sited in easily accessible locations, such as town centres or adjacent to A&E departments.¹⁷

An additional goal of the nurse-led centres was to maximise the role of nurses in primary care. Beginning with pilot sites, the Department of Health eventually established about 72 nurse-led walk-in centres throughout England.¹⁸ This included a final wave of centres established in 2004 that were mostly co-located with A&E departments as way to reduce pressure on A&E services.¹⁹ The centres had to be managed by an NHS body (such as an NHS trust) or GP co-operatives and were expected to build on, rather than duplicate, existing services, and to have links with

¹³ Department of Health, [NHS Next Stage Review: Our vision for primary and community care](#), June 2008, p.28.

¹⁴ See, eg, NHS Office of the Strategic Health Authorities, [Emergency Services Review, Good practice in delivering emergency care: a guide for local health communities](#), July 2009, p.13 (urgent care centres, walk-in centres, and minor injury units "are intended to provide alternatives to Emergency Department attendance").

¹⁵ In addition to walk-in centres that started as part of these national initiatives, our research suggests that there are a small proportion (we estimate less than 10% of all centres) that started as part of local initiatives or evolved from existing local services.

¹⁶ See press release, 1999/0226, [Up to £30 million to develop 20 NHS fast access walk-in centres](#), 13 April 1999.

¹⁷ NHS Executive, NHS Primary Care Walk-in Centres, *Health Service Circular*, 1999/116, 11 May 1999.

¹⁸ [The rise of the walk-in centre](#), *Nursing Times*, 18 August 2008. Other sources gave a slightly different number of nurse-led centres that opened as part of the national initiative.

¹⁹ Salisbury et al, *The impact of NHS walk-in centres on A&E services*, February 2006.

local GP practices.²⁰ Some centres had access to a GP for patients who needed one.²¹

GPs and other health professionals initially voiced concerns that the walk-in centres would adversely affect continuity of care or that the centres would increase demand.²² However, in later years, some GPs began referring their patients to the centres for services such as blood pressure checks and dressings.²³

Although walk-in centres were new to the NHS, minor injuries units had already been established in several towns in the UK to serve patients with urgent care needs on a walk-in basis. And walk-in centres were already operating in a number of other countries, including the US, Canada, Australia and South Africa.²⁴

2.2. 2005-2007: Commuter walk-in centres

Building on the policies behind the first walk-in centre initiative, the government established six GP-led walk-in centres between 2005 and 2007 aimed at commuters in London, Manchester, Leeds and Newcastle.²⁵

The commuter centres were introduced as part of the Independent Sector Treatment Centres programme launched in 2002. The programme sought to increase independent sector involvement in the NHS to increase capacity and reduce waiting-times as well as to offer patients greater choice of services to stimulate improvements in quality through competition.²⁶

At the time, walk-in centres were viewed as part of a broader vision for primary care, as set out in Table 1.

²⁰ NHS Executive, NHS Primary Care Walk-in Centres, *Health Service Circular*, 1999/116, 11 May 1999.

²¹ L. Mountford, R. Rosen, [NHS Walk-in Centres in London: An initial assessment](#), The King's Fund, 2001.

²² [A walk-in? Now you're talkin'](#), *Health Service Journal*, 4 May 2000.

²³ [The rise of the walk-in centre](#), *Nursing Times*, 18 August 2008.

²⁴ C. Salisbury, J. Munro, [Walk-in centres in primary care: a review of the international literature](#), *British Journal of General Practice*, January 2002; pp.53-59.

²⁵ Department of Health, [The NHS Improvement Plan: Putting People at the Heart of Public Services](#), June 2004, paragraph 5.8. The government pledged to open more so-called "commuter centres" in 2006, but these openings did not occur.

²⁶ Department of Health, *Independent Sector Treatment Centres*, Report to the Secretary of State for Health, 16 February 2006.

Table 1: The government's vision in 2004 for primary care

THE NHS IN 2000	THE NHS IN 2008
Patient has to make an appointment with a registered GP for advice, diagnosis and referral	Patient chooses whether to make an appointment with a GP or practice nurse, visit an NHS Walk-in Centre or Pharmacy Service Centre, or contact NHS Direct for advice and diagnosis
Patient may wait several days for an appointment with their GP	Patients see a primary care practitioner within 24 hours when they need to or a GP within 48 hours
GP makes decision about how, when and where patient is treated	Patient chooses how, when and where they are treated – from a range of providers funded by the NHS and accredited by the Healthcare Commission

Source: Department of Health, *The NHS Improvement Plan: Putting People at the Heart of Public Services*, June 2004, p.33.

The commuter centres were to be open from 7am to 7pm, 365 days a year and were to offer treatment for minor illness and injuries, prescriptions and pharmacy services, and other services such as physiotherapy and blood pressure checks.²⁷ Six centres were contracted from independent providers using five-year contracts at a total cost of about £9 million a year.²⁸ However, by December 2011, all six commuter centres had been closed upon contract expiration, mainly because they saw fewer than expected patients,²⁹ were poorly located, or were not thought to represent value for money.³⁰

2.3. 2007-2010: The Next Stage Review and the emergence of GP-led health centres

In October 2007, as part of his *Next Stage Review*, health minister Lord Darzi announced new investment to develop 150 GP-led health centres that offered both:

- a list-based GP practice at which patients could register if they chose; and
- a GP-led service open to any member of the public, including those registered at GP practices elsewhere or those not registered with any GP practice. The

²⁷ Department of Health, [New surgeries offer commuters fast-track to treatment](#), Press release, 4 November 2004.

²⁸ Bureau Investigates, [Get the data: Commuter walk-in centre closures](#), May 2011.

²⁹ www.ncbi.nlm.nih.gov/pubmed/2087525.

³⁰ <http://alternativeprimarycare.wordpress.com/2011/06/16/the-light-nhs-leeds-walk-in-centre-to-close/>.

service was to allow any member of the public to access GP services through pre-bookable appointments or walk-in appointments that did not require pre-booking.³¹

Under the Equitable Access to Primary Medical Care (EAPMC) programme, each Primary Care Trust (PCT) was expected to commission at least one GP-led health centre in their area.^{32,33}

The centres were to be open between 8am and 8pm, 7 days a week, and were to be situated in easily accessible locations. They were intended to be responsive to local needs and, to foster integrated care, they were to be co-located where possible with other community-based services such as diagnostic, therapeutic (for example, physiotherapy), pharmacy and social care services.³⁴

The GP-led health centres – commonly referred to as “Darzi centres” – were commissioned between 2008 and 2010. PCTs procured the centres primarily through competitive tender for Alternative Provider Medical Services (APMS) contracts, which allowed bids to provide the services from the independent sector, GP-formed companies, traditional GP practices, social enterprises and NHS trusts.³⁵ The Department of Health raised PCTs’ baseline funding to pay for the centres.³⁶

The centres were controversial from the start. For example, the British Medical Association (BMA) stated in a submission to our review that it “*supported establishing these centres where there was a proven need for the services they offered*” but it did not support the blanket approach requiring every PCT to open a centre. The BMA also stated: “*the resources invested in walk-in centres would be better targeted at existing GP services, which have been stretched for many years.*”³⁷ Several stakeholders also told us that some PCT commissioners felt they were being forced to procure a service that they did not need.³⁸ In some cases,

³¹ Department of Health, [NHS Next Stage Review Interim report](#), October 2007, p.25.

³² We identified 150 GP-led health centres that opened under the EAPMC programme (including those that have now closed). Our research suggests that a few PCTs out of 150 did not commission any centres at all, while a few commissioned more than one. The EAPMC also provided funding for 113 new standard GP practices (with no walk-in requirement) in the most under-doctored (and often the most deprived) areas of the country.
<http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Aboutus/Procurementandproposals/Procurement/ProcurementatPCTs/index.htm>.

³³ Department of Health, [NHS Next Stage Review Interim report](#), October 2007; Department of Health, [High Quality Care For All: NHS Next Stage Review Final Report](#), June 2008.

³⁴ Department of Health, *Equitable Access to Primary Medical Care, Commercial Strategy, Framework and Provisions Guidance for PCTs*, Version 3, August 2008.

³⁵ See J. Ellins, C. Ham, & H. Parker, *Choice and Competition in Primary Care: Much Ado About Nothing?*, University of Birmingham Health Services Management Centre, November 2008.

³⁶ Department of Health, *Equitable Access to Primary Medical Care, Commercial Strategy, Framework and Provisions Guidance for PCTs*, Version 3, August 2008, p.9.

³⁷ BMA submission to Monitor review, June 2013.

³⁸ Reflecting last year on how the GP-led health centres were established, Lord Darzi wrote that while he still believes the centres are “a good idea,” “the initiative’s credibility was badly damaged by its top-

PCTs closed existing walk-in centres in 2008 or 2009 to replace them with GP-led health centres.³⁹

On the other hand, we were told that some commissioners welcomed the walk-in centres and the opportunity to design the services around local needs.

However, soon after (or in some instances even before) the centres opened, some PCTs began to renegotiate contracts to change the services provided by the centres, moving away from initial policy guidance, such as by reducing opening hours or dropping the option of patient registration (see Section 6 for a description of changes to walk-in centre provision).

We refer throughout this document to the walk-in centres established as a result of the EAPMC programme as “GP-led health centres.” These have both a registered list GP practice and a walk-in service that is available to patients who are registered or not registered with the practice.

down nature” and did not always reflect local needs. A. Darzi and P. Howitt, Integrated care cannot be designed in Whitehall, *International Journal of Integrated Care*, 18 May 2012.

³⁹ See, for example, www.bristolpost.co.uk/Anger-closure-south-Bristol-walk-health-centre/story-11314060-detail/story.html.

3. Since 2010, policy objectives have evolved to focus on improving access to 24/7 care and better managing demand

The policy context and the economic climate have changed since walk-in centres were established. In 2010, the government's whitepaper, *Equity and excellence: Liberating the NHS*, provided a blueprint for the Health and Social Care Act 2012 (the 2012 Act). Among other reforms, the 2012 Act abolished PCTs and transferred commissioning responsibilities to NHS England and to clinical commissioning groups (CCGs) (made up of providers of primary medical services, including GPs). *Equity and excellence* also reaffirmed the government's commitment to offer patients greater choice of service providers.⁴⁰

Financial pressures are a key focus of policymakers, commissioners, and providers today. The Quality, Innovation, Productivity and Prevention (QIPP) programme was launched to achieve £20 billion in savings to be reinvested in the NHS. In October 2013, Monitor published a report on the challenge of closing a predicted £30 billion funding gap by 2021.⁴¹

There also are efforts underway to better manage demand for services. NHS England has set out a vision for redesigned urgent care and emergency services that includes:

- offering better support for people to self-care;
- enhancing NHS 111⁴² to help people who need urgent care find the right service at the right time;
- providing responsive urgent care services outside of hospital so that people with non-emergency needs no longer seek treatment at A&E departments;
- introducing two levels of emergency departments to replace the inconsistent levels of service available at different departments; and
- connecting urgent and emergency care services together in emergency care networks.⁴³

Work is now underway to develop plans to implement this vision.

⁴⁰ *Equity and Excellence: Liberating the NHS*, July 2010, pp.16-18.

⁴¹ Monitor, *Closing the NHS funding gap: how to get better value health care for patients*, 2013, available at www.monitor.gov.uk/closingthegap.

⁴² For information about NHS 111, see Annex 1.

⁴³ *Transforming urgent and emergency care services in England, Urgent and Emergency Care Review, End of Phase 1 Report*, NHS England, November 2013, available at www.england.nhs.uk/2013/11/13/keogh-urgent-emergency/.

The National Audit Office also published a report in November 2013 looking at the causes behind increased emergency admissions, how well emergency admissions are managed and what might be done to better manage demand.⁴⁴

Improving access to primary care continues to be a major policy goal. In early October 2013, the Prime Minister announced a proposal to implement seven-day 8am-8pm GP access to “help thousands who struggle to find GP appointments that fit in with their family and work life.”⁴⁵ Under the proposal, at least nine GP groups will operate pilots to provide extended and flexible access, including email, Skype and phone consultations, as well as online registration and choice of practice. The groups will apply to a £50 million fund for support for the pilots.

Alongside these efforts, NHS England is developing a national strategic framework for commissioning of GP services that addresses key challenges facing the sector: an ageing population; growing co-morbidities and increasing patient expectations; increasing pressure on NHS financial resources; growing dissatisfaction with access to services and persistent inequalities in access and quality of primary care; and growing workforce pressures.⁴⁶

The Department of Health’s recent consultation on its Mandate to NHS England also stated: “*we want to improve people’s access to primary care through new forms of provision including rapid walk-in access*”.⁴⁷

⁴⁴ National Audit Office, *Emergency admissions to hospital: managing the demand*, 31 October 2013, available at www.nao.org.uk/report/emergency-admissions-hospitals-managing-demand/.

⁴⁵ <https://www.gov.uk/government/news/seven-day-8am-8pm-gp-access-for-hard-working-people>.

⁴⁶ NHS England, *Improving General Practice – A Call to Action, Slide Pack*, August 2013.

⁴⁷ Department of Health, *Refreshing the Mandate to NHS England: 2014-2015*, Consultation, p.9.

4. Walk-in centres today: service features vary by locality

While walk-in centres were largely established under national initiatives, local commissioners often tailored the centres to reflect local needs and priorities. As a result, many key features of walk-in centres, such as where they are sited, opening hours, skill-mix of staff, the range of services provided, and the degree of co-location with other health and social care services vary by walk-in centre.

The names of walk-in centres also vary and are not necessarily indicative of the services provided. Labels include NHS walk-in centre or simply walk-in centre, GP-led health centre, equitable access centre, open access centre, 8 to 8 centre, same day centre, health centre, medical centre, and primary care centre.

There is no central repository containing data and information about all walk-in centres in England.⁴⁸ In this section, we provide an overview of walk-in centres that is based on our compilation of publicly available information, data and information received from commissioners and providers, and conversations with stakeholders.

We also provide an overview of services that might be considered an alternative to walk-in centre services. While facilities labelled as urgent care centres and minor injuries units often look very similar to a walk-in centre, the nature of services can be different to walk-in centre services and many offer a suitable alternative only for certain health care needs (see Section 4.3).

4.1. Numbers and locations of walk-in centres in England

Our research identified 185 walk-in centres operating throughout England.⁴⁹ A list of these is provided in Annex 2. This number includes 135 walk-in centres that are GP-led⁵⁰ and 50 that are nurse-led.

Walk-in centres exist in most areas of England (see Figure 1), and are present in all of the (former) Strategic Health Authority (SHA) areas of England.⁵¹ We found that

⁴⁸ The Department of Health collects some data about walk-in centres operated by NHS trusts and NHS foundation trusts (Department of Health, National Schedule of Reference Costs 2011-12 for NHS trusts and NHS foundation trusts, available at <https://www.gov.uk/government/publications/nhs-reference-costs-financial-year-2011-to-2012>); however, trust-run centres represent a small fraction of the total number of walk-in centres. Likewise, NHS England A&E statistics include attendance figures for some NHS trust-run and independently-run walk-in centres but not the full universe of walk-in centres (NHS England, Weekly A&E SitReps, available at www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/weekly-ae-sitreps-2013-14/).

⁴⁹ This figure reflects centres that were in operation in England at the time of our review that fit our definition of a walk-in centre, as described in Section 1.1. Our list of walk-in centres was developed using information from the Care Quality Commission, the Health and Social Care Information Centre, submissions from providers and commissioners, CCG information request responses, and our own web research and conversations with stakeholders.

⁵⁰ Of the 135 GP-led walk-in centres that we identified, 124 are GP-led health centres (known as “Darzi” centres) that opened under the Equitable Access to Primary Medical Care programme. The other 11 GP-led walk-in centres appear to have developed from local initiatives.

centres are more prevalent in the North East and North West, London and West Midlands compared to other areas of England (see Table 2). We identified 81 CCGs out of a total of 211 that do not have a walk-in centre in their geographical boundaries. Nineteen CCGs told us that they have no walk-in centres, no urgent care centres and no minor injuries units located within their geographical boundaries.⁵²

⁵¹ Although SHAs no longer exist, they are a convenient way of dividing England into smaller regional areas. SHAs were also responsible for overseeing health care services in each region when the latest wave of walk-in centres was established. The SHA areas adopted are those that were formed in 2006. The 10 SHA areas are: North East, North West, Yorkshire & Humber, East Midlands, East of England, West Midlands, South Central, South East Coast, South West, and London.

⁵² The number of CCGs without these services in their areas is most likely an underestimate as approximately half of the 211 CCGs in England responded to our request for information. See Section 4.3 and Annex 1 for a description of these other services.

Figure 1: Walk-in centres in England



Source: Monitor analysis

Table 2: Number of walk-in centres by (former) SHA areas

Strategic Health Authority	Number of walk-in centres	Population mid-2012 ('000)	Number of walk-in centres per million residents
North East	19	2,602	7.3
London	42	8,308	5.1
West Midlands	25	5,643	4.4
North West	31	7,084	4.4
Yorkshire and the Humber	15	5,317	2.8
South East Coast	11	4,514	2.4
South West	12	5,340	2.2
East Midlands	10	4,568	2.2
East of England	12	5,907	2.0
South Central	8	4,211	1.9
Total	185	53,494	

Sources: Monitor analysis; ONS Population Estimates mid-2012

Walk-in centres are often located within areas of relative deprivation. Our research suggests that 28% of walk-in centres are located within the 10% most deprived areas, whereas 1% of walk-in centres are located within the 10% least deprived areas (see Table 3).⁵³

⁵³ This has been calculated using the Index of Multiple Deprivation (IMD), a combination of 7 indices that measure aspects of deprivation including income, employment, health and crime. Indices are calculated by Lower Layer Super Output Areas (LSOAs), of which there are 32,482 in England. Source data and more information about the IMD are available here: <https://www.gov.uk/government/organisations/department-for-communities-and-local-government/series/english-indices-of-deprivation>.

Table 3: Deprivation levels of walk-in centre locations

Percentile of deprivation	Number of walk-in centres	Proportion of total walk-in centres
10 th	2	1%
20 th	9	5%
30 th	6	3%
40 th	10	5%
50 th	12	6%
60 th	12	6%
70 th	26	14%
80 th	23	12%
90 th	34	18%
100 th	51	28%

Least deprived areas



Most deprived areas

Sources: Monitor analysis; *The English Indices of Deprivation 2010*

At a local level, our research indicates that walk-in centres are generally sited in one of five types of locations:

- in urban city/town centres such as in a central shopping area or close to a train station;⁵⁴
- within suburban locations, for example, close to or within large residential estates;⁵⁵
- within or on the fringes of commercial/industrial areas, sometimes close to residential estates;⁵⁶

⁵⁴ There are many examples of walk-in centres in urban/town centres including Reading Walk-in Centre, Liverpool City Walk-in Centre, Brighton Station Health Centre, Worcester Walk-in Health Centre, Soho Walk-in Centre, Walsall Walk-in-Health Centre, Birmingham NHS Walk-in Centre and Swindon Walk-in Centre.

⁵⁵ Examples of walk-in centres located within residential areas include Battle Hill Health Centre, Dudley Borough Walk-in Centre, The Practice Loxford (Loxford Polyclinic), and Putnoe Medical Centre.

⁵⁶ For example, Barkantine Practice, Cardrew Health Centre and Quayside Medical Centre.

- in community hospitals or other community health care hubs;⁵⁷ and
- at acute hospital sites, with or without an A&E.⁵⁸

4.2. Overview of services provided

Most walk-in centres are open seven days per week for extended hours, such as from 8am to 8pm, or 7am to 10pm.⁵⁹ Services provided vary and may depend on whether a walk-in centre is nurse-led or GP-led; however, walk-in centres commonly provide advice and treatment for minor illnesses and injuries including:

- coughs, colds and flu-like symptoms;
- skin conditions or skin infections;
- stomach upset or pain;
- breathing problems (such as asthma);
- back pain;
- urinary tract infections;
- ear, eye and throat infections;
- cuts, strains and sprains; and
- insect and animal bites.

Beyond advice and treatment for these and other minor conditions, the services provided depend on the centre and local commissioning priorities.

Nurse-led walk-in centres

Nurse-led centres often provide health promotion and advice and some provide information such as opening hours and contact numbers for other local health services. Several offer assessment, diagnosis and initial therapy for deep vein thrombosis (DVT) upon referral from GPs. Some centres provide blood tests, emergency contraception or travel vaccinations. Nurses or other staff who are qualified prescribers can issue prescriptions, and the centres may be authorised to offer certain medications within set guidelines.

⁵⁷ For example, Solihull Healthcare & Walk-in Centre and Finchley Walk-in Centre.

⁵⁸ For example, Royal Devon & Exeter Walk-in Centre.

⁵⁹ A number now operate with reduced opening hours. (See Section 6 for a description of changes to walk-in centre provision.)

Some centres provide wound care such as the removal of sutures and dressings; others do not. Some centres have access to x-ray services, although these may be offered for limited hours and may be operated by a separate provider.

Generally, nurse-led centres provide a single episode of care – they do not provide ongoing care for patients with chronic conditions although they may treat patients with symptoms of such conditions. However, some providers of nurse-led centres said they are looking to develop joint pathways for certain services. For example, 5 Boroughs Partnership NHS Foundation Trust, with three walk-in centres in the Knowsley area near Liverpool, is working with commissioners and other providers to develop pathways for people with chronic conditions to go direct from a walk-in centre to specialist care, including one for patients with chronic obstructive pulmonary disease.

GP-led health centres

GP-led health centres can offer many of the same services as nurse-led centres, however, services available may depend on whether the patient is registered with the practice or not. The original EAPMC template contract for the GP-led health centres⁶⁰ required them to offer, at a minimum, “essential services” for registered patients. These are services that a traditional GP practice would offer and include care for patients “who are, or believe themselves to be”:

- (a) ill, with conditions from which recovery is generally expected;
- (b) terminally ill; or
- (c) suffering from chronic disease.⁶¹

In addition, PCTs could choose to contract for a host of additional or enhanced services⁶² for registered patients, which could include a range of nationally-defined or locally-defined services, such as cervical screening, contraceptive services, vaccinations and immunisations, minor surgery, weight loss or smoking cessation clinics, anticoagulation monitoring and others.

⁶⁰ The Department of Health issued a contract template for PCTs to use, and (other than with respect to terms mandated under the APMS Directions) tailor locally when procuring the GP-led health centres. We refer to this as the “EAPMC template.” We examined the template dated 7 January 2009 that is available in Department of Health online archives at http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Aboutus/Procurementandproposals/Procurement/ProcurementatPCTs/DH_086657.

⁶¹ The definition of essential services comes from the National Health Service (General Medical Services Contracts) Regulations 2004, which govern General Medical Services (GMS) contracts for GP services.

⁶² The additional services that could be on offer are defined in the EAPMC contract template. For a definition of enhanced services, see: www.nhsemployers.org/PayAndContracts/GeneralMedicalServicesContract/DirectedEnhancedServices/Pages/EnhancedServices.aspx.

For non-registered patients, PCTs could exclude some essential services, so long as the centres offered them advice or care for a defined set of minor conditions. PCTs could choose which additional, enhanced or specialist services (if any) the GP-led health centre was required to offer to non-registered patients.

Our review of several GP-led health centre contracts suggests that some PCTs contracted their centres to offer non-registered patients close to the full range of services provided for registered patients. Some went even further to try to target certain high need populations. For example, the Walsall GP-led health centre in West Midlands was commissioned to provide special services for homeless patients, violent patients, nursing home patients, alcohol misusers, and people with learning disabilities as well as “street-doctoring” and sexual health services.⁶³

Providers told us that, in practice, the main difference between services offered to registered and non-registered patients is the ongoing nature of care for registered patients. Non-registered patients do not, for example, receive regular treatment for chronic conditions, but may be encouraged to see their GP practice or to register with the centre’s GP practice for further care.

GP-led health centres were intended to offer both bookable and non-bookable (walk-in) appointments to both registered and non-registered patients. We found that some centres have a greater proportion of bookable appointments, while others more often provide walk-in appointments. Some services at some centres are available only by booking an appointment in advance.

Although walk-in centres are typically described as “nurse-led” or “GP-led,” in practice, a walk-in patient is likely to see a nurse-practitioner at either type of centre, and at some centres will have access to a GP if needed.

4.3. Alternative service options to walk-in centres

Based on the types of services available at different walk-in centres, a number of alternatives to walk-in centres may be available within a locality for people needing advice or treatment for minor illness or injury. These include:

- urgent care centres;
- minor injuries units;
- A&E departments;
- NHS Direct and NHS 111 services;
- GP services (in hours);

⁶³ The PCT closed the registered list practice at Walsall in December 2011; however, the walk-in element and full range of services are still available for unregistered patients.

- out-of-hours GP services;
- community pharmacy services; and
- self-care and self-management.

These alternatives are described in detail in Annex 1.

Like walk-in centres, the service features for each of these alternatives can also vary widely by locality. However, broadly, walk-in centres typically differ from other services in the following service features:

- whether services are only available to patients with urgent care needs;
- whether services are available on a walk-in basis;
- whether services are available to unregistered patients;
- the time and day of week that services are available;
- where services are located within a local area; and
- who is responsible for leading delivery of services (for example, a nurse, a GP, or consultant).

An overview of how the services vary is provided in Table 4. The table illustrates a number of distinctions between walk-in centres and alternative services. Urgent care centres and minor injuries units, for example, while offering services with extended hours and on a walk-in basis, will sometimes turn away patients with non-urgent needs (instead sign-posting them to their registered GP practice) (See Annex 1 for further discussion).

Likewise, services such as the new 111 initiative and out-of-hours GPs are not accessible on a walk-in basis (they are telephone-based); they also refer patients back to their registered GP practice if their needs are assessed to be non-urgent. GP services (in hours) typically offer more restricted opening hours compared to walk-in centres; also services generally are not available on a walk-in basis and patients must first register before using services.

Table 4: Features of different health care providers offering routine and urgent primary care

Service options	Routine primary care	Urgent primary care	Services accessible on a walk-in basis	Opening hours ⁽¹⁾	Service lead
Walk-in centre	✓	✓	✓	Extended	Nurse or GP
Urgent care centre	? ⁽²⁾	✓	✓	Extended or 24/7	GP
Minor injuries unit	X ⁽³⁾	✓	✓	Extended or 24/7	Emergency Nurse
A&E department	X ⁽⁴⁾	✓	✓	24/7	Consultant
NHS Direct / 111 services	X	✓	X	24/7	Nurse / GP / non-clinical adviser
Out-of-hours (OOH) GP services	X ⁽⁵⁾	✓	X	OOH	GP
GP services (in hours)	✓	✓	? ⁽⁶⁾	Core ⁽⁷⁾	GP
Community pharmacy	✓	✓	✓	Extended ⁽⁸⁾	Pharmacist
Self-care and self-management	✓	X	X	24/7	-

Notes: (1) Opening times are defined as either: Core, OOH, Extended, or 24/7. Core is 8:00 to 18:30 weekdays (not including bank holidays); OOH is 18:30 to 8:00 weekdays, 24 hours on weekends and bank holidays; Extended will vary by location, eg, 8:00 to 20:00 or 7.00 to 22.00 every day of the week (including bank holidays). (2) Not all urgent care centres treat routine primary care cases, eg, some centres will direct non-urgent cases to other services (such as patients' registered GP practice). (3) Minor injuries units only treat minor injuries and will often re-direct patients with routine care needs to other services. (4) A&E departments are not intended for patients with routine needs, however these patients are often accepted if they present. (5) Services are accessible by telephone; after a clinical assessment, the caller will be directed to a service that best suits their needs (eg, an OOH GP appointment may be booked for patients with urgent needs). (6) Some GP practices offer walk-in appointments for their registered patients. (7) Some GP practices offer extended hours one or two evenings a week or on the weekend; similarly other practices may offer more restricted hours (eg, they may also be closed one or two afternoons during the week). (8) Some pharmacies may have more restricted opening hours, eg, some high street community pharmacies.

4.4. Providers of walk-in centres

There are many different providers of walk-in centres in England. Large independent sector companies (such as Care UK and Virgin Care) operate about 17% of walk-in centres; acute and community NHS trusts and foundation trusts operate 25%; and 58% are operated by other providers including GP-formed limited companies (such as Malling Health, The Practice, Danum Medical Services), mid-to-small size GP partnerships (such as GTD Primary Care, Brisdoc), partnerships between GP practices and NHS Trusts (such as Freeman Clinics), social enterprises (Local Care Direct) and individual GP practices.

Walk-in centre providers tend to also offer other NHS services such as out-of-hours services or GP practices.

Table 5: Providers with the largest number of walk-in centres

Provider	Number of walk-in centres	Proportion of total walk-in centres
Care UK ⁽¹⁾	14	7.6%
Virgin Care ⁽²⁾	13	7.0%
Malling Health	8	4.3%
The Practice	6	3.2%
Liverpool Community Health NHS Trust ⁽³⁾	4	2.2%
The Hurley Group ⁽⁴⁾	4	2.2%
Central London Community Healthcare NHS Trust	4	2.2%
Primecare	4	2.2%
South Tyneside NHS Foundation Trust	4	2.2%
5 Boroughs Partnership NHS Foundation Trust	3	1.6%
Bondcare Medical Services	3	1.6%
Bridgewater Community Healthcare NHS Trust	3	1.6%
Danum Medical Services	3	1.6%
DMC Healthcare	3	1.6%
GTD Primary Care	3	1.6%
Local Care Direct	3	1.6%
One Medicare	3	1.6%
Wirral Community NHS Trust	3	1.6%
Total	88	47.6%

Source: Monitor analysis.

Notes: (1) includes walk-in centres formerly operated by Harmoni; (2) includes those formerly operated by Assura in partnership with local GPs; (3) The Liverpool Community Health NHS Trust operates an additional walk-in centre for children only; (4) The Hurley Group provides three GP-led health centres plus one branch site which also offers a walk-in service.

4.5. Links and relationships with other providers

Delivering care in an integrated way means that patients have a person-centred, well-co-ordinated experience when accessing different providers or services to get the care they need.⁶⁴ As noted in Section 2, the government intended walk-in centres to be well-integrated with other services and providers, but the extent of their actual links and relationships varies. Some walk-in centres appear to be well integrated, while others operate mostly in isolation, according to stakeholders. Several walk-in centre providers told us that they seek to build stronger relationships with other health and social care providers. Other providers emphasised that walk-in centres can be quickly adapted to provide rapid response services, such as for flu outbreaks, or to deliver evolving urgent care strategies.

We observed how walk-in centres link with other providers or services across several areas:

Co-location

Reflecting the original intent that walk-in centres foster integrated care, many are co-located with other health or social care services. Some have a pharmacy on site;⁶⁵ some are co-located with diagnostics, such as x-ray services.⁶⁶ Some are housed in a facility with a range of other services such as other GP practices, GP out-of-hours, and dental services. Walk-in centres may also operate or may be co-located with a variety of community clinics, such as sexual health or family planning. Co-location in some instances has led to stronger links between providers, such as shared working among staff.⁶⁷

Relationships with GPs

Walk-in centres typically have contact with GP practices because often they are contractually required, subject to a patient's permission, to send a report of an attendance to the patient's GP practice.

In addition, walk-in centre providers say that some GP practices advise patients to attend walk-in centres when they have no same-day appointments available.⁶⁸ Some

⁶⁴ See National Collaboration for Integrated Care and Support, [Integrated care and support: Our shared commitment](#), May 2013.

⁶⁵ Some walk-in centres are located within the pharmacy itself (for example, Birmingham NHS Walk-in Centre, Yeovil Health Centre, and Bristol City Walk-in Centre are located within a Boots chemist); others have a pharmacy onsite (for example, St Andrew's Health Centre).

⁶⁶ For example, Garston Walk-in Centre operated by Liverpool Community Health NHS Trust and Battle Hill Health Centre operated by Freeman Clinics.

⁶⁷ See, eg, Lattimer et al, *The impact of changing workforce patterns in emergency and urgent out-of-hours care on patients experience, staff practice and health system performance*, March 2010, p.92 (shared working of staff from walk-in centre and co-located out-of-hours).

⁶⁸ See also BMG Research and Communications and Engagement Team, NHS Central Midlands CSU, *Understanding people's use and experience of the Birmingham and Solihull walk-in and urgent*

walk-in centre providers suggested that this might work better for patients if the centres could work with GP practices to enable GPs to use phone triage to direct appropriate patients to walk-in centres (those with one-time minor conditions) instead of using a “first-come, first-served” approach to scheduling same-day appointments. This would prevent patients who need care for chronic or complex conditions from being directed to a walk-in centre. GP practices may also direct their patients to walk-in centres for certain services, such as blood tests or DVT services.

Two walk-in centre providers told us that they have entered into subcontracts with local GP practices to provide phone answering services or out-of-hours services during afternoon closing hours or for holiday cover.

Relationships with A&E departments

Walk-in centres send patients needing emergency care on to A&E departments, although evidence indicates that the proportion of walk-in patients sent to A&E is low.⁶⁹ Some A&E departments will direct patients with minor conditions to a walk-in centre during times of pressure; however, several stakeholders told us that A&E departments can be reluctant to redirect patients and do not refer as many patients as they could to walk-in centres or other primary care services.⁷⁰

Some walk-in centres, such as Solihull Healthcare and Walk-in Centre, have agreed with ambulance services to receive their non-emergency patients, or patients with minor injuries that can be treated in primary care, directly into the walk-in centre. In another example of walk-in centres building relationships with emergency services, Malling Health has agreed to station a GP and a nurse from one of its walk-in centres at a nearby A&E department to provide triage and treatment for less serious conditions.

Referrals to secondary care and joint pathways

Evidence suggests that most walk-in centres have limited ability to refer patients on to secondary care services (unless patients are registered with a GP-led health centre practice).⁷¹ Patients needing a referral to secondary care are typically told to see their GP for a referral, as GPs are the traditional gatekeeper. However, some commissioners have developed referral pathways (such as for DVT services) for both nurse-led and GP-led walk-in centres. For example, clinicians at the Reading Walk-in Centre are able to refer patients on to secondary care services.

care centres, 2012, p.51 (GPs sometimes signpost patients to the walk-in centre); see Section 7.1 of this document for further discussion of issues related to access to GP practices.

⁶⁹ Sources indicate that referrals can be up to 5%.

⁷⁰ See also NHS Nottinghamshire County, *Walk-in Centres Review Business Case*, NHS Nottinghamshire County Board Meeting, 24 March 2011, p.14, available at: www.nnotts.nhs.uk/board/default.aspx?recid=2083.

⁷¹ GP-led health centres are able to refer their registered patients in the same way that a GP practice can, and the EAPMC template called for the centres to offer registered patients Choose and Book for specialist services.

Access to patients' records

Commissioners and health professionals sometimes raise concerns that walk-in centres do not provide continuity of care, particularly because they do not have access to patients' general practice medical records. This may be changing, as it appears that most walk-in centres are able to access patients' nationally-held summary care records, which show medications, allergies and adverse reactions.⁷² In addition, the Department of Health intends to give patients access to their records online by 2015 – this could facilitate access for walk-in centres if patients agree to make the records available to them.⁷³

In some areas, walk-in centres and other providers share access to urgent care records. For example, St Andrews GP-led health centre in London shares a database with a local out-of-hours provider and other area walk-in centres. The providers also have shared access to a database of all children subject to a child protection plan to make this information visible to clinicians.

But shared access to patients' full medical records continues to present a challenge to the NHS, in part because providers may use different technology platforms.⁷⁴ Even where walk-in centres use the same system as other GP practices or urgent care providers (such as SystmOne), stakeholders told us that the centres do not always have the required access permissions from the providers holding the records.

Some stakeholders said, however, that continuity of care is not a large concern for patients attending walk-in centres because many feel they have an urgent one-time need and simply want to see a doctor or nurse.⁷⁵ Younger people, in particular, are less likely to have a preferred GP.⁷⁶

4.6. Pricing for walk-in centre services

Walk-in services generally are paid for on a per-attendance basis or through a block contract (a contract for a fixed value that does not vary with the volume of activity).

Evidence suggests that nurse-led centres are often paid on a block contract basis and that services were commissioned through various contractual arrangements,

⁷² See www.nhscarerecords.nhs.uk/. So far about half the population of England have a summary care record; www.nhscarerecords.nhs.uk/havescr. Patients have the ability to opt out.

⁷³ See www.pulsetoday.co.uk/patients-given-access-to-full-gp-record-by-2015/13131402.article#.UmlrA3Nrrlc.

⁷⁴ Some GPs are switching to a common system to enable shared access to patients' records. See, eg, *West London GPs start switch to SystmOne*, EHI ehealth insider, 1 August 2013. www.ehi.co.uk/news/EHI/8798/west-london-gps-start-switch-to-systmone.

⁷⁵ See also The King's Fund and Nuffield Trust, *Securing the future of general practice: new models of primary care*, July 2012. ("Sometimes speed of access will trump the desire to see the same person or team, and this can be mitigated by a shared record.")

⁷⁶ See 2012-13 GP Patient Survey, question 8.

such as through the NHS Standard Contract for Community Services or through an APMS contract.⁷⁷

Most GP-led health centres were commissioned under APMS⁷⁸ contracts, procured through a competitive tender process. The typical duration of contracts was five years.

Because the contracts for GP-led health centres included two elements of service, a registered-list GP practice and a service available for any member of the public, including those not registered with the practice, the EAPMC template developed by the Department of Health recommended that PCT commissioners divide the payment structure accordingly:

- **For registered patients**, PCTs could pay a set price per patient for each contract year to cover essential and any included additional services for each patient on the practice's registered list, and could top that up with a national tariff-based payment for national enhanced services (NES) or directed enhanced services (DES) and a locally-negotiated payment for local enhanced services (LES). (See Section 4.2 for a definition of these types of services).

This is similar to the way that traditional GP practices are paid under the general medical services (GMS) contract – by capitated payment based on the number of patients on their registered list, and by an add-on payment for enhanced services. One difference, though, is that for the GP-led health centres, providers could submit a bid price, per-patient, whereas for traditional GP practices the per-patient price is set by national negotiations (for GMS contracts) or local contract negotiations with GPs (for personal medical services contracts).⁷⁹

⁷⁷ As noted in Section 2.1, nurse-led walk-in centres were introduced as a pilot programme in which GPs, GP co-operatives, or other NHS bodies (such as trusts), could operate the centres through primary care groups, which were precursors to PCTs. See NHS Executive, NHS Primary Care Walk-in Centres, *Health Service Circular*, 1999/16, 11 May 1999. Following the pilot, the Department of Health funded the opening of additional centres. Some of these centres were operated by PCTs, which then transferred them to other providers, such as NHS trusts, social enterprises, or community foundation trusts, through the Transforming Community Services programme. We found other examples of nurse-led walk-in centres co-located with GP practices that were contracted under local initiatives with APMS contracts.

⁷⁸ APMS contracts are Alternative Provider Medical Services contracts for primary medical services. They place minimum requirements on APMS contractors which broadly reflect those for Personal Medical Services agreements (which along with GMS contracts are the traditional categories of contracts for providing primary medical care services) but otherwise allow the remainder of the contract to be negotiated between the commissioner and the contractor or, more commonly, stipulated by the commissioner during the course of a tender process. NHS England, *Managing Regulatory and Contract Variations*, June 2013. www.england.nhs.uk/wp-content/uploads/2013/07/mng-reg-con-vari.pdf.

⁷⁹ Another slight difference is in how additional services are handled. Under the GMS contract, additional services are included in the per-patient price, but GP practices may opt out of them in

As an alternative to this more traditional payment structure for registered list patients, PCTs could combine essential, additional, NES and DES together in the per-patient price, with only LES priced separately. The price for the combined services could be paid for based on a bidder's price, or according to a weighted capitation price formula. LES were to be priced separately.

- **For unregistered patients**, the Department of Health recommended that PCTs use a price per attendance, with providers to bid on the price.

Our analysis of several GP-led health centre contracts and our conversations with stakeholders suggest that most providers are paid according to one of the Department's recommended approaches and a minority are paid using a block payment structure instead.

In addition to these payments, some GP-led health centres were paid a minimum income guarantee for the first two years while the practices were building their list size.⁸⁰

The GP-led health centres can also receive performance-based Quality Outcomes Framework (QOF) payments, like traditional GP practices.⁸¹

Moreover, at GP-led health centres, providers often are not paid on a per-attendance basis for walk-in attendances by registered patients (as those payments are deemed to be covered under the capitated payment for the registered list).⁸²

Some commissioners also have used marginal payments for walk-in attendances. In these instances, providers are paid a marginal rate for walk-in attendances exceeding the contractual targets, in some cases gradually declining to no payment.

The EAPMC contract template called for GP-led health centres to have up to 25% of their total payment for services provided tied to their performance against key performance indicators (KPIs). We have seen some local modifications of the amount tied to KPIs. The KPIs are quality measures designed around indicators regarding access, quality (which may be based on the centre's QOF score), service delivery, value-for-money and patient experience. Commissioners have tailored KPI measures to meet local priorities. Evidence suggests that some, but not all, commissioners have separate sets of KPIs applying to registered patients and to non-registered patients.

exchange for a slight income reduction. See National Health Service (General Medical Services Contracts) Regulations 2004, Regulation 17.

⁸⁰ See EAPMC contract template, Schedule 3.

⁸¹ For a description of the QOF, see:

www.nhsemployers.org/PayAndContracts/GeneralMedicalServicesContract/QOF/Pages/QualityOutcomesFramework.aspx.

⁸² We understand that there are some GP-led health centres that do not allow their registered patients to access services on a walk-in basis, but require them to pre-book appointments.

The GP-led health centre contracts include some demand management tools for both the registered list and unregistered list elements. The EAPMC template and several contracts we examined require providers to obtain consent from commissioners before registering new patients or seeing walk-in unregistered patients who come close to or slightly exceed target numbers of patients set in the contract.⁸³

As demand in many cases has exceeded contractual targets, particularly for walk-in services, providers told us that they have gone to commissioners to seek additional payment. This has happened under both block and per-attendance contracts. Our evidence suggests that in some cases, commissioners have agreed to provide more funding; in others they have not. Where they have not, it appears that some providers do not turn patients away, but some do.

⁸³ See EAPMC contract template, Schedule 2, Part 2, Section 2.3 and Part 5, Section 2.2.

5. Demand for walk-in centre services is strong

Providers and commissioners say demand for services at many walk-in centres is rising year-on-year. In this section, we look at who is using walk-in centres and how often.

5.1. Who uses walk-in centres?

The types of people using walk-in centres will vary by locale; however, evidence on the use of walk-in centres suggests that:

- younger people are the predominant users, with people between 16 and 45 attending at higher rates than other age groups;⁸⁴
- there are slightly higher proportions of women attending, compared to men at most centres (some centres in our survey show higher proportions of men attending, for example at the Putnoe Medical Centre);⁸⁵
- people from lower socio-economic groups tend to be the most common users of walk-in centres;⁸⁶
- the majority of patients attend on their own behalf, although people often attend on behalf of their child particularly at some centres;⁸⁷ and
- populations served often depend on locations. City centre sites often cater to working people. Sites on residential estates often serve young families. Some centres see high numbers of university students, who tend not to be registered with a GP in the area in which they are attending university.

We also found that the needs of most patients attending a walk-in centre are being met at the centre. For example, our patient survey found that 84% of patients did not intend to use the services of another health care provider following their visit to the walk-in centre.⁸⁸ A small minority of patients (1% or 13 patients) had already seen

⁸⁴ The age breakdown of patients from our patient survey shows those in the 25 to 34 year age bracket (23%) and the 16 to 24 age bracket (16%) were the most commonly attending patients. Monitor patient survey report, p.23.

⁸⁵ In our patient survey, for example, almost three-fifths of patients were female (59%) and just over two in five were male (41%). Monitor patient survey report, pp.21-22. This is consistent with information submitted by walk-in centre providers.

⁸⁶ Our patient survey suggested that 36% of patients attending walk-in centres were from social grade DE, with a further 19% from C2 and 30% from C1 (see pp.24-25 of the Monitor patient survey report, including definitions of each grade).

⁸⁷ Our patient survey indicated that up to 23% of people attended on behalf of their child at some walk-in centres. Monitor patient survey report, pp.21-22.

⁸⁸ Two percent of patients said they did not know whether they would use another service, while 14% of patients indicated they would use the services of another health care provider following their visit to the walk-in centre. Of the 14%, 7% indicated they would see their GP; 2% indicated they would visit a pharmacy; 1% indicated that they would go either to A&E or another walk-in centre. About 3% said they would use "other" services. Monitor patient survey report, pp.46-47.

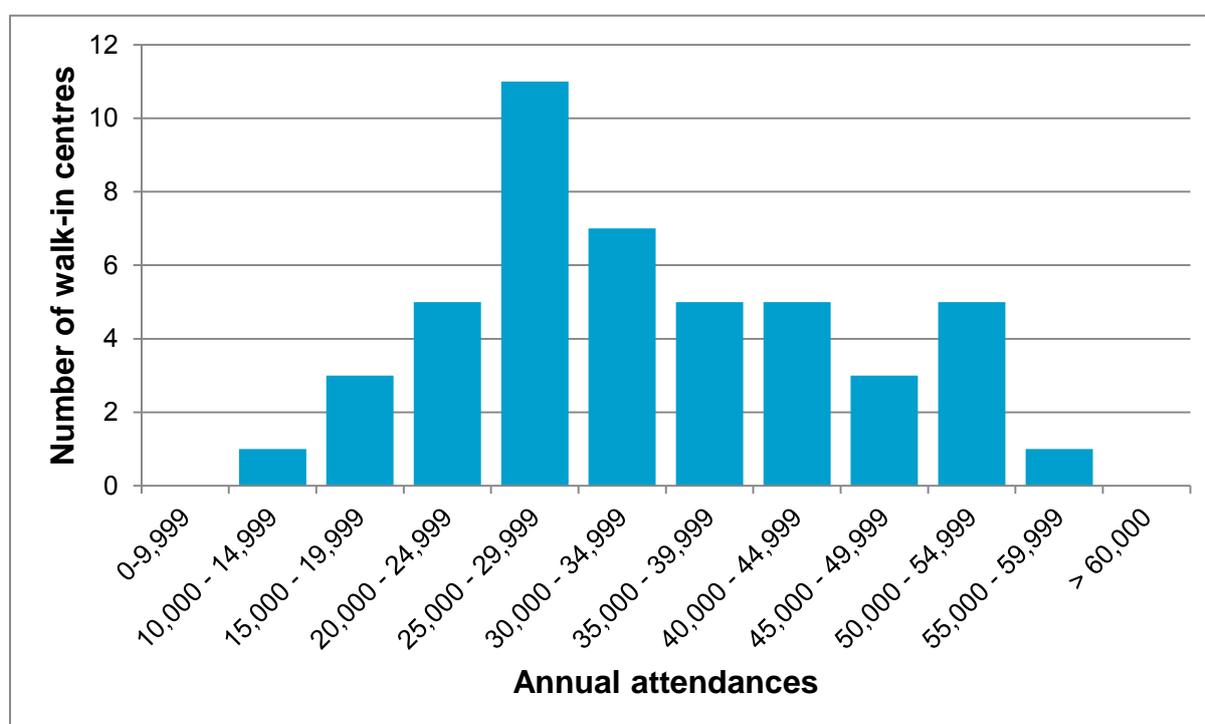
their GP before coming to the walk-in centre. Five of these 13 patients had wanted a second opinion and a further four patients had wanted treatment or medication that their own GP would not prescribe.⁸⁹

Evidence also suggests that the majority of people would have gone to a GP practice or an A&E department if the walk-in centre was not available. Very few people indicated that they would stay at home and attempt self-care.⁹⁰

5.2. Numbers of walk-in attendances

Evidence supplied by providers indicates that walk-in attendances can range from 12,000 to 60,000 attendances per year, depending on the centre. Figure 2 shows the range of attendances at 46 walk-in centres. Over 70% (33 walk-in centres) provide between 20,000 and 45,000 walk-in appointments per year, with 24% (11 walk-in centres) providing between 25,000 and 30,000 walk-in appointments per year.

Figure 2: Current annual walk-in attendances in a sample of 46 centres



Source: Data submitted to Monitor by providers of walk-in centres

Notes: Figures reflect walk-in attendances at 46 walk-in centres in England over the last 12 months or financial year. Estimates do not include pre-booked appointments.

⁸⁹ Monitor patient survey report, pp.72-73.

⁹⁰ In our patient survey, when patients were asked spontaneously what option they would choose in place of the walk-in centre they had attended if it were not available, 34% indicated they would go to a GP practice (for example, their own GP practice or a different practice, depending on where the patient was registered), 21% said that they would go to A&E, and 16% indicated that they would go to a different walk-in centre. Only 8% indicated that they would stay at home or attempt self-care. Even fewer people indicated that they would visit a pharmacist (5%) or call an NHS helpline (4%). Monitor patient survey report, pp.74-75. This result is consistent with survey results we received from several walk-in centre providers, which typically indicate that around 20-40% of patients say they would attend a GP practice and 20-30% of patients say they would visit an A&E department if the walk-in centre was not available.

Walk-in attendances at some walk-in centres exceeded the levels originally anticipated when they were initially opened.⁹¹ Attendances anticipated (or targeted) in commissioning contracts were typically in the range of 12,000 to 24,000 attendances, rising to 35,000-60,000 in years four and five for some contracts.

Providers report that when walk-in centres first opened, in some cases excess demand strained resources, staffing, and facilities. Press reports also suggest that some centres were forced to close for temporary periods while capacity was extended or reconfigured to meet the volumes of patients attending.⁹²

NHS England reports that attendances at walk-in centres and minor injury centres have increased by around 12% per year since data was first recorded in 2003.⁹³

Increased demand for walk-in services is part of a larger trend of increased demand for other NHS services. The average number of GP practice consultations per patient rose from 3.9 to 5.5 per year between 1995 and 2008.⁹⁴ Attendances at major and single specialty A&E departments have also increased, by about 18 per cent between 2003 and 2011 (or 2% per year).⁹⁵

Patterns of walk-in attendances by time of day and week vary by walk-in centre. Most report Mondays or Saturdays as their busiest days. Some walk-in centres report, on average, higher attendances during weekday regular business hours,⁹⁶ and others report peak times during GP closure hours in the evenings and on weekends and bank holidays.⁹⁷

Figure 3 shows average attendance patterns over the week for six walk-in centres.⁹⁸ It shows that on weekdays, centres are typically busy from 9am, with surges in

⁹¹ See, eg, www.thebureauinvestigates.com/2011/06/23/over-popular-nhs-walk-in-centres-are-forced-to-close/; www.thestar.co.uk/what-s-on/out-about/walk-away-from-walk-in-centre-1-2965911; www.thetelegraphandargus.co.uk/news/8763859. *Walk in medical centre a success* /.

⁹² For example, Trafford Health Centre closed temporarily so that capacity could be reconfigured to handle the large number of patients attending. See:

www.traffordpct.nhs.uk/Latest_News/NHS_walk_in_service.aspx and www.thebureauinvestigates.com/2011/06/23/over-popular-nhs-walk-in-centres-are-forced-to-close/.

⁹³ NHS England, Evidence Base from the Urgent and Emergency Care Review, 17 June 2013, p.18 [NHS England, Evidence Base] www.england.nhs.uk/wp-content/uploads/2013/06/urg-emerg-care-ev-bse.pdf; see also John Appleby, *Pressures on accident and emergency services*, The Kings Fund, 4 June 2013. www.slideshare.net/kingsfund/john-applebyqmrjune13; www.kingsfund.org.uk/blog/2013/04/are-accident-and-emergency-attendances-increasing.

⁹⁴ Health and Social Care Information Centre, *Trends in consultation rates in general practice 1995/1996-2008/2009: Analysis of the Q research database*, 2009.

⁹⁵ NHS England, Evidence Base from the Urgent and Emergency Care Review, 17 June 2013, p.18.

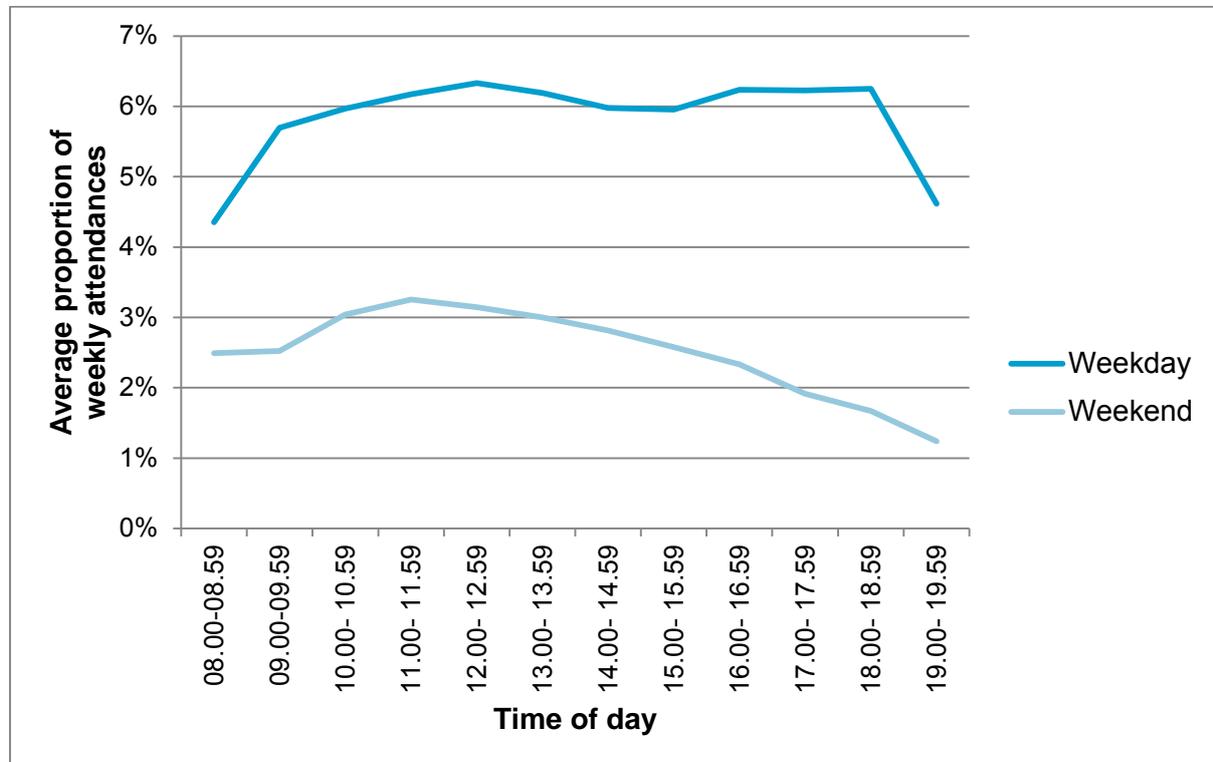
⁹⁶ See, eg, Barking & Dagenham consultation documents: 70% of attendances during GP opening hours.

⁹⁷ See, eg, NHS East London and the City, Pre-Consultation Business Case, January 2012 (peak times weekdays from 4pm-8pm); NHS Southampton City PCT consultation (64% used walk-in centre during evenings or weekends).

⁹⁸ We received (descriptive and quantitative) data on attendance patterns for almost 40 walk-in centres. A lack of data compatibility meant that we had to restrict our graphical presentation to only

activity between 11am and 1pm and between 3pm and 7pm. A higher proportion of attendances are earlier in the day during weekends than during weekdays.

Figure 3: Walk-in attendances by time of day and week in a sample of six centres



Source: Data submitted to Monitor by providers of walk-in centres

5.3. Registration with GP-led health centres

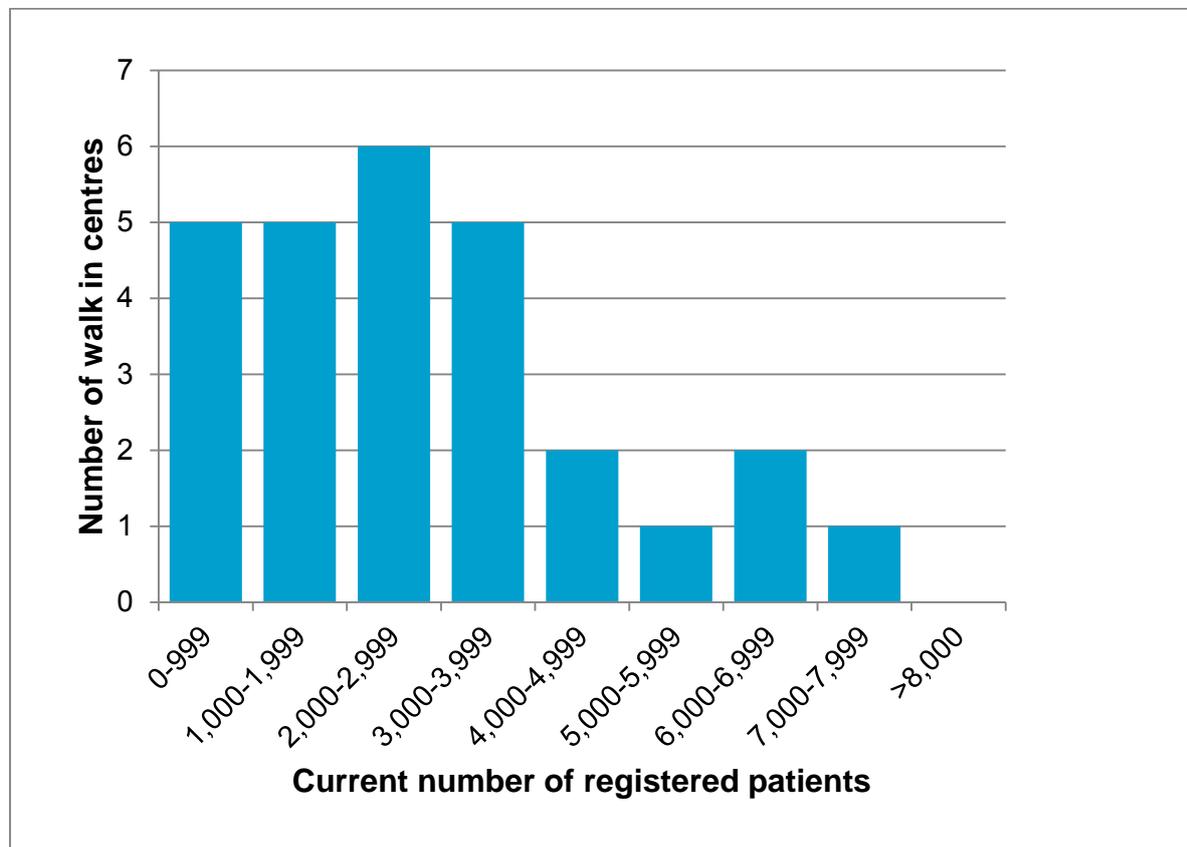
As noted, GP-led health centres offer a registered-list GP practice as well as walk-in services open to any member of the public. The take-up of registration at the GP practices of GP-led health centres has been more modest compared to the numbers of walk-in attendances seen. Most centres started without any registered patients.

With many now in or approaching their fifth year of operation, our research shows that registered list sizes for these practices tend to be between 1,000 and 3,000 patients, although we observed several centres with a registered list of between 5,000 and 6,000 patients. This compares to an average list size for a GP practice of

six walk-in centres. The data is broadly consistent with the attendance patterns described by providers for other walk-in centres.

6,891 in 2012.⁹⁹ Figure 4 shows the distribution of current list sizes for 27 GP-led health centres for which we have data.

Figure 4: Current number of registered patients in a sample of 27 GP-led health centres



Source: Data submitted to Monitor by providers of walk-in centres.

Notes: figures shown are only for GP-led health centres that started with no patients on their lists.

Data on registered list size over time indicates that, for most walk-in centres, registered patient numbers have grown at a steady rate. Provider data indicates that growth in list sizes ranges from between 200 to 2,000 patients per year depending on the location of the walk-in centre. Across all GP practices, average list size grew by about 1,000 patients in total over the 10 years from 2002-2012.¹⁰⁰

As noted in Section 4.6, list size tended to be contractually limited, requiring providers to seek the commissioner’s consent to go beyond the targets.

The practice boundaries for registered patients at GP-led health centres were set through negotiations between the provider and the PCT, often with input from local

⁹⁹ See Health and Social Care Information Centre, *NHS Staff – 2002-2012, General Practice, Selected Practice Statistics*.

¹⁰⁰ Average list size grew from 5,833 in 2002 to 6,891 in 2012. Average list size varies between 5,993 in the North West and 8,760 in South Central England. See Health and Social Care Information Centre, *NHS Staff – 2002-2012, General Practice, Selected Practice Statistics*.

GPs. The practice boundaries usually overlapped with some other GP practices. (The centres generally have no practice boundaries for walk-in patients who are not registered at the centre's GP practice, and they can and do treat walk-in patients who are registered with a different practice.)

Our patient survey indicates that of all patients in our survey who chose to register with a GP-led health centre, about half were previously registered with a different GP practice locally;¹⁰¹ a further 25% were registered previously in another area and the final 25% had not been registered with a GP practice before. Patients who had not been registered with a GP practice before were more likely to be female; between 25 and 34 years of age; working full-time; and/or from a lower socio-economic group.¹⁰²

¹⁰¹ A few walk-in centres had a very high proportion of patients stating that they had previously been registered with another GP locally, including Battle Hill Health Centre (79%), Shropshire Walk-in Health Centre (76%) and The Skelton Medical Centre (76%).

¹⁰² See Monitor patient survey report, pp.54-56.

6. There is a trend to close walk-in centres

Of the 238 walk-in centres that we estimate originally opened, we found that commissioners closed 51 between 2010 and 2013, the time frame for our research. Of these closures, about one-third were part of reconfigurations to replace the walk-in centres with urgent care centres co-located with A&E departments at hospital sites,¹⁰³ or with models that integrated primary care staff within an A&E department.

Of the 51 centres that closed, 20 were nurse-led centres, six were commuter centres, and 25 were GP-led health centres. One-third of the GP-led health centres that closed ceased to provide walk-in services for non-registered patients, but continue to operate as a GP practice.

See Annex 3 for our list of walk-in centre closures; see Figure 5 (below) for a map of open and closed walk-in centres in England.

Our review focused on closures after 2009 because most GP-led health centres (the majority of walk-in centres) were opened in 2009 and were unlikely to have closed before 2010. Our initial research also indicated that the trend to close walk-in centres began after 2009. However, we found a handful of examples in which, prior to 2010, PCTs closed nurse-led walk-in centres to replace them with GP-led health centres. There may have been other walk-in centre closures before 2010 that were not captured in our research.

¹⁰³ Some of these were already located on a hospital site, but as separate walk-in centres.

Figure 5: Open and closed walk-in centres in England



- Closed walk-in centre
- Open walk-in centre

Source: Monitor analysis

We are aware of a further 23 walk-in centres that have had their services reduced or modified in some way. These modifications include:

- discontinuing the registered list element of a GP-led health centre;
- reducing the hours or days the walk-in centre is open;
- reducing the volume of activity commissioners will pay for;
- reducing the range of services;
- moving from being GP-led to nurse-led; and
- restricting the service to patients with urgent conditions.

We reviewed PCT and CCG documentation underlying a number of closures and changes in walk-in centre services as well as submissions to our review from commissioners. We also spoke to commissioners involved in decisions to close centres. Our aim has been to understand the reasons why commissioners have closed walk-in centres or made changes to the services; in this report, we are not seeking to challenge or endorse particular decisions.

In deciding not to continue walk-in centre services, commissioners have given the following reasons (often not one, but several, of these reasons are behind decisions to close a walk-in centre):

- **Funding pressures**

Many centres have seen greater numbers of walk-in patients than commissioners initially anticipated (see Section 5). In some cases, this has led to higher payments to walk-in centre providers than expected.¹⁰⁴

Commissioners have cited annual costs for a walk-in centre as being between £450,000 and £1.5 million.

“We are spending far too much money on treating people in walk-in centres and in A&E with primary care type conditions which could be managed by the GP practice.”

Barking and Dagenham CCG,
[Urgent care – the case for change](#) (issued as part of the CCG’s decision to close a walk-in centre)

Alongside these unpredicted costs, commissioning budgets as a whole have been under growing pressure. Some commissioners told us that they felt they could no longer fund the convenience that walk-in centres offer and others

¹⁰⁴ See, eg, The Bureau of Investigative Journalism, *NHS forced to close walk-in health centres because they are ‘too popular’*, 23 June 2011, www.thebureauinvestigates.com/2011/06/23/over-popular-nhs-walk-in-centres-are-forced-to-close/. We also are aware of cases in which the provider chose to withdraw from a walk-in centre contract because it had become financially unviable. See for example, walk-in services at the Laurels Healthy Living Centre, www.haringeyindependent.co.uk/news/8927389.Health_trust_will_not_restore_walk_in_service/.

have closed walk-in centres as part of efforts to achieve savings and contain costs.¹⁰⁵

- **Failure to reduce A&E attendances**

Some stakeholders viewed reducing A&E attendances as a key purpose of walk-in centres. (See Section 2 for a discussion of the policies behind walk-in centres). One commonly-cited reason for closures is that the centres have not reduced A&E attendances.¹⁰⁶ The focus of many commissioners is on improving the availability and configuration of urgent care services in the hope of reducing pressure on A&E departments. As a result, a number of commissioners have closed or plan to close walk-in centres to reconfigure services alongside or within A&E departments, with the intention of reducing A&E attendances.¹⁰⁷

- **“Paying twice” or duplicating services**

A commonly-cited concern among commissioners is that they are “paying twice” for walk-in centre services because most patients attending are registered with a GP practice elsewhere, and those GP practices are already paid to provide those patients with primary care services through the capitated payment structure. Commissioners argue that walk-in centres duplicate services already provided because patients attend the centres for the same reasons that they would see their GP, often during GP core hours. They believe that patients should see their GP as a “first port of call.”¹⁰⁸ (See Section 7.3 for further discussion on concerns about paying twice).

¹⁰⁵ See, eg, NHS Salford, Trust Board Meeting paper, *Urgent Care, Report of Strategic Commissioning / Interim Deputy Chief Executive*, 31 August 2010, p.4 and Appendix 3.

¹⁰⁶ For example, the Stockport walk-in centre opened in October 2009, and the PCT had hoped that the centre would help reduce the number of patients attending Stepping Hill’s A&E for non-emergency treatment. But reports suggest that attendances at A&E had increased by about 5% and commissioners felt they could not justify the amount spent on the walk-in centre. See www.pulsetoday.co.uk/darzi-centre-closes-due-to-duplication-in-services/11042967.article and <http://alternativeprimarycare.wordpress.com/2010/10/27/walk-in-centre-to-close-stockport-pct/>; See also NHS Salford, *Urgent Care Engagement, 30 September 2010*.

¹⁰⁷ Several commissioners cited a King’s Fund study recommending that commissioners should evaluate walk-in centres “rigorously” and, where possible, “co-locate and integrate” them with emergency departments. The King’s Fund, *Urgent and Emergency Care: A review for NHS South of England*, March 2013. We spoke to several commissioners who have experience with a model of integrating walk-in or urgent care services or primary care services with A&E departments. They discussed challenges in the model meeting its goal to reduce A&E attendances in part because of a reluctance of some A&E departments to redirect patients to primary care services. They told us that this may stem from A&E triage clinicians being more risk-adverse or from concerns about loss of revenue to A&E departments. The Primary Care Foundation has pointed to similar challenges with the model.

¹⁰⁸ See, eg, NHS Barking and Dagenham CCG, *Walk-in centres in Barking and Dagenham*, consultation on proposals to close walk-in service, 2013.

- **Walk-in centres create demand**

The convenience and accessibility of walk-in centres, as well as the relatively minor clinical nature of conditions they treat, has led some commissioners to take the view that walk-in centres create demand unnecessarily.¹⁰⁹ Some commissioners and even some walk-in centre providers said walk-in centres cater mostly to the “worried well” who could otherwise self-manage or go to a pharmacy, rather than serving patients who previously had unmet needs.

- **Concerns over confusion and duplicative use of services**

In some communities, commissioners closed walk-in centres in part due to concerns that the various points of access to urgent care, and the variation in types of services provided, has created confusion among patients about where to seek appropriate treatment. In some cases, commissioners said, this confusion may result in mistrust of the system and fragmented care, in which the patient is referred onwards to another service such as their GP practice or A&E. Some commissioners said it also may introduce clinical risk if patients requiring emergency services attend a walk-in centre instead.¹¹⁰

In addition, commissioners have cited concerns that walk-in centres result in duplicative use of services based on evidence that some patients use walk-in centres and other services for the same problem, for example, in seeking a second opinion.¹¹¹ (See Section 5.1 for the proportion of patients in our survey who used or intended to use more than one service for the same problem.)

- **“Inequity” of access**

A few commissioners said that their walk-in centres created inequity of access because they were mostly used by people who lived close by, rather than by groups from areas of high deprivation or those with significant health needs.¹¹² (See Section 5.1 for a discussion of the types of patients using walk-in centres.)

Finally, we found a few examples in which commissioners cited high numbers of attendances by out-of-area patients or insufficient use of walk-in centres as reasons for closure.

Although in many areas commissioners favour closing or changing walk-in centre services, several commissioners we spoke to said that their walk-in centres play an

¹⁰⁹ See Pulse, *Darzi centres are fuelling PCT deficits*, 21 Jan 2011, www.pulsetoday.co.uk/darzi-centres-are-fuelling-pct-deficits/11051000.article#.UnnZZXNR7lc.

¹¹⁰ See, eg, NHS Bolton CCG, Public Board Meeting paper, *Walk-in Centre Implementation – Urgent and emergency care for the future*, 4 May 2012.

¹¹¹ See, eg, NHS Bolton CCG, Public Board Meeting paper; NHS Barking and Dagenham CCG, *Walk-in centres in Barking and Dagenham, consultation on proposals to close walk-in service*, 2013.

¹¹² See, eg, NHS Nottinghamshire County, *Walk-in centres review* (public consultation document).

important role in meeting health needs and provide value for money. We were told that some have extended walk-in centre hours, or are looking to expand services and establish stronger links between walk-in centres and other providers. In some places, community members, often with support from local politicians, have lobbied successfully to keep a walk-in centre open.¹¹³

Many commissioners are currently reviewing walk-in centre provision or will begin reviews shortly. The reviews are being driven in part by the five-year contracts for the GP-led health centres, procured in 2009 or 2010 and set to expire in 2014 or 2015. In addition to this, many CCGs are reviewing walk-in services as part of wider reviews of urgent care services.

¹¹³ For example, the strong views of the local community is said to have influenced the commissioner in its pre-engagement phase regarding its decisions on the future of the Bitterne walk-in centre in Southampton; NHS Southampton City, *Consultation on the future of the walk-in service provided at Bitterne Health Centre, Public Consultation Feedback Report*, February 2011.

7. Analysis and preliminary findings

As the preceding sections indicate, walk-in centre provision and the issues surrounding decisions about whether to continue to procure these services depend largely on local circumstances. However, we were able to draw out some common themes from our review of evidence from various locales that relate to the key factors we examined in our review:

- What is the potential impact of closures on patients?
- Are commissioning arrangements and practices related to walk-in centres working in patients' interests?
- Are the payment mechanisms for walk-in centres and GP services generating benefits for patients?

This section describes our analysis and findings on these questions.

7.1. In some cases, walk-in centre closures may adversely affect patients' access to primary care for some patients

Walk-in centres were intended to improve access to primary care both in and out of normal GP practice hours. Government policies establishing walk-in centres sought to offer patients a service model believed to be more flexible and better suited to the needs of those most likely to find access difficult (see Section 2).

We find from our review that walk-in centre closures may have the potential to affect some patients adversely by:

- making it more difficult for people to access primary care services where there are problems with access to local GP practices; and
- limiting the ability of primary care to reach particular groups of people who find it difficult to engage with the traditional model of GP services or whose uptake and interaction with primary care has traditionally been poor.

Our findings and analysis, described below, suggest that local commissioners must carefully consider the extent to which patients' needs for access to primary care (or for other needs that walk-in centres may be meeting) are present in their communities when taking decisions about walk-in centres.

7.1.1. Access to GP services

Access to GP services is still frequently cited as a problem. The 2013 call to action by NHS England to improve general practice, for example, identifies growing dissatisfaction with access to GP services as a key challenge for the sector.¹¹⁴

Evidence also indicates that patients' experience of GP services, particularly when related to ease of access, affects their uptake and interaction with primary care, which in turn can affect quality of care and clinical outcomes. Ease of access to GP services can affect quality of care and outcomes through its impact on a patient's attendance rates, continuity of care, communication and engagement with clinical staff, compliance and adherence with treatment, and out-of-hours access.¹¹⁵

The results of NHS England's 2013 national GP patient survey showed that across different CCGs the percentage of people that were:

- able to get an appointment when they wanted - ranged from 71% to 92%;
- able to easily contact their GP surgery by telephone - varied from 49% to 89%; and
- satisfied with the opening hours of their GP - ranged from 71% to 85%.¹¹⁶

We found that people routinely cite difficulties, and perceived difficulties, in getting an appointment with their GP practice or being seen at a convenient time as a reason for attending walk-in centres. In our patient survey, the majority of patients attending the walk-in centres (62%) were registered with a GP practice elsewhere. Of those patients:

- 22% said that they had tried to contact their GP practice before attending the walk-in centre, but either found that no appointment was available (14%), or not available at a convenient time (4%) or within a suitable waiting time (3%), or they simply could not get through (1%);
- 24% said they did not try to contact their GP practice because of perceptions that they would not be able to get an appointment that was convenient; and
- 6% had been directed to the walk-in centre by their GP.¹¹⁷

¹¹⁴ NHS England, *Improving general practice – a call to action*, 2013, www.england.nhs.uk/ourwork/com-dev/igp-cta/.

¹¹⁵ The King's Fund, *Data briefing: improving GP services in England: exploring the association between quality of care and the experience of patients*, November 2012, www.kingsfund.org.uk/publications/improving-gp-services-england.

¹¹⁶ www.gp-patient.co.uk/results/latest_weighted/ccg/.

¹¹⁷ See Monitor patient survey report, pp.72-73.

For patients who had chosen to register with a GP-led health centre (34% of those surveyed), 19% said they registered because of “not having to phone ahead to book an appointment”¹¹⁸ and 18% indicated “time of day or week that appointments are offered” as the reason for registering.¹¹⁹

Other surveys of people attending walk-in centres show similar results.¹²⁰ For example, more than two thirds of patients surveyed at eight walk-in and urgent care centres across Birmingham and Solihull indicated they had attended because of an access-related issue, such as they could not get an appointment with their GP or would have had to wait to be seen.¹²¹ Patients in that survey also expressed concern over the opening hours of their GP practices, wanting them to be open earlier in the mornings, later in the evenings and on weekends.

“I am absolutely horrified to hear that there are plans to close the walk-in centres as I believe they are a vital health resource in our community. I have personal experience of the [local walk-in centre] having used it two or three times with various family members with excellent results to deal with the medical issue and returning home. I feel it provides an essential service for those people who cannot get in to see their doctor but need medical attention for whatever reason.”

Angela, submission to Monitor

There is wide variation in how well GP practices manage demand for appointments.¹²² For example, the Primary Care Foundation’s survey of 150 GP practices found that some had fewer than 10% of their appointments available for same-day appointments, while others had well over 70%.¹²³ In addition, while many practices appear to offer appointments during core or extended hours, some

¹¹⁸ Not having to phone ahead to book an appointment was particularly important for patients choosing to register at Cardrew Health Centre, Reading Walk-in Centre, and Shropshire Walk-in Health Centre.

¹¹⁹ Time of day or week that appointments are offered was particularly important for patients choosing to register at Reading Walk-in Centre. Monitor patient survey report, p.57.

¹²⁰ We reviewed patient surveys conducted by providers for about 12 walk-in centres and the following studies: Healthwatch Barking & Dagenham, *A response from the public: consultation on proposals for urgent care services and the Broad Street walk-in service*, 21 May 2013; Barking and Dagenham LINK, *Patient survey of walk-in services, Upney Lane Walk-in Centre and Broad Street Walk-in Centres*, December 2012; Arain Mubashir, Jon Nicholl and Mike Campbell, *Patients’ experience and satisfaction with GP led walk-in centres in the UK*; a cross sectional study, BMC Health Services Research, 2013, 13:142.

¹²¹ The survey was conducted on behalf of NHS Central Midlands CSU in 2012; a total of 1,106 patients were interviewed. BMG Research and Communications and Engagement Team, NHS Central Midlands CSU, *Understanding people’s use and experience of the Birmingham and Solihull walk-in and urgent care centres*, 2012.

¹²² See Primary Care Foundation, *Urgent Care: a practical guide to transforming same-day care in general practice*, 2009.

¹²³ See Primary Care Foundation, *Urgent Care: a practical guide to transforming same-day care in general practice*, 2009, p.17. The Foundation recommends that one-third of appointments be reserved for same-day access.

practices close for some afternoons each week or for stretches in the middle of the day.¹²⁴

Patients and other community members also have raised concerns about access to GP services when commissioners have proposed closing a walk-in centre. In response, many commissioners pledged to improve access to existing local GP practices to mitigate the impact.

In some cases, commissioners analysed walk-in centre data to determine which local GP practices had high numbers of their registered patients attending the walk-in centre. One commissioning body found “broad correlation between satisfaction with GP access and use of the [two local] walk-in centres, with some of the most represented practices having received low MORI patient satisfaction survey scores.”¹²⁵

In another example, commissioners found that a local practice was having difficulties matching resources to peak demand times and was leaving phone calls unanswered because staff members were too busy with other tasks.¹²⁶ Another commissioner told us that his CCG found that a practice was not making arrangements to cover periods when the practice was closed for holidays or training amounting to several weeks each year. Commissioners worked with these practices to improve services.

However, in some cases, city or borough council leaders have expressed concerns about walk-in centres closing before GP access problems were adequately addressed.¹²⁷ In Manchester, for example, the City Council Health and Wellbeing Overview and Scrutiny Committee contested NHS Manchester’s decision to close three community-based walk-in centres due to concerns that commissioners had not demonstrated that all GP practices in the city were providing “genuine same day access to GP appointments.”¹²⁸

¹²⁴ NHS Nottinghamshire walk-in centre review documents, Appendix 17, available at www.nnotts.nhs.uk/board/default.aspx?recid=2083; NHS Choices spot research; The GMS contract requires GP practices to be open during core hours, 8:30am – 6pm, however, we understand that GP practices may close for surgery appointments during those hours so long as phone lines are open.

¹²⁵ NHS East London and the City, Pre-consultation business case, Appendix C, Patient profiles, attendance and clinical outputs, January 2012, p.9. The MORI scores refer to the GP Patient Survey by Ipsos MORI.

¹²⁶ NHS Nottinghamshire walk-in centre review documents, Appendix 17, available at www.nnotts.nhs.uk/board/default.aspx?recid=2083.

¹²⁷ See for example, Letter from The London Borough of Barking and Dagenham to Barking and Dagenham CCG, 21 May 2013, available at www.barkingdagenhamccg.nhs.uk/Get-involved/Consultations/consultation-report-and-associated-documents.htm

¹²⁸ The city council committee twice referred their concerns to the Independent Reconfiguration Panel (IRP) of the Secretary of State for Health. See IRP letters to Secretary of State for Health, 22 Nov. 2011 and 26 Oct. 2012. In its first letter of advice, the IRP determined that the centres should remain open until assurances of same-day access to GP services were provided. In the second, almost one year later, the IRP urged the parties to settle differences and move forward with the proposals to close the centres and develop urgent care centres co-located with A&E departments.

Several GPs told us that it is difficult, within the bounds of current primary care funding, for some smaller practices to offer extended hours or to invest in improvements that would lead to better access for patients. Practices are looking at new organisational models to meet demand and improve services.

Some commissioners have discounted the possibility of an adverse impact of walk-in centre closures on patients' access because they found unused capacity in the system, such as local GP practices with open lists or reports of same-day appointments being unused. However, while open lists or appointments may be factors to consider, other features of GP practices might make access difficult, such as demand that is beyond the capabilities of phone-answering systems or a lack of extended hours.¹²⁹

Some commissioners have said that the cohort of patients using walk-in centres are attending for minor conditions that could be handled instead by a pharmacist or through self care.¹³⁰ But, while self-care or a pharmacy may be suitable for certain medical needs, the public often can lack awareness or confidence in these options.¹³¹

We spoke to commissioners who said they saw no increases in demand for GP services in the wake of walk-in centre closures, although we found no post-closure studies evaluating the impact on patients' access to primary care and whether patients' needs are being met elsewhere or not. However, walk-in centre closures are occurring at a time of increasing demand for GP services overall.¹³²

Some commissioners have reported a lack of complaints as an indication of no or minimal impact on patients. A lack of complaints from patients is unlikely to be sufficient evidence of no or little impact on patients. Patients can be reluctant to complain about a lack of access to service, for example, due to a lack of awareness

¹²⁹ See, for example, Section 8.1 of this document describing types of needs related to access that patients may have.

¹³⁰ Some stakeholders said they perceive a cultural change among service users. For example, they suggested that some patients, particularly those of younger generations, have higher expectations of services including wanting more immediate advice, care, or reassurance for self-limiting minor conditions, whereas in the past patients were more willing to self-care or "wait-and-see".

¹³¹ NHS England, *High quality care for all, now and for future generations: Transforming urgent and emergency care services in England, The Evidence Base from the Urgent and Emergency Care Review*, 2013,

www.england.nhs.uk/wp-content/uploads/2013/06/urg-emerg-care-ev-bse.pdf.

¹³² The King's Fund and Nuffield Trust, *Securing the future of general practice: new models of primary care*, 2013, p.9,

www.nuffieldtrust.org.uk/sites/files/nuffield/130718_securing_the_future_of_general_practice_full_report_0.pdf.

about who to complain to or because they fear it will affect the quality of service they might receive in future.¹³³

7.1.2. Reaching people who find it difficult to access primary care

As well as filling a gap where easy and convenient access to GP services may be lacking, some walk-in centres appear to be successfully reaching people who ordinarily would find access to GP services difficult and for whom uptake and interaction with primary care has generally been poor. This is perhaps unsurprising given that some walk-in centres, particularly GP-led health centres, were explicitly contracted to offer health promotion and disease prevention services for “hard-to-reach” or “equality target groups”.¹³⁴ Overall, we found that walk-in centre closures may risk increasing health inequality if suitable alternatives are not put in place.

We found few studies evaluating whether walk-in centres have improved access to primary care for certain groups. An early evaluation of the first nurse-led walk-in centres found that the centres improved access primarily for younger, more affluent people, including young and middle-aged men who had been relatively low users of general practice.¹³⁵ The authors concluded that walk-in centres may not improve access to health care for those who may need it most.

“We treat around 100 homeless patients and many others who are not registered with any other practice, we see substance misusers that other practices don't want to see, and during times of peak demand such as Christmas, or the recent failed NHS 111 launch, we are able to quickly increase capacity to ease pressure on appointments generally.”
Malcolm Sampson, Director,
Worcester Walk-in Centre

However, our research suggests that the characteristics of patients using walk-in centres have changed somewhat since the centres were first introduced, at least in some locations. While younger adult groups are still the predominant users of walk-in centres, women and those from lower socio-economic groups often account for a higher percentage of users than men and those of affluent status (see Section 5.1).

¹³³ *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Volume 1: Analysis of evidence and lessons learned*, chaired by Robert Francis QC, February 2013, Chapter 3, p.245; Patients' Association, *Primary Care: Patients and GPs – Partners in Care?*, September 2012, p.6.

¹³⁴ See EAPMC contract template. “Hard to reach” or “equality target” groups were defined to include: those who do not understand English; those who cannot hear, see or have other disabilities; working single parents; asylum seekers or refugees; those who have no permanent address; black or minority ethnic communities; adolescents; elderly and/or housebound people; those who have mental illness; those who misuse alcohol or illicit drugs; and those who belong to a lower socio-economic class or who are unemployed.

¹³⁵ Salisbury, C., et al, *The National Evaluation of NHS Walk-in Centres*, Final Report, July 2002.

In addition, we found examples of walk-in centres serving:

- People who can find it difficult to schedule and keep GP appointments, such as homeless patients, traveller communities, substance misusers and ex-offenders. GP-led health centre providers told us that over time, some of these patients could be persuaded to register at the practice ensuring more consistent care, particularly for chronic conditions.
- Asylum seekers, refugees, and other groups facing language and cultural barriers. Stakeholders told us that these groups typically find it difficult to access GP services, or would use A&E for their primary care needs instead, because of a lack of understanding or experience of the NHS or the process of registering with a GP practice. Some providers of GP-led health centres told us that, in areas with high migrant populations, they sought to reach out to these groups and educate them about the NHS and the benefits of registration to ensure continuity of care.
- Workers and students. Accessing traditional GP practices often requires people to take time off work,¹³⁶ yet this can be difficult or simply not possible for some.¹³⁷ The extended and weekend opening hours of walk-in centres, as well as the locations of some in city or town centres, allow those finding it difficult to take time off work to attend to primary care needs, including seeking preventative services and routine checks for chronic conditions. Walk-in centres located near universities tend to serve high numbers of students who are living away from home and are often unregistered in the locales where they are studying. Our patient survey indicates that about 6% of patients attending walk-in centres work or study near the centre but do not live near it, rising to between 19% and 31% for some centres.¹³⁸
- Minority ethnic groups. Our patient survey indicates that some walk-in centres serve high proportions of minority ethnic groups relative to the local population.¹³⁹ Also, of those choosing to register at GP-led health centres, patients who previously had not been registered with a GP practice are more likely to be from black and minority ethnic groups.¹⁴⁰ The Birmingham and Solihull survey found that the eight centres they studied are “particularly

¹³⁶ In a recent survey by the Patients’ Association, 1 in 5 (21.7%) of working age respondents said that they had to take time off to attend an appointment with their GP. Submission to Monitor from Patients’ Association, Call for Evidence for GP services, July 2013.

¹³⁷ The 2012-13 GP Patient Survey indicates that, of those in part or full-time work, 32% could not take time away from work to see a GP.

¹³⁸ For example, the Urgent Care Centre at Guys’ Hospital and Liverpool City Walk-in Centre. See Monitor patient survey report, p.27.

¹³⁹ For example, 23% of patients surveyed at Derby Open Access Centre were Pakistani (which compares to 1% of local population), Monitor patient survey report, p.23.

¹⁴⁰ Of patients who were not previously registered with a GP practice, 38% were from black and minority ethnic groups. Monitor patient survey report, p.59.

popular with black and Asian communities, with a disproportionate percentage of these groups using them.”¹⁴¹

- Patients not registered with a GP practice. While only 3% of all patients attending walk-in centres in our survey are not registered with a GP practice,¹⁴² this number rises to up to 12% at some centres.¹⁴³ Other sources report that up to 28% or even up to 50% of patients attending some centres are not registered with a GP practice.^{144,145}

At a June meeting of the National Inclusion Health Board, the Department of Health reported improvements in registering homeless people and travellers with a GP practice, but noted that “homeless people, asylum seekers, and other transient groups are still frequently being refused registration by GP practices. Information suggests registration is a particular barrier for migrants or those with perceived ‘irregular’ immigration status.” The Department also reported that “current models of primary care usually require patients to conform to patterns of access which assume certain characteristics and resources. For those with additional needs or whose circumstances make it difficult to meet these expectations, engagement in traditional models of care can be problematic and can lead to exclusion from any mainstream services.”¹⁴⁶

Our evidence suggests that while walk-in centres mostly serve people with minor conditions, some centres are providing an important route into primary care for high-risk groups. Lower socio-economic status is associated with poorer health outcomes and less healthy behaviours, and lifestyle risk factors in the young in particular have been identified as a key challenge for the NHS.¹⁴⁷ Both of these groups are being served by walk-in centres.

¹⁴¹ BMG Research’s Birmingham study for NHS Central Midlands CSU, p.28. The study found that the ethnicity of patients at five centres was roughly proportionate with residents within a 3-mile radius of the centres, but the other three centres had much higher proportions of non-white patients than their local populations. Results of all centres combined showed a disproportionately high number of non-white groups using the centres compared to the ethnic make-up of Birmingham and Solihull counties. Appendix 1 of Birmingham study.

¹⁴² Not including non-UK residents who are temporary visitors to England or those who stated that they did not know or were unsure or refused to say. Monitor patient survey report, p.54.

¹⁴³ For example, New Cross GP Walk-in Centre, the Urgent Care Centre at Guys’ Hospital, Brighton Station Health Centre, Putnoe Medical Centre, and Reading Walk-in Centre.

¹⁴⁴ For example, NHS North East London and the City, Pre-Consultation Business Case (28%); Mountford, L. and R. Rosen, *NHS Walk-in Centres in London: An initial assessment*, Kings Fund, 2001, Executive Summary (up to 45%).

¹⁴⁵ This compares to a figure of 1% for the population as a whole. NHS England, *Improving general practice – a call to action*, slide pack, August 2013, p.6, www.england.nhs.uk/wp-content/uploads/2013/08/igp-cta-slide.pdf.

¹⁴⁶ *Sixth National Inclusion Health Board Meeting Notes*, 4 June 2013. The Department of Health statements were based on an internal report that has not been published.

¹⁴⁷ NHS England, *The NHS belongs to the people: A call to action*, July 2013, p.14, www.england.nhs.uk/wp-content/uploads/2013/07/nhs_belongs.pdf.

Walk-in centres that were carefully thought out in terms of their locations and services on offer appear to have been most successful at reaching these groups.

Overall, the evidence we collected suggests that walk-in centre closures, or possibly relocations/reconfigurations, can risk increasing health inequality if suitable alternatives are not put in place. Commissioners are conducting Equality Impact Assessments in some cases before closing or reconfiguring walk-in centre services, but it is not clear whether they are adequate to determine the needs of certain populations and what is being done to mitigate the impacts of changes.

The potential impact on patients' access to primary care highlights the need for commissioners to do a careful needs assessment as a first step in any decision about whether to continue to procure walk-in centre services (see Section 8 for more about needs assessments in commissioning decisions).

7.2. The split in commissioning responsibilities for walk-in centres is causing confusion and could lead to decisions that do not take a system-wide view of the potential impact of changes to walk-in centre provision

The split in commissioning responsibilities between NHS England and CCGs has created confusion about which body is responsible for deciding whether to continue to procure walk-in centre services. In addition, this split has created a risk that NHS England and CCG commissioners are not sufficiently joined up to make decisions about walk-in centres that will deliver the most benefits for patients.

Responsibility for commissioning walk-in centres

Since April 2013, CCGs generally have responsibility for commissioning urgent care, while NHS England is responsible for commissioning primary care.¹⁴⁸ But the division is not so clear-cut and the commissioning of walk-in centres, which provide both routine and urgent primary care, straddles the boundary.

Based on this rough division of responsibilities, CCGs have taken responsibility for managing the nurse-led walk-in centre contracts and deciding whether to continue to procure walk-in centre services, as these centres are considered to provide urgent care. For GP-led health centres, the Department of Health has said that NHS England should manage and monitor the contracts until a decision needs to be made about whether to continue services. At that time, CCGs are to decide whether to

¹⁴⁸ NHS England is responsible for commissioning primary medical services, primary dental services, primary ophthalmic services and pharmaceutical services under Parts 4 to 7 of the National Health Service Act 2006, while CCGs are responsible for commissioning other services under sections 3 and 3A of the Act (which covers secondary care, but also community health services, ambulance and urgent care services). In addition, since April 2013, local authorities are responsible for commissioning public health services.

continue to procure the walk-in element of the contracts for non-registered patients and NHS England will decide whether to continue the registered list practice.¹⁴⁹

We found that, in practice, walk-in centre contracts are being handled differently in different locations. In some cases, CCGs are leading reviews about whether to continue to procure walk-in centre services, while in other cases NHS England local area teams are leading reviews. It is not always clear how the separate bodies are working together in these decisions, and some commissioners said they were unsure about what would happen if there was disagreement between the two commissioning bodies about what to do.

In some areas, we found commissioners adhering strictly to the Department of Health's guidance about splitting responsibilities by trying to split the GP-led health centre contracts into two: one being a contract for a registered list practice and one a contract for walk-in services for non-registered patients. However, the Department also noted in its direction that "it would not be practicable to separate out the 'open access' element of the contract from the registered patient element."¹⁵⁰

The picture is further complicated by other divisions of responsibility between NHS England and CCGs, and the involvement of other entities. For example:

- While CCGs are responsible for commissioning urgent care, NHS England is responsible for commissioning urgent care from GP practices, to the extent that such care falls within the GP contract.¹⁵¹
- NHS England is responsible for commissioning primary care and monitoring quality, while CCGs have a complementary duty to improve quality of care. CCGs do this in part by monitoring whether GP practices, including GP-led health centre practices, have achieved QOF indicators.
- CCGs are responsible for commissioning out-of-hours services and other primary care services that are not included in GP contracts.¹⁵² This means

"...there has been confusion in some areas over responsibility for future commissioning of walk-in centres. Local commissioners require greater clarity around the respective roles of CCGs and the local NHS England Area Team and would welcome further guidance as to how commissioning of the services is to be divided."
BMA submission to Monitor

¹⁴⁹ Letter from Dame Barbara Hakin, Department of Health, 3 February 2011, available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215793/dh_123926.pdf.

¹⁵⁰ Letter from Dame Barbara Hakin, Department of Health, 3 February 2011.

¹⁵¹ NHS Commissioning Board (NHS England), *Commissioning fact sheet for clinical commissioning groups*, October 2012.

¹⁵² NHS England has delegated responsibility for commissioning out-of-hours primary care services to CCGs (except for the small number of GP practices that did not opt-out of responsibility for out-of-hours care). CCGs also have responsibility to decide whether or not to commission any services that

that CCGs are able to procure new services from their member GP practices, including services currently being provided by walk-in centres.

- Local authorities are responsible for commissioning public health services, such as smoking cessation and weight loss clinics, which are offered at some walk-in centres.
- It is unclear, with respect to GP-led health centres that are currently being managed by NHS England, whether funds now being used for walk-in services for non-registered patients will be allocated to CCGs to continue those services if CCGs decide they wish to do so.
- Urgent care review boards and health and wellbeing boards, made up of local stakeholders, also are involved in reviewing walk-in centre provision in some areas as part of their review of wider services.

The various divisions in responsibilities appear to have created confusion. Several stakeholders told us of concerns about the lack of clarity around commissioning.

Joined-up commissioning

The split and, in some cases, overlapping responsibilities related to walk-in centres may make it difficult for commissioners to achieve the system-wide approach they need to take when considering changes to the provision of walk-in centre services. Any change in the provision of walk-in centre services has the potential to affect patients' needs and demand for services across primary care and urgent/emergency care. In particular, a needs assessment related to walk-in services must look at the availability and quality of other services across the system, including whether the community has good provision and access to high quality GP practice services.

Our conversations with some stakeholders raised concerns that because the walk-in element is considered to be part of urgent care, commissioners may not be fully considering the relationship between the walk-in services and other primary care services. We found that, in some locations, NHS England local area teams appear to be focused only on decisions about what to do with the registered list element of GP-led health centres, while CCGs appear to be focused on decisions about the walk-in centres with no registered list or the walk-in element of GP-led health centres.

For example, in commissioning decisions concerning walk-in services for non-registered patients at both nurse-led and GP-led health centres, it is not clear that NHS England local area teams, which have responsibility for commissioning primary care, are involved in working with CCGs to establish:

go beyond the scope of the GP contract when contracts for local enhanced services originally commissioned by PCTs come to an end. NHS England, *Primary medical care functions delegated to clinical commissioning groups: Guidance*, 26 April 2013.

- whether demand for walk-in centres may be related to difficulties in accessing some local GP practices and how GP access or capacity can be improved;
- the potential impact of a closure on current provision by GP practices and other primary care services, such as pharmacy;
- whether NHS 111 is operating locally in a way that helps patients get the right care in the right place while making the most efficient use of resources, including appropriate use of any local walk-in centres;
- whether different models, such as walk-in services provided by GP practices, may be the best way to meet the specific routine or urgent primary care needs identified within the local population;
- how local urgent care strategies are aligned with primary care strategies.

There also is some evidence that the timing of the commissioning reforms and the split in responsibilities have led to delays in reviewing walk-in centre contracts that are set to expire in 2014.

Possible drawbacks for patients

The lack of clarity around commissioning responsibilities and the division of responsibilities has potential drawbacks for patients, including:

- lack of clear accountability for decision-making;
- lack of transparency as to who key decision-makers are; and
- potential for decisions to not take a system-wide view of patients' needs and impact of changes.

In our preliminary report, we sought views from stakeholders about whether one commissioning body – either NHS England or CCGs – should take lead responsibility for making decisions about walk-in centres, including GP-led health centres. Most stakeholders who responded to this question said that CCGs should be responsible as they are closer to local health economies than NHS England local area teams, which cover a larger geographic territory. However, providers consistently raised concerns about potential conflicts of interest among CCG members taking decisions about walk-in centres (see Section 8.4).

At this time, we do not recommend that one commissioning body take lead responsibility for all walk-in centres; rather, we seek to make commissioning responsibilities clearer and the decision process more transparent.

We also encourage CCGs and NHS England to work together to consider whether to continue to procure walk-in centre services, for both non-registered patients and those registered at GP-led health centres. See Section 9 for our recommendations.

7.3. Walk-in centres would work better for patients if payment mechanisms are reformed

Even where the walk-in centre model works well to improve patients' access to primary care and provides high-quality, efficient services, current payment mechanisms:

- discourage commissioners from using the walk-in centre model; and
- do not strengthen incentives for GP practices' to improve quality and efficiency of their services so that their patients are more likely to choose to their services instead of using a walk-in centre.

7.3.1. Payment mechanisms are discouraging commissioners from offering walk-in centre services

As discussed in Section 6, the payment mechanisms for GP practices and walk-in centres has led some commissioners to view attendances at walk-in centres as “paying twice” for patients who are registered at a GP practice.

Some commissioners have tried to address their concerns by requiring a GP-led health centre to encourage frequent attendees to register with the centre's practice or to use their own registered GP. For example, a commissioner in Reading required an arrangement in which the GP-led health centre would not be paid for patients registered elsewhere who visited more than six times, other than in exceptional circumstances.

However, some commissioners told us that they have not been able adequately to address their concerns about paying twice through local contract arrangements. Other stakeholders, including a few commissioners and some walk-in centre providers, were sceptical of concerns about “double-payment,” noting that the same concern could be raised with respect to patients attending urgent care centres or A&E departments for primary care needs.

We found that concerns about “double payment” are not new. At the time of the EAPMC initiative, the Department of Health issued a set of FAQs for local commissioners regarding procurement of the GP-led health centres. One question was: “*Isn't there a risk of paying twice for the same patient if these health centres are able to see local patients who are already registered with a local practice?*” The Department answered: “*The White Paper ‘Our Health Our Care Our Say’ committed the Department to review the funding arrangements for walk-in services. This review is currently underway is expected to make recommendations shortly.*”¹⁵³ Other than a statement in the cited white paper, we could find no additional evidence of the referenced review or recommendations.

¹⁵³ Equitable Access to Primary Medical Care, Local Procurements of GP Practices and GP-led Health Centres FAQs.

Our research suggests that concern about “double-payment” is a key factor driving decisions to close walk-in centres as commissioners seek to address funding pressures. There is a risk that this factor distracts commissioners from an analysis of the merits of the walk-in centre model itself in meeting patients’ needs and in providing value-for-money in comparison to other services. Commissioners might find it more practical to support and enable the easy-access walk-in centre model if payment structures were different.

7.3.2. Payment mechanisms do not strengthen incentives for GP practices to improve quality and efficiency so that their patients are more likely to choose their services instead of using a walk-in centre

Choice and competition are tools that commissioners can use to create stronger incentives for providers to improve quality and efficiency of services, thereby benefiting patients. Commissioners can do this by allowing providers to compete to provide services or by allowing patients to choose between competing providers. For example, offering walk-in centres to patients as a choice for certain primary care needs could encourage GP practices to improve their services so that their patients would choose them instead of using a walk-in centre. However, the payment mechanisms currently in place do not always reinforce the right incentives for choice and competition among walk-in centres and other providers of primary care to generate benefits for patients.

This is because GP practices receive the majority of their income through payments that are based on the number of patients registered on their lists; their income is not directly affected when their patients choose to attend a walk-in centre (or another service offering primary care) instead of using their practice. Thus, where their patients have a choice to use a walk-in centre, GP practices have little incentive to improve their services so that their patients will choose to see them instead of attending the walk-in centre.

For example, several walk-in centre providers and commissioners told us that some GP practices point their patients to a walk-in centre when they are unable to offer a same-day or otherwise convenient appointment slot.¹⁵⁴ This suggests that some practices are using the centres to meet the needs of some patients for whom they are paid to provide primary care, rather than responding to what these patients want by, for example, accommodating more same-day or convenient-time appointments for these patients. The payment mechanism creates little incentive for GP practices to respond in this way because they are still paid the same amount to provide primary care for those patients, even when they direct them to a walk-in centre.

¹⁵⁴ We also received some results of patient surveys taken by walk-in centre providers showing that between 4% and 25% of patients attending the walk-in centre indicated that they heard about the centre through their GP practice, although it is not clear what portion of these patients were referred by GP practices for particular services offered by the walk-in centre, such as blood tests or a DVT service (see Section 4.5).

If payment mechanisms created stronger incentives for GP practices to encourage their patients to choose their services instead of using a walk-in centre, this competition for patients could drive GP practices and walk-in centres to continually improve their own services. Such improvements might include delivering services in a more innovative way, such as with telephone or online consultations, improving quality of customer service features like telephone systems or receptionist skills, better prioritising the needs of patients when they ring for appointments, and/or extending hours or offering walk-in appointments. GP practices and walk-in centres could also work harder to improve clinical quality or to offer a broader range of services.

We note that payment mechanisms limit incentives for GP practices to improve services only with respect to walk-in services, including the walk-in element of GP-led health centres, but not the registered list practice of GP-led health centres. Current payment mechanisms do create an incentive for GP practices to improve their services in order to retain patients that might otherwise prefer to register with a GP-led walk-in centre. This is because GP practices' income is affected if their patients choose to switch their registration. We did find some evidence suggesting that the introduction of the registered list element of GP-led health centres caused some GP practices to "raise their game."¹⁵⁵

There are some other financial incentives for GP practices to improve services, including access, such as QOF measures and the nationally-sponsored enhanced service, the Extended Hours Directed Enhanced Services Scheme, which offers additional payments for practices that open beyond core hours.¹⁵⁶ However, it appears that some enhanced services schemes merely encourage additional opening hours and not better practice management of in-hours appointments, or utilisation of those appointments. In addition, commissioners' additional payments to

¹⁵⁵ For example, some practices responded by extending opening hours. See, eg, A. Coleman, et al, *The limits of market-based reforms in the NHS: the case of alternative providers in primary care*, BMC Health Services Research, 24 May 2013. *Ten ways to face down competition from a Darzi centre*, Pulse, 12 Feb. 2010. However, other evidence we received suggested that, in some areas, when GP-led health centres first opened, commissioners placed advertising restrictions on them or decided not to let them register patients (we were told this was in response to concerns from existing GPs in those areas). Also, original procurement guidance from the Department of Health recommended that PCTs define the centres' target population and area "as widely as possible (within reason) to stimulate competition" but at the same time recommended that PCTs adopt the principle of "nil detriment", which meant the new providers had to demonstrate that their services would not negatively impact "existing services in the locality or in near proximity...from a patient perspective." PCTs were to define "protected areas" where the principle would apply. See Department of Health, EAPMC Commercial Strategy, Framework and Provisions Guidance for PCTs, August 2008.

¹⁵⁶ For GMS practices, core hours are from 8:00am to 6:30pm Monday to Friday excluding Good Friday, Christmas Day and bank holidays.

GP practices for enhanced services may or may not represent better value for money than walk-in centres.¹⁵⁷

NHS England has noted that the current system of capitated remuneration for GP services has been very successful since 2006 in controlling and containing costs. Monitor recognises that any approach to payment must carefully consider all incentives arising from different payment models, including how incentives are likely to affect costs. Primary care payment mechanisms should enable and encourage providers to deliver both higher quality and better value for money. They also need to align with payment structures in secondary care, including urgent and emergency care, so that the entire system offers incentives that continually create more benefits for patients within the limits of NHS funding.

¹⁵⁷ Walk-in centre providers have raised an additional concern about conflicts of interests where CCGs decide to close walk-in centres and commission similar services from member GP practices. See Section 8.4 of this document for a discussion of conflicts of interest.

8. Factors for commissioners to consider when deciding whether to continue to procure walk-in centre services

We found that walk-in centres are most valued today where they were introduced following a careful assessment of local needs, located in an area of the community where the services could be conveniently accessed by those who need it, and procured using a sound process that resulted in value for money.

Good commissioning continues to be critical when taking decisions about the future of walk-in centres. Commissioners' objective is to ensure that they secure high-quality, efficient services that meet patients' needs. The Procurement, Patient Choice and Competition Regulations¹⁵⁸ provide the framework for taking decisions about what services to procure and how to procure them. Monitor has published guidance to assist the sector in understanding the regulations.¹⁵⁹

There are a number of factors that commissioners are likely to need to consider to be confident that the decisions that they take meet patients' needs and can achieve quality and efficiency improvements. We have set out below the factors likely to be particularly relevant to decisions about the future of walk-in centres, based on the themes that have emerged from our review. In practice, what is best for patients will depend on local circumstances. Commissioners will need to consider the Procurement, Patient Choice and Competition Regulations in the round and should refer to our substantive guidance for more detail on how the regulations apply in practice.¹⁶⁰

The purpose of this review was not to investigate whether individual commissioners have acted consistently with the Procurement, Patient Choice and Competition Regulations. If stakeholders have concerns that the regulations may have been breached, they may make a formal complaint to Monitor.¹⁶¹

¹⁵⁸ The National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 (the "Procurement, Patient Choice and Competition Regulations"). The Regulations replaced the Principles and Rules for Cooperation and Competition and the Procurement Guide for Commissioners of NHS Funded Services.

¹⁵⁹ See Monitor, *Substantive guidance on the Procurement, Patient Choice and Competition Regulations*, available at <http://monitor.gov.uk/s75>.

¹⁶⁰ See Monitor, *Substantive guidance on the Procurement, Patient Choice and Competition Regulations*, available at <http://monitor.gov.uk/s75>.

¹⁶¹ Details of how to do so are set out in Monitor's enforcement guidance, available at www.monitor-nhsft.gov.uk/sites/default/files/publications/ToPublishEnforcementGuidance20May2013.pdf. Decisions on whether or not to investigate complaints that we receive are taken in accordance with the prioritisation criteria set out in our guidance.

8.1. Assessing patients' needs

Commissioners' main objective is to secure the needs of health care service users and improve the quality and efficiency of services. This is set out in Regulation 2 of the Procurement, Patient Choice and Competition Regulations.¹⁶²

We recognise that commissioners face financial constraints and that some commissioners view walk-in centres as treating illnesses and injuries that could be dealt with through self care or by other existing services.¹⁶³ In addition, many commissioners have prioritised consolidating urgent care services into one point of access within or near an A&E department, so that patients can be triaged and those without emergency care needs can be easily directed to an urgent care centre or primary care service. This may involve closing a walk-in centre, including one that may be centrally-located within a community.

However, before developing plans to close or change walk-in centre services, commissioners should do a needs assessment to develop a clear understanding of the health care needs of the particular population for which they are responsible and the role of the walk-in centre in meeting those needs. Doing so will allow commissioners to determine the best model of service to meet patients' needs in their local areas.

Our findings suggest that issues concerning access to care are likely to be highly relevant to patients in most areas.¹⁶⁴ Commissioners may have to consider in particular:

¹⁶² CCGs also have a general duty to arrange for the provision of health care services to such extent as they consider necessary to meet the reasonable requirements of the persons for whom they are responsible. See section 3 of the National Health Services Act 2006. NHS England has a similar duty to secure primary medical services to such extent as it considers necessary to meet all reasonable requirements. See section 83(1) of the National Health Service Act 2006.

¹⁶³ NHS England notes that increases in attendances at walk-in centres and minor injury units since they were introduced could mean the services are meeting previously unmet demand or are creating unwarranted demand or could indicate a failure to meet needs earlier in the system. NHS England, *High quality care for all, now and for future generations: Transforming urgent and emergency care services in England, The Evidence Base from the Urgent and Emergency Care Review*, 2013, p.18. <http://www.england.nhs.uk/wp-content/uploads/2013/06/urg-emerg-care-ev-bse.pdf>. Evidence that we examined in our review suggests that whilst most people use walk-in centres for needs that are not clinically urgent, almost half of the patients in our survey viewed their conditions as urgent. More than 80% said they would try to use other services if the walk-in centre was not available, with the majority saying that they would seek advice from a GP or A&E. Very few would have self-treated or not sought advice (8%).

¹⁶⁴ Commissioners are also subject to the public sector equality duty (PSED) in the Equality Act 2010. The PSED requires public authorities to have due regard to the need to: eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010; advance equality of opportunity between people who share a protected characteristic (including, for example, age, disability, race, religion or belief) and those who do not; and foster good relations between people who have a protected characteristic and those who do not. The Equality and Human Rights Commission has published guidance on procurement and the Equality Act 2010: [Buying better outcomes](#).

- The needs of people who find it difficult to access traditional primary care services. These might include particular populations, such as those with language barriers, travellers or homeless people, who may have difficulties registering with a GP or booking and keeping appointments.
- The need for primary care services to be available outside of normal working hours, such as during evenings and at weekends and when GP practices are closed in areas where there are large numbers of workers who cannot afford to be absent from work for a GP appointment.
- The extent to which there is a need in the area for better access to same-day or immediate care for conditions that are urgent or that patients view as urgent.
- The need for primary care services to be available across different locations, including, for example, in an area of high deprivation or in rural areas far from hospital or urgent care services, which might lack sufficient primary care services without a walk-in centre.
- Overall primary care and urgent needs, including general demand for primary care services, which a walk-in centre may be helping to meet.
- A need for specific services that are not currently available, indicated by a significant number of patients seeking advice, treatment or services at the walk-in centre that are not provided there or in another local setting.

Based on the commissioning practices examined in our review and on conversations with stakeholders, we identified some examples of best practice that commissioners should normally include as part of a needs assessment. These include:

- Carrying out a patient survey to better understand why patients are using the walk-in centre.
- Examining the range of conditions and injuries presented at the walk-in centre and the types of advice and treatment being offered.
- Engagement in the community, which might include sponsoring public discussion forums, meetings with local patient organisations and local constituent groups, interviews or focus groups with a selection of individual patients, and/or online and community-based communications and outreach activities.¹⁶⁵ Local Healthwatch organisations may be able to help

¹⁶⁵ NHS England and CCGs have an obligation to ensure that patients are involved in (i) planning commissioning arrangements; (ii) developing and considering proposals for changes in commissioning arrangements that impact how services are delivered to patients or the range of services; and (iii) decisions affecting how the arrangements operate where these have such an impact. See Sections 13Q and 14Z2 of the National Health Services Act 2006.

commissioners reach the people within their communities who are likely to be affected by changes in provision, including hard-to-reach groups.

- Engaging with providers across the local health economy to understand how the walk-in centre interacts with other services (for example, with ambulance services, A&E, and local GP practices). This could help determine whether services need to be better integrated for patients.
- Seeking evidence of gaps or duplication in local services. For example, the West Midlands Ambulance Service NHS Foundation Trust maintains the Directory of Services (DOS) and provides information to commissioners about instances when it could have been clinically appropriate to refer a patient calling either 999 or 111 to a walk-in centre, but where none was available.¹⁶⁶ This allows commissioners to identify any areas where a walk-in centre is needed, where hours or services could be altered to meet demand, or where walk-in centres are not being used due to overprovision. Commissioners should consider whether they need to improve the DOS in their areas, as stakeholders told us that in some areas the directory is not up to date or is not being put to its best use in matching demand with services.

8.2. Choosing a service model and provider

Where commissioners have identified that a walk-in centre is meeting particular health care needs in their area, or have identified unmet needs in the course of their review of walk-in centre services, they will need to decide what services to procure, and from whom, to best meet those needs within available funding when the contract with the walk-in centre expires.

Deciding what services to procure to meet patients' needs

Having conducted a needs assessment, commissioners should consider what models of care may be appropriate to best meet the health care needs that it has identified.¹⁶⁷

It may be that some of the needs that are currently being met by a walk-in centre in the area could be secured through a variety of different models of primary and urgent care. These might include, for example:

- continuing to offer the walk-in centre;
- enhancing walk-in centre services by offering them in a way that is more integrated with other services (see Section 8.3);

¹⁶⁶ See West Midlands Ambulance Service NHS Foundation Trust submission to Monitor's walk-in centre review, p.1.

¹⁶⁷ Commissioners will also need to have regard to the joint strategic needs assessment and joint health and wellbeing strategy prepared by the Joint Health and Wellbeing Board covering their area. See section 116B of the Local Government and Public Involvement in Health Act 2007.

- relocating or reconfiguring the services provided by an existing walk-in centre;
- procuring services targeted specifically at particular vulnerable patient groups (for example, services for the homeless);
- procuring additional services from GP practices;
- enhancing provision of pharmacy or NHS 111 services; or
- some combination of these options.

In some circumstances there may be a more limited number of models that would be suitable. If, for example, the service needs to cater primarily to unregistered people or others with specific needs, it may be that extended or out-of-hours cover from GP practices would not be an appropriate choice.

Commissioners may want to pilot a new arrangement intended to replace a walk-in centre to evaluate whether it is likely to represent the best model for patients. In that case, commissioners should, where funding permits, consider keeping the walk-in centre open until after the pilot is evaluated.

Identifying the best service model to meet patients' needs includes evaluating which model offers the best value for money. Commissioners also should examine the impact of any potential changes to walk-in centre services on other services. This might entail:

- Considering the location, opening hours, capacity, and quality of local GP practices, pharmacies, other walk-in or urgent care centres and A&E departments, and the nature of services available from these providers.
- Analysing likely patient flows under each possible model of care and the potential impact on the costs and quality of other services within the local health care economy (for example, modelling the potential costs associated with increased use of A&E, urgent care centres, or other services if a walk-in centre were to close).
- Looking at data on the impact of walk-in centre closures in other locations with similar local health economies and examining the effectiveness of any alternative models put in place.

Commissioners have a duty to involve patients, and those who may use health services, in decisions.¹⁶⁸ Public consultation can be an effective way of gathering views from the local community on the options being considered by commissioners and the assumptions and evidence underlying those options. A number of

¹⁶⁸ See footnote 166 for a description of the duty to involve patients.

commissioners we spoke to chose to do a formal consultation with the public on proposed changes to walk-in centre services.

We saw examples of Local Healthwatch organisations helping commissioners develop a robust public engagement and consultation plan. They may also be able to connect commissioners with organisations representing hard-to-reach groups to engage with them about plans to reconfigure walk-in centre services.

Following a review, if commissioners decide not to continue to procure walk-in centre services or replacement services (for example, if they intend for patients to seek care from their GP practices), commissioners should, as best practice, develop plans for how local GP practices and other existing services will absorb any additional demand resulting from the closure of the walk-in centre. The plan might include, for example, details about additional appointments that will be available from GP practices. Where a significant number of patients using the walk-in centre are not registered with a GP practice, the plan should also address how those patients might continue to access primary care after the walk-in centre is closed. Commissioners should also consider how to involve patients in developing the plan and how to communicate the proposed service changes to the public in good time.

Choosing a provider(s) to deliver the service model

Regulation 3(3) of the Procurement, Patient Choice and Competition Regulations requires commissioners to procure services from the provider or providers most capable of securing patients' needs and improving services, and that provide best value for money. Regulation 3(2) also requires commissioners to treat providers equally, which includes giving all potential providers of a service a fair opportunity to provide them. These two requirements are closely linked. By giving full consideration to the relative ability of a wide range of different providers, commissioners are more likely to end up securing services from the provider that will achieve the best outcome for patients.

Once commissioners have chosen a particular model of care, there are a number of ways in which they might go about selecting a future provider or providers. What is appropriate will depend on local circumstances. For example:

- Commissioners may decide to procure services through a competitive tender process. This may be appropriate, for example, if there are a large number of potential providers or some providers have contacted commissioners to express an interest in providing the service in the area. It may also be appropriate where commissioners have concerns about the quality or efficiency of existing provision and want to understand whether there are other capable providers in the area.
- Commissioners may decide to announce their intention to extend or renew the contract with an existing provider some time before reaching a final decision.

This may be appropriate, for example, where commissioners are satisfied that the existing provider is delivering a high quality service that is good value for money and is unsure about whether there are other providers that might be interested in providing the service. Commissioners could make this announcement on their website and Supply2Health a reasonably long time before the contract is due to expire, for example, 12 months. This would enable other providers to express interest. If other providers do express an interest, commissioners would need to consider whether those providers might be capable of delivering a better service.

- Commissioners may decide to extend or renew the contract with the existing provider. This may be appropriate, for example, where commissioners are aware that the current provider is the only provider in the area capable of delivering the particular services offered at the walk-in centre; or where the existing provider is performing well and the commissioner is confident, taking all available information and evidence into account, that the provider is the most capable of meeting patients' needs, improving quality and efficiency, and providing the best value for money.

Whatever process commissioners decide to follow, they will need to consider how best to run a proportionate process that it is sufficiently robust to identify the most capable provider.

8.3. Improving services by providing them in a more integrated way

Commissioners are expected to consider ways of improving services, including through services being delivered in a more integrated way.¹⁶⁹

Some commissioners raised concerns that walk-in centres may be contributing to the fragmentation of care because, for example, walk-in centres generally do not have access to patients' medical records and may not be able to refer patients on to secondary care services. However, we found that the strength of links between walk-in centres and other services in the local health economy varies by locality (see Section 4.5).

Whenever commissioners are considering what services to procure and how to do so, they should consider whether services could be improved by being delivered in a more integrated way with other health and social care services.

Commissioners should not discount a walk-in centre model simply because an existing walk-in centre does not have strong links with other services in the local health economy. Rather, commissioners should consider whether practical steps

¹⁶⁹ This is required by regulations 2 and 3(4)(a) of the Procurement, Patient Choice and Competition Regulations; see also National Health Service Act 2006 sections 13N and 14Z1.

could be taken to ensure that care is delivered in a more integrated way by creating better links between different services (including those provided by a walk-in centre).

Some examples of this might include:

- establishing care pathway protocols between the centre and other primary and secondary care providers;
- developing more and stronger links with public health and social care services;
- introducing access to shared patient records;
- integrating walk-in centre clinicians into multi-disciplinary teams; and
- addressing any confusion that might exist in the community about the different services that are available in the area (including by offering clear information to the public describing what services are on offer at a walk-in centre and when, and ensuring that the name of the centre appropriately signals the services offered at the centre; for example, centres should not be labelled walk-in centres if walk-in services are offered only on a very limited basis).

As some stakeholders pointed out, such a model would also support policies designed to move care into communities and out of hospital settings.

8.4. Managing conflicts of interest

Commissioners are required to comply with a number of rules designed to ensure that conflicts of interest are appropriately declared and managed. These include Regulation 6(1) of the Procurement, Patient Choice and Competition Regulations, which prohibits commissioners from awarding a contract for NHS services where conflicts or potential conflicts between the interests involved in commissioning such services and providing them affect, or appear to affect, the integrity of the award of that contract.¹⁷⁰

Conflicts of interest may materialise in a number of different ways when decisions are being taken about the future of a walk-in centre. A CCG may decide, for example, to close a walk-in centre and instead buy additional services from member GP practices (such as opening a weekend walk-in clinic at a local GP practice).

¹⁷⁰ CCGs are also required to comply with section 140 of the National Health Service Act 2006. This includes requirements to maintain a register of interests, to declare conflicts of interest and to manage them when they arise. Members of commissioners that are registered doctors must also comply with their professional obligations in so far as they concern conflicts of interest. These are set out in the General Medical Council's guidance [Good Medical Practice](#) (see paragraphs 77 to 80 "honesty in financial dealings") and [Financial and commercial arrangements and conflicts of interest](#). In relation to conflicts of interest, this states that if faced with a conflict of interest, doctors must be open about the conflict, declare their interest formally, and be prepared to exclude themselves from decision-making.

Member GP practices of CCGs may therefore have a direct financial interest in decisions about whether or not to continue to procure services from a walk-in centre.

Some stakeholders raised concerns with us that these and other potential conflicts of interest may lead to flawed procurement decisions that are motivated by financial interests rather than the interests of patients.

CCGs are required to ensure that conflicts of interests are declared as soon as practicable and included in the CCG's register of interests (which must be published or otherwise made accessible to the public on request).¹⁷¹

Given concerns about potential conflicts of interest, we suggest that CCGs publish on their website details of conflicts of interest ahead of taking any decision that affects a walk-in centre together with an explanation of how they propose to manage them.¹⁷²

Depending on the circumstances, there may be a number of different ways of managing a conflict of interest in order to prevent it from undermining the integrity of a CCG's decision about the future of a walk-in centre. Options may include:

- Excluding conflicted GPs from participating in decision-making (ie, voting on relevant decisions). Relevant decisions – such as decisions about whether or not to close a walk in centre; which provider to select to run a walk-in centre; and/or what services (if any) to procure instead of an existing walk-in centre – could be taken by the non GP members of the governing body of the CCG, including the lay persons, the registered nurse and secondary care consultant (assuming that a quorum can be achieved). What is possible will depend on the CCG's constitution, but another option may be to arrange for other individuals that are not conflicted to be co-opted to vote on decisions about the future of the walk-in centre.
- Excluding conflicted GPs from participating in particular steps involved in the review of walk-in centre services. GPs might be excluded not only from taking decisions, but also from more general participation in the review, such as from drafting proposals for future service provision.
- Arranging for third parties with relevant experience and expertise to review decisions taken to provide ongoing scrutiny. This might include, for example,

¹⁷¹ CCGs are required to maintain one or more registers of interest. They must also make arrangements to ensure that any conflict or potential conflict of interest is declared as soon as practicable after the person becomes aware of it (and in any event within 28 days) and that any such declaration is included in the register of interests. See section 14O of the National Health Service Act 2006.

¹⁷² See NHS England's [Guidance for Clinical Commissioning Groups on Managing Conflicts of Interest](#) which suggests that openness and transparency are integral safeguards for managing conflicts of interest when taking commissioning decisions (p.12).

getting the local health and wellbeing board to review the CCG's proposals at various stages of the process.

- Seeking appropriate expertise and evidence. Regardless of whether there are potential conflicts of interests, commissioners must make sure that their decisions are evidence-based and rely on appropriate expertise. Doing so will also help to ensure that any conflicts of interest that do exist do not affect the decisions that are taken (or appear to do so).

More guidance on handling conflicts of interest is available in Monitor's *Substantive guidance on the Procurement, Patient Choice and Competition Regulations* (Section 7) and NHS England's guidance for CCGs on managing conflicts of interest.¹⁷³

8.5. Acting transparently

Commissioners are required to act in a transparent way when procuring services (Regulation 3(2) of the Procurement, Patient Choice and Competition Regulations). Transparency is important in ensuring that commissioners are accountable for their decisions. As noted, commissioners also have a duty to involve the public in commissioning decisions.

It appears from our review that some decisions about the future of walk in centres may not always be shared or communicated as effectively as they might be. For example, while we saw several examples of a public consultation exercise that explained the processes and reasons for a proposed closure, we also saw examples in which commissioners appeared to have decided to close walk-centres without setting out their reasons for doing so or explaining the process they followed to reach their decision. Some providers also told us that they were unsure about what their local commissioners' intentions were with respect to the walk-in centre services that they provide, even though the contract was due to expire in the near future.

We also saw examples in which commissioners had consulted with the public on proposals to relocate a walk-in centre to an A&E department as an urgent care centre, giving an impression that the centre would still be available to walk-in patients at a new location. However, the actual service put in place triages patients who queue for emergency services. Those not needing emergency care are seen by a primary care service within A&E. The service does not offer a distinct urgent care centre or walk-in centre that is visible to patients. It is important for commissioners, when consulting the public on proposed new models of service, to explain clearly the features of the proposed model and how patients will be able to access it in the future.

Commissioners must consider what steps they should take to ensure that people understand the reasons for the decisions that they are taking and the process that

¹⁷³ [Guidance for Clinical Commissioning Groups on Managing Conflicts of Interest.](#)

they are following to take them. This may include, for example, announcing when they are proposing to review the future of a walk-in centre, what process they intend to follow, and the decision that they ultimately take and the reasons for it (see our recommendations in Section 9).

9. Our recommendations

In this section, we recommend actions that commissioners can take now to help make walk-in centre services work better for patients. We are aware of the statutory framework for commissioning and the duties placed on NHS England and CCGs. The recommendations in this section are designed to assist commissioners in carrying out their commissioning functions. It is up to commissioners to decide whether to adopt these recommendations or to use a different approach; however, we believe, based on the findings of our review, that these recommendations represent good practice that will help commissioners achieve the best results for patients.

9.1. Bring greater clarity and transparency to commissioning responsibilities for walk-in centres

In Section 7.2, we discussed how the split in commissioning responsibilities has led to confusion about which commissioning bodies are responsible for walk-in centres or particular services offered at walk-in centres. To clear up any confusion, provide more transparency for patients and providers, and promote joint work between NHS England and CCGs, we recommend that commissioners provide more information to the public about walk-in centres.

We recommend that by 31 March 2014, CCGs publish information on their websites that describes for each walk-in centre in their geographic area:

- the name of the centre and the provider;
- the expiration date of the contract for the centre;
- which commissioning body (or bodies) is holding and managing the contracts associated with the centre;
- which commissioning body (or bodies) funds the walk-in centre or, if relevant, funds particular services provided by the walk-in centre;
- the date that any review of walk-in centre services commenced or will commence;
- which commissioning body (or bodies) is leading or will lead the review;
- where walk-in centre services are under review, what other organisations are taking part or will take part in the review and in what role; and
- which commissioning body (or bodies) is ultimately responsible for deciding whether to continue to procure the walk-in centre or particular services provided by the walk-in centre (such as the registered list and the non-registered patient services for GP-led health centres).

The statement should be in plain language so that patients as well as providers have the opportunity to understand what is happening with their local walk-in centre.

We recommend that CCGs publish this information for all open walk-in centres, including those for which a review process is already underway or near completion.

Our purpose in recommending that commissioners publish this information is to help clear up confusion around commissioning responsibilities, and to encourage CCG and NHS England commissioners to work together to clarify their responsibilities. CCGs and NHS England commissioners will need to think about how and when they will take decisions about walk-in centres. CCGs may also need to gather information, such as the date of contract expiration from NHS England if NHS England holds the contract. CCGs should then post this information on pages of their websites that give information about walk-in centre services within their areas. This could be published on a CCG's website as a joint statement with the NHS England local area teams or other local bodies.

We also recommend that the commissioning body responsible for managing a walk-in centre contract ensure that walk-in centre providers are informed of any contract review or other relevant developments (such as possible reconfigurations or changes in services under consideration) at least six months before expiration of the contracts. Six months' notice is sometimes required under contracts, but we are aware of instances in which providers have had no discussions with commissioners even though contracts were due to expire within a few months.

9.2. Ensure that decisions are joined-up

In addition to causing confusion, the split in commissioning responsibilities has created a risk that decisions are not joined-up and do not take into account the impact of changes in walk-in centre provision across local health care economies, affecting both primary and secondary care.

We recommend that CCGs and NHS England local area teams work more closely together to make decisions about the future of walk-in centres.

In particular, NHS England, as the commissioner of primary care, should work with CCGs to consider the effect of any potential closing or change to walk-in centre services (for both registered and non-registered patients) on primary care services in the local area.

CCGs should work with NHS England to consider the effect of any potential closing or changes to walk-in centre services (for both registered and non-registered patients) on other services that the CCG commissions, including urgent care services and A&E departments.

In addition, NHS England local area teams should work with CCGs to co-ordinate the timing of decisions about GP-led health centres. In some areas, we found that CCGs

have decided to close or reconfigure walk-in services for non-registered patients, while NHS England has not yet decided whether to continue the contract for the registered list element of the centre. This has left registered patients uncertain and concerned about whether their GP practice will be available in the future.

NHS England and CCG commissioners also may need to work with local authorities to make decisions about public health services where those types of services are offered at walk-in centres.

We encourage CCG and NHS England commissioners to reach decisions jointly about walk-in centres, both with and without a registered list. Currently, NHS England and CCGs can work together to make joint decisions, although these decisions need separate approval through the governance processes of each respective commissioning body if they relate to CCGs' functions.¹⁷⁴ For these functions, they might make decisions together, for example, by setting up joint working groups, as commissioners in some local areas have done.

NHS England and CCGs also may make joint decisions to exercise NHS England's functions, through a joint committee, without needing separate approval from each commissioning body. Whatever mechanism is used, it will be in patients' best interests for NHS England and CCGs to reach decisions jointly when considering the future of walk-in centres.

9.3. Involve local Healthwatch and health and wellbeing boards

To varying degrees, local Healthwatch and Health and Wellbeing Boards are taking part in commissioners' decisions about walk-in centres. These organisations can bring valuable insight to the process and can help ensure commissioners' decisions are in patients' best interests.

We recommend that commissioners work with their local Healthwatch group to engage and consult with the public, and with their health and wellbeing boards to align their commissioning decisions with local joint health and wellbeing strategies for meeting patients' health and social care needs.

Healthwatch

Healthwatch was created to give patients a stronger voice in decisions about health and social services. We have seen some examples in which local Healthwatch groups have worked with commissioners to develop a public engagement and consultation plan as part of a review of walk-in centre services in their local area. Local Healthwatch groups have been commissioned, in some cases, to conduct patient surveys and sponsor public discussion forums. They have also helped to

¹⁷⁴ The Department of Health has proposed a change to the Health and Social Care Act 2012 that would allow CCGs and NHS England to make decisions by joint committee to carry out CCG functions. See Section 10 for further discussion.

make sure that commissioners have gathered views from all communities and patients that might be affected by changes in walk-in centre services, for example, by identifying and engaging with organisations representing particular groups in the local area (such as travellers).

Healthwatch may be able to play these roles at both the needs assessment stage and when commissioners are consulting or using another form of public involvement to put options before the public.

Health and wellbeing boards

Health and wellbeing boards began in shadow form in 2012 and became fully operational in April 2013. They bring together members of local authorities, CCGs, social care and public health officials, local Healthwatch and others involved in health and social care. Their primary duty is to encourage provision of health and social care services in an integrated way.¹⁷⁵ Most have produced joint strategic needs assessments and joint health and wellbeing strategies.¹⁷⁶

We examined several examples of how health and wellbeing boards are involved in decisions about walk-in centres. We found that some commissioners are informing or consulting with the boards about their plans for walk-in centres or for urgent care more broadly. Some boards are playing a role similar to a local authority overview and scrutiny committee by trying to ensure that commissioners have a transparent and thorough process, and that their proposals will continue to meet the needs of patients. Others have been supportive of commissioners' proposals and have helped to sponsor public consultation.

CCGs have a duty to consult their health and wellbeing boards about their general commissioning plans.¹⁷⁷ As good practice, CCGs and NHS England local area teams should consult the boards on an ongoing basis about specific proposals to change walk-in centre services or urgent care services generally so that the boards can ensure that proposals are aligned with local needs assessments and strategies.

NHS England representatives are required to appoint a representative to health and wellbeing boards for the purpose of preparing joint strategic needs assessments and joint health and wellbeing strategies for delivering health and social care in an integrated way.¹⁷⁸ NHS England also must have regard to them when commissioning services;¹⁷⁹ however, NHS England local area teams are not required to have

¹⁷⁵ See section 195 of the Health and Social Care Act 2012.

¹⁷⁶ See R. Humphries, A. Galea, The King's Fund, *Health and wellbeing boards: One year on*, Oct. 2013, available at www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/health-wellbeing-boards-one-year-on-oct13.pdf.

¹⁷⁷ See section 14Z13 of the Health and Social Care Act 2012.

¹⁷⁸ See section 197(1) of the Health and Social Care Act 2012. Under sections 197(3) and (4), NHS England must also appoint a representative where the Board requests its participation to consider a matter relating to the exercise or proposed exercise of NHS England's commissioning functions.

¹⁷⁹ See section 116B of the Local Government and Public Involvement in Health Act 2007.

regular membership on the boards, as are CCGs. Where NHS England local area teams are not members, health and wellbeing boards should consider how the local area teams might participate in the board's consideration of proposals related to walk-in centres or urgent care more generally.

9.4. Work with local GP practices to improve access where problems are identified

Walk-in centres may be able to provide commissioners with information that will help them to identify GP practices that may have problems with access (or other problems). The centres usually track where their non-registered patients are registered if they are registered with a GP practice elsewhere.

We recommend that commissioners work with GP practices that have a high number of patients using a walk-in centre to identify and help to address any problems that may be causing patients to have difficulties accessing services.

In Section 7.1.1, we give examples of how some commissioners have used information provided by walk-in centres to identify GP practices with access problems and work with them to improve access, including by better managing demand for same-day care.

9.5. Take steps to ensure that any changes are achieving the desired benefits for patients

We found, generally, a lack of follow-up information on the impact of walk-in centre closures. As with changes to any services, follow-up analysis can help commissioners determine whether patients' needs are being met. It can also provide information and insight to help others in the sector develop a better understanding of how well different models are working for patients within different local health economies.

We recommend that commissioners follow-up decisions to close walk-in centre services with analysis to determine whether the changes are working for patients as intended.

This might be accomplished, for example, through the course of a regular evaluation or review of services commissioned to replace a walk-in centre; or it may be accomplished by doing an impact study on demand for other local services in both primary and secondary care. Commissioners may also seek further engagement with patients and other stakeholders. For example, if commissioners intended patients with minor conditions to consult GPs, NHS 111 or pharmacies, we recommend that they investigate the extent to which patients are doing so and how well those services are working for patients.

We also suggest that commissioners publish follow-up studies or reports on their websites to share with the sector.

10. Long-term work to make services work better for patients

Organisations across the sector are working to bring about changes that are likely to address some of the issues identified in our report, including the need to improve access to primary care, to clarify commissioning responsibilities and join-up decision-making, and to use payment mechanisms that create incentives that benefit patients. It is important that leaders of the sector ensure that this work results in a consistent, coherent framework for improvement that also allows local flexibility.

Improving access to routine and urgent primary care

Efforts are underway at the national and local levels to identify and support drivers of improvement and innovation in GP services and to help practices develop new models of care that are more responsive to patients' needs. These include:

- NHS England is developing a strategic framework for primary care services that includes plans for new models of primary care that will enable general practice to expand access and the scope of services on offer.¹⁸⁰
- Monitor's call for evidence on GP services has been followed up with a discussion document, published in February 2014, which identifies key issues raised by stakeholders related to:
 - access and quality;
 - the ability of new or existing providers of GP services to develop the scope of their offer to the NHS; and
 - the ability and incentives of providers to work together to benefit patients.

We have proposed further work for this year to support improvements in general practice, including examining the supply and demand of GP services to gain a better understanding of variations in access and quality across England and how these may be addressed.

- NHS England will soon begin overseeing at least nine pilots, funded through the Prime Minister's £50 million Challenge Fund, to test ways of improving access to appointments for up to half a million patients. The pilots will explore a number of ways to extend access to GP services to better meet local patient needs, including:
 - longer opening hours, such as extended weekday opening (8am to 8pm) and opening on Saturdays and Sundays;

¹⁸⁰ See NHS England, *Improving general practice: a call to action*, at www.england.nhs.uk/ourwork/qual-clin-lead/calltoaction/igp-cta/.

- greater flexibility about how people access general practice, for example the option to visit a number of GP surgery sites in their area;
 - greater use of technology to provide alternatives to face-to-face consultations via phone, email, webcam and instant messaging;
 - greater use of patient online services, including online systems of patient registration;
 - greater use of telecare and healthy living apps to help people manage their health without having to visit their GP surgery as often; and
 - greater choice of practice.
- The 2014/2015 general medical services (GMS) contract will potentially lead to greater choice for patients by allowing GP practices to register patients from outside their catchment area without responsibility for home visits. The contract also requires practices to promote and offer all patients the ability to book appointments online, order repeat prescriptions online and access their medical notes online.
 - The Department of Health has also recognised that vulnerable and disadvantaged groups still face barriers to accessing primary care, and is working to develop better models of care for these groups.
 - Beyond general practice, as noted in Section 3, NHS England's Urgent and Emergency Care Review is working to develop a framework for urgent care designed to reduce confusion about where to go for care and to ensure access to high-quality urgent care 24/7.

Making responsibilities clearer and joined-up commissioning easier

Confusion around responsibilities and a risk of fragmented commissioning is not limited to the provision of walk-in centres. The Department of Health is proposing to use a legislative reform order, subject to Parliamentary approval, to create the ability for CCGs to make joint decisions through a joint committee with other CCGs and for CCGs to make joint decisions through a joint committee with NHS England in areas that are within CCG functions.¹⁸¹ This could facilitate, for example, joint decisions about walk-in centre services.

Further, NHS England, in its Urgent and Emergency Care Review, is considering the appropriate size of commissioning footprints over local health economies. Its intention is to bring together a network of actors within each local footprint to facilitate joined-up decision-making that is based on a local system-wide view. In its

¹⁸¹ See the [Consultation on a proposal to use a Legislative Reform Order to make changes to the National Health Service Act 2006](#).

planning guidance, NHS England has asked commissioners to identify how they will “be ready to determine the footprint of your urgent and emergency care network during 2014/15”.¹⁸²

Using payment mechanisms to generate incentives that lead to benefits for patients

Under the 2012 Act, Monitor and NHS England share responsibility for setting prices within the national tariff payment system. As part of these responsibilities, Monitor and NHS England are working to improve payment mechanisms for urgent and emergency care services. This includes trying to better understand the costs of providing these services.

NHS England and Monitor have also pledged to work together to ensure there is a coherent payment system for both primary and secondary care, particularly for emerging new models of delivering integrated care across primary and secondary care settings.¹⁸³ This is an issue that we will continue to consider with NHS England as we develop our long-term strategy for the payment system.

¹⁸² NHS England, [Everyone Counts: Planning Patients 2014/15 to 2018/19](#), p.30.

¹⁸³ See [The 2014/15 National Tariff Payment System](#), p.8.

Annex 1: Alternatives to walk-in centres

This Annex describes a number of alternatives to walk-in centres that may be available within a locality for people needing advice or treatment for minor illness or injury. The alternatives are:

- urgent care centres;
- minor injuries units;
- A&E departments;
- NHS Direct and NHS 111 services;
- GP services (in hours);
- out-of-hours GP services;
- community pharmacy services; and
- self-care and self-management.

Urgent care centres

Urgent care centres (UCCs) often provide services that are very similar to those offered at walk-in centre, though there can be “wide variation” in the nature of services labelled as urgent care centres.¹⁸⁴ As services are GP-led, many UCCs allow patients to walk in and will treat routine primary cases which could ordinarily be dealt with by out-of-hours GP services or walk-in centres.¹⁸⁵ However, some UCCs will receive only patients who have been streamed from an A&E department, or will direct non-urgent cases back to their own GPs.

Many UCCs are co-located with a hospital with access to a full range of staff and services or are located away from a hospital but act as mini-A&Es with a full range of diagnostics and clinical staff. Others that are remote from a hospital may have more limited services (for example, a limited capability for dealing with fractures).¹⁸⁶

UCCs are generally open seven days a week; some open for 24 hours a day, others for extended hours.¹⁸⁷ They are required to provide care for patients within the four hour standard, as is required for A&E departments.¹⁸⁸

¹⁸⁴ Primary Care Foundation, Urgent Care Centres: What works best, Oct. 2012, p.3. Available at: www.primarycarefoundation.co.uk/files/PrimaryCareFoundation/Downloading_Reports/Reports_and_Articles/Urgent_Care_Centres/Urgent_Care_Centres.pdf

¹⁸⁵ Primary Care Foundation, Urgent Care Centres: What works best, Oct. 2012.

¹⁸⁶ Primary Care Foundation, Urgent Care Centres: What works best, Oct. 2012, p.8.

¹⁸⁷ Primary Care Foundation, Urgent Care Centres, What works best, Oct. 2012, p.14.

¹⁸⁸ Healthcare for London, A service delivery model for urgent care centres: Commissioning advice for PCTs, p.12, available at: www.londonhp.nhs.uk/wp-content/uploads/2011/03/Urgent-care-centres-

UCCs evolved as a way to reduce A&E attendances, as well as to reduce waiting times for patients with minor conditions who could otherwise face long waiting times at an A&E.^{189,190}

Minor injuries units

A minor injuries unit (MIU) is an assessment and treatment centre led by specially trained nurses, such as emergency nurse practitioners.^{191,192} It is designed to handle less serious injuries than would ordinarily be treated at an A&E department, including broken bones, sprains, wound infections, minor eye problems, minor burns, bites and cuts.¹⁹³ As MIUs do not have the full range of facilities and support services that A&E departments have, the units cannot treat major injuries, chest and stomach pains, breathing difficulties, allergic reactions, overdoses and other more serious health problems.^{194,195} If a patient requires further diagnosis and treatment, (s)he will most likely be sent to the A&E department (which may be on another site) or referred to another, more appropriate service. Some MIUs, like some nurse-led WICs, do not treat young children, setting a minimum age for patients that they can treat.¹⁹⁶

Services at MIUs are available on a walk-in basis.¹⁹⁷ Opening hours vary by location. They are generally open seven days a week; some operating 24 hours a day, others with set opening times (such as 7am-10pm or 9am-8pm). The main difference between an MIU and a walk-in centre is that MIUs do not typically deal with patients' routine primary care needs.¹⁹⁸ The service is nurse-led, and onsite staff are not typically trained in primary care. Like UCCs and major A&E departments, MIUs are required to provide care within a four hour standard.¹⁹⁹

[delivery-model.pdf](#); Department of Health, Urgent and emergency care services <http://webarchive.nationalarchives.gov.uk/+/dh.gov.uk/en/healthcare/urgentandemergencycare/urgentandemergencycareservices/index.htm>

¹⁸⁹ Primary Care Foundation, Urgent Care Centres: What works best, Oct. 2012, p.3.

¹⁹⁰ For example, Urgent care centre pilot launched at UCH, 19 September 2011, www.uclh.nhs.uk/news/Pages/UrgentcarecentrepilotlaunchedatUCH.aspx

¹⁹¹ See NHS Choices: Emergency and urgent care services,

www.nhs.uk/NHSEngland/AboutNHSservices/Emergencyandurgentcareservices/Pages/Minorinjuriesunit.aspx

¹⁹² For example, www.bartshealth.nhs.uk/your-visit/in-an-emergency/

¹⁹³ www.nhs.uk/NHSEngland/AboutNHSservices/Emergencyandurgentcareservices/Pages/Minorinjuriesunit.aspx

¹⁹⁴ www.nhs.uk/NHSEngland/AboutNHSservices/Emergencyandurgentcareservices/Pages/Minorinjuriesunit.aspx, www.collemergencymed.ac.uk/asp/document.asp?ID=2980

¹⁹⁵ www.herefordshire.nhs.uk/docs/Policies/MIU_Operational_Policy.pdf

¹⁹⁶ www.herefordshire.nhs.uk/docs/Policies/MIU_Operational_Policy.pdf

¹⁹⁷ For example, www.bartshealth.nhs.uk/your-visit/in-an-emergency/

¹⁹⁸

www.nhs.uk/NHSEngland/AboutNHSservices/Emergencyandurgentcareservices/Pages/Minorinjuriesunit.aspx

¹⁹⁹ See, eg,

www.warringtonandhaltonhospitals.nhs.uk/page.asp?fldArea=3&fldMenu=1&fldSubMenu=0&fldKey=965

MIUs began to appear in the UK in the mid 1990s, typically replacing small A&E departments. This was motivated by policies to move health care into the community and to rationalise and centralise the provision of emergency care.²⁰⁰

A&E departments

A&E departments are intended to deal with serious injuries and illnesses. An A&E department can provide care for emergency conditions of all types and for patients of all ages.^{201,202} This includes illness and injury, mental health problems and life-threatening emergencies including:

- loss of consciousness;
- acute confused state and fits that are not stopping;
- persistent, severe chest pain;
- breathing difficulties; and
- severe bleeding that cannot be stopped.²⁰³

Major A&E departments –Type 1 A&Es – are consultant-led and have access to full resuscitation facilities and designated accommodation for the reception of accident and emergency patients.²⁰⁴

Most A&E departments offer guaranteed access to care 24 hours a day, seven days a week.²⁰⁵ Patients can self-present or be brought to A&E by an ambulance.

NHS Direct and NHS 111 services

Rolled out nationally in October 2000, NHS Direct was established as a national provider of a 24-hour nurse-led telephone health advice line. The NHS Direct service was first introduced as part of the government’s plans to modernise NHS services, and its main aim was to “provide people at home with easier and faster advice and

²⁰⁰ See, for example, Brian Dolan, Jeremy Dale, [Characteristics of self referred patients attending minor injury units](#), *Journal of Accident and Emergency Medicine*, 1997; 14:212-214

²⁰¹ A&E may not be suitable for patients with multiple, serious injuries. Such patients may need to be transferred to a major trauma centre. This is a hospital where there is a full range of trauma specialists, including orthopaedics, neurosurgery and radiology teams. Care at major trauma centres is led by a trauma consultant, who is available 24 hours a day.

²⁰² NHS England, *High quality care for all, now and for future generations: transforming urgent and emergency care services in England – the Evidence Base from the Urgent and Emergency Care Review*, June 2013, p.49.

²⁰³ www.nhs.uk/NHSEngland/AboutNHSservices/Emergencyandurgentcareservices/Pages/AE.aspx

²⁰⁴ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/206267/15_01final3_v3.pdf

²⁰⁵ NHS England, *High quality care for all, now and for future generations: transforming urgent and emergency care services in England – the Evidence Base from the Urgent and Emergency Care Review*, June 2013, p.49.

information about health, illness, and the NHS.”²⁰⁶ The service was also meant “to point people in the right direction for the most appropriate form of treatment.”²⁰⁷ The service was replaced from 2013 by the NHS 111 service.

NHS 111 was launched as the new telehealth and patient triage service to help people access NHS health care services for urgent medical problems. It was introduced in response to public concern and frustration about accessing NHS care, especially at weekends and out-of-hours.²⁰⁸ It is intended to simplify access to non-emergency health care by providing a memorable number (111) that is free to the caller,²⁰⁹ to provide consistent clinical assessment at the first point of contact, and to route customers to the right NHS service first time. A key difference to the NHS Direct service is that the NHS 111 service is commissioned locally, and is intended to be linked electronically to a skills-based directory of local services. It is hoped that this will make the service more integrated with the local health economy and therefore make it easier for users to access the most appropriate health care service, quickly.²¹⁰

The service is available 24 hours each day of the year. Calls are free of charge from landlines and mobile phones. The service is designed for situations that are not life threatening²¹¹ and where callers are unsure about what service they need or they need access to care out-of-hours. Key features of the service are:

- calls are assessed by a trained, non-clinical call adviser using clinical assessment software to determine both the type of service needed and the timescale within which help is required;
- where possible, appointments are made with the correct service at the time of the call;
- calls that require further clinical assessment can be transferred to a clinical nurse advisor or GP within the same call; and
- if a call requires an emergency ambulance response, a vehicle can be dispatched without the need for further triage.²¹²

²⁰⁶ Pilot NHS Direct programmes began in 1998 and a complimentary website was launched in 1999. www.nhsdirect.nhs.uk/About/WhatIsNHSDirect/History

²⁰⁷ www.nhsdirect.nhs.uk/About/WhatIsNHSDirect/History

²⁰⁸ www.england.nhs.uk/2013/06/07/nhs-111-improving/

²⁰⁹ NHS Direct operated a national phone line; while the service was free to use, callers would incur calling charges.

²¹⁰ University of Sheffield, Evaluation of NHS 111 pilot sites, Final Report, August 2012. www.sheffield.ac.uk/polopoly_fs/1.227404!/file/NHS_111_final_report_August_2012.pdf

²¹¹ The NHS 111 service is not intended to replace the 999 number for life threatening emergencies. www.nhs.uk/NHSEngland/AboutNHSServices/Emergencyandurgentcareservices/Pages/NHS-111.aspx

²¹² University of Sheffield, Evaluation of NHS 111 pilot sites, Final Report, August 2012. www.sheffield.ac.uk/polopoly_fs/1.227404!/file/NHS_111_final_report_August_2012.pdf

The service was first introduced as a pilot scheme in 2010. Initially due for rollout to the whole of England by April 2013, the deadline was extended in some areas by up to six months.^{213,214}

A range of providers have been contracted to provide the service, including Ambulance Service Trusts and out-of-hours GP service providers.²¹⁵ NHS Direct was originally contracted to provide the service to about a third of England's population. However, it withdrew from the 111 service on financial grounds²¹⁶ and has since announced that it will cease operations at the end of March 2014.²¹⁷

The launch of the 111 service has not run smoothly and may take some time to win public confidence. For example, when NHS Direct launched its two largest services in March 2013, it found that it did not have sufficient capacity to handle the calls it received. Calls had to be diverted back to GP out-of-hours organisations and to its original service.²¹⁸ Some have expressed concerns regarding inadequately trained staff, a lack of personnel, long waits and out-of-hours GPs having to take on extra work.²¹⁹

²¹³ Department of Health, Subject: NHS 111 rollout deadline extension, 14 June 2012, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214977/dh_134585.pdf

²¹⁴ Eight CCGs apply for NHS 111 delay, *Pulse*, 1 August 2012, www.pulsetoday.co.uk/eight-ccgs-apply-for-nhs-111-delay/14370420.article#.UmK9C7wYLV0

²¹⁵ By way of example, NHS 111 in Devon is run by the South Western Ambulance Service Foundation Trust; the service in Nottinghamshire is operated by Derbyshire Health United, a GP-led social enterprise company operating the Out-of-Hours GP service. www.bbc.co.uk/news/uk-england-devon-23935801 <http://www.nottinghamnortheastccg.nhs.uk/community/reassurance-over-nhs-111/>

²¹⁶ NHS Direct, The Future of NHS Direct's 111 Services: press release, 29 July 2013, www.nhsdirect.nhs.uk/About/~media/Files/2013PressReleases/NHS%20Direct_111future20130729.ashx

²¹⁷ NHS Direct, NHS Direct To Close At The End Of The Financial Year: press release, 24 October 2013, <http://www.nhsdirect.nhs.uk/News/LatestNews/NHSDirectToClose>

²¹⁸ NHS Direct, The Future of NHS Direct's 111 Services: press release, 29 July 2013, www.nhsdirect.nhs.uk/About/~media/Files/2013PressReleases/NHS%20Direct_111future20130729.ashx

²¹⁹ CCG places NHS 111 rollout on hold indefinitely, *Pulse*, 13 May 2013, www.pulsetoday.co.uk/commissioning/commissioning-topics/urgent-care/nhs-111-implodes-as-gpc-withdraws-support-for-urgent-care-hotline/20002392.article#.UI2Sz7wYLV0

Out-of-hours GP services

The out-of-hours (OOH) GP service is an urgent primary care service provided outside of standard GP practice working hours.²²⁰ The service is available from 6.30pm – 8am during weekdays, and 24 hours at weekends and on bank holidays.

If a patient urgently needs to see a GP when a GP practice is closed, and the patient cannot wait until the practice is open, the patient can call the OOH service using a given phone number.²²¹ A nurse or GP will assess the caller's symptoms over the phone and the caller will then be:

- given advice over the phone on how to best manage their symptoms;
- asked to come into the nearest OOH centre for an appointment with a GP or nurse; or
- offered a home visit from a GP or nurse.²²²

OOH GP services are not designed to deal with routine primary care needs; therefore the provider will not, for example, make routine appointments on the caller's behalf or issue routine prescriptions. Instead, the caller will be advised to contact their GP practice during opening hours.²²³

Changes to the GP contract in 2004 gave practices that had previously been required to provide OOH services to their patients the ability to opt-out of OOH services. Where GPs have opted out, OOH services are commissioned from a separate provider.²²⁴ It has been estimated that around 90% of GPs have opted out.²²⁵

Out-of-hours cover may include some or all of the services below:

- GPs working in A&E departments, MIUs or walk-in centres;
- teams of health care professionals working in A&E departments, MIUs or walk-in centres;

²²⁰ This service is distinct from extended opening hours schemes that many GP practices provide which allow patients to receive their normal in-hours GP services beyond the core times of 8am – 6.30pm.

²²¹ The intention is that once the 111 service is operational in an area all calls to the out-of-hours GP service will be transferred automatically to 111. During transition, depending on the arrangements for the GP practice, a patient calling her/his GP practice when it is closed will either be given the OOH GP service phone number or asked to call NHS 111 or will be automatically directed through to one of these numbers.

²²² OFT, [Completed Acquisition by Care UK Group of HWH Group Limited](#), ME/5840/12, 8 March 2013, paragraph 11.

²²³ www.pelc.nhs.uk/services/out-of-hours-gp-services.html

²²⁴ www.england.nhs.uk/wp-content/uploads/2013/04/pri-med-care-ccg.pdf

²²⁵ OFT, Completed Acquisition by Care UK Group of HWH Group Limited, ME/5840/12, 8 March 2013, paragraph 13. www.of.gov.uk/shared_of/mergers_ea02/2013/care-uk.pdf

- GPs or other health care professionals operating from mobile facilities making home visits; and/or
- ambulance services moving patients to places where they can be seen by a GP or nurse, to reduce the need for home visits.²²⁶

GP practices (in hours)

GP practices provide a broad range of health services to patients, including but not limited to, health advice, assessment of symptoms, prescription of drugs, care or advice for minor illness, urgent primary care, and management of long-term conditions.²²⁷ GP practices are usually staffed by GPs and nurses, but may also include other health care professionals such as health assistants and health visitors.²²⁸ Practices may have other health professionals co-located in the same building, such as pharmacists, physiotherapists, midwives, and district nurses.

If a GP cannot treat a patient, the GP is able to refer the patient to a specialist health practitioner or to a hospital for further investigation and treatment.²²⁹

Core opening hours for GPs under the GMS contract and PMS and APMS contracts providing essential services are from 8:00am to 6:30pm, Monday to Friday, except Good Friday, Christmas day or bank holidays.²³⁰ In addition, NHS England, and previously PCTs, must offer directed enhanced services (DES) contracts to GPs for extended hours, based on a formula of 30 minutes per week for every 1,000 registered patients.²³¹ But GPs need not offer extended hours. Some GP practices – particularly single-GP practices – close for one or more afternoons a week or during holidays or other breaks.

Services are available for patients registered at the GP practice, although practices may also see out-of-area patients as temporary residents.²³²

For the most part, patients must book an appointment to see a GP, although the process for managing appointments often differs across practices. Some practices may provide offer a web-based online booking system or telephone consultations.

²²⁶ www.nhs.uk/NHSEngland/AboutNHSservices/doctors/Pages/out-of-hours-services.aspx

²²⁷ www.nhs.uk/NHSEngland/AboutNHSservices/doctors/Pages/NHSGPs.aspx

²²⁸ A health visitor is a nurse with a specialist training particularly related to children and pregnancy. Health visitors can be employed by the GP practice, but more often are salaried NHS staff.

²²⁹ www.nhs.uk/NHSEngland/AboutNHSservices/doctors/Pages/NHSGPs.aspx

²³⁰ NHS Employers, BMA, NHS England, 2013/14 extended hours directed enhanced service guidance, May 2013.

www.nhsemployers.org/Aboutus/Publications/Pages/2013_14_extended_hours_DES_guidance.aspx

²³¹ Id.

²³² People may register as a temporary resident with a GP practice in England if they are in an area for longer than 24 hours but less than three months. NHS Choices, www.nhs.uk/chq/Pages/how-do-i-register-as-a-temporary-resident-with-a-gp.aspx?CategoryID=68&SubCategoryID=158

For urgent appointments, some practices triage requests with a GP telephone consultation to assess the patient, provide advice or make a same-day appointment, or provide a queuing service by making a certain number of urgent same-day appointment slots available on a first come first served basis; these are allocated either by patients arriving during set times of the day on a first come first served basis, or by patients telephoning the practice and being allocated an appointment time.²³³ GP practices are required to provide emergency and immediately necessary treatment to anyone, whether or not they are registered with the GP practice.

Community pharmacy services

The traditional role of community pharmacies has been to prepare and dispense prescription and non-prescription medicines to the general public, and offer advice on the safe use of medicines. However, this role has expanded recently to include:

- advice and treatment of minor ailments (such as coughs, colds, aches and pains, minor injuries, skin conditions and allergies);
- the provision of advice to promote healthy lifestyles (such as advice on healthy eating and stopping smoking);
- testing and screening for particular conditions (such as pregnancy testing, chlamydia screening and treatment); and
- supporting people with particular long-term conditions using new medicines.

²³⁴

Some pharmacies may also do flu jabs, medicines reviews, emergency contraception and weight management.

Pharmacists can also help patients decide whether they need to see a GP.²³⁵

Pharmacies are often located within the community, and they may be co-located within a primary care setting (such as a GP practice or walk-in centre). Sometimes they are located near or within a hospital setting.²³⁶

Services are accessible without patients needing to make an appointment. Consultation can also be private; around 85% of pharmacies now have a private

²³³ www.hsj.co.uk/home/innovation-and-efficiency/better-gp-access-better-ae-outcomes/5061857.article

²³⁴ www.nhs.uk/NHSEngland/AboutNHSservices/pharmacists/Pages/pharmacistsandchemists.aspx; and NHS England, *High quality care for all, now and for future generations: transforming urgent and emergency care services in England – the Evidence Base from the Urgent and Emergency Care Review*, June 2013, p.33.

²³⁵ www.nhs.uk/NHSEngland/AboutNHSservices/pharmacists/Pages/pharmacistsandchemists.aspx

²³⁶ www.nhs.uk/NHSEngland/AboutNHSservices/pharmacists/Pages/pharmacistsandchemists.aspx

consultation area where patients can discuss issues with pharmacy staff without being overheard by other members of the public.²³⁷

Community pharmacy services are currently seen as playing an important role in enabling self-care, particularly amongst patients with minor ailments and long-term conditions. However, reports suggest that there is little public awareness of the range of services provided by pharmacies.²³⁸

Self-care and self-management

Self-care for minor ailments and self-management of long-term conditions are increasingly being promoted within the NHS. Around 80% of all health problems are currently treated or managed at home without the use of NHS services, and it is thought that, by improving access and encouraging the use of support for self-care and self-management, this can help free capacity in routine primary care and prevent unnecessary use of urgent and emergency care services.²³⁹

There is a range of services available to support self-care and self-management. This includes:

- web-based health tools (for example, online symptom checker applications provided by NHS Choices);
- self-management education programmes and courses for patients;
- establishment of peer support groups;
- embedding self-care and self-management support into primary care environments.²⁴⁰

²³⁷ NHS England, Evidence Base from the Urgent and Emergency Care Review, June 2013, p.33.

²³⁸ NHS England, Evidence Base from the Urgent and Emergency Care Review, June 2013, p.33.

²³⁹ NHS England, Evidence Base from the Urgent and Emergency Care Review, June 2013, p.29.

²⁴⁰ NHS England, Evidence Base from the Urgent and Emergency Care Review, June 2013, p.29.

Annex 2: List of current walk-in centres

Name	Address
1. 8am to 8pm Health Centre	79a Upper Parliament Street, Nottingham, NG1 6LD
2. Accrington Victoria Health Access Centre	Accrington Victoria Community Hospital, Haywood Road, Accrington, BB5 6AS
3. All Day Health Centre	Arrowe Park Hospital, Arrowe Park Road, Upton, Wirral, CH49 5PE
4. Angel Medical Practice	34 Ritchie Street, London, N1 0DG
5. Ashford Health Centre	Ashford Hospital, London Road, Ashford, Middlesex, TW15 3FE
6. Ashton GP Led Health Centre	Old street, Ashton under Lyne, OL6 7SR
7. Banbury Health Centre	58 Bridge Street, Banbury, Oxfordshire, OX16 5QD
8. Barbara Castle Way Health Centre	Simmons' St, Blackburn, BB2 1AX
9. Barkantine Practice	121 Westferry Road, London, E14 8JH
10. Bath NHS Healthcare Centre	Riverside Health Centre, James Street West, Bath , BA1 2BT
11. Battle Hill Health Centre	Battle Hill Health Centre, Belmont Close, Wallsend, Tyne and Wear, NE28 9DX
12. Birmingham NHS Walk-in Centre	66 High Street, Birmingham, West Midlands, B4 7TA
13. Bitterne Walk-in Centre	Commercial Street, Southampton, Hampshire, SO18 6BT
14. Blackpool GP Led Walk-in Centre	Whitegate Health Centre, 150-158 Whitegate Drive, Blackpool, FY3 9ES
15. Blaydon GP Practice and Minor Injury and Illness Unit	Shibdon Road, Blaydon, NE21 5NW
16. Boscombe & Springbourne Health Centre	66-68 Palmerston Road, Bournemouth , BH1 4JT

17. Brent GP Access Centre	Wembley Centre for Health & Care, 116 Chaplin Road, Wembley, HA0 4UZ
18. Brighton Station Health Centre	Aspect House, 84-87 Queens Road, Brighton, BN1 3XE
19. Broad Street Medical Centre	Morland Road, Dagenham, RM10 9HU
20. Broadmead Medical Centre	59 Broadmead, Bristol , BS1 3EA
21. Broughton Gate Health Centre	Glyn Valley Place, Broughton, Milton Keynes, Buckinghamshire, MK10 7EF
22. Bunny Hill Minor Injury and Illness Unit	Bunny Hill Primary Care Centre, Hylton Lane, Downhill, Sunderland, SR5 4BW
23. Burntwood Health and Wellbeing Centre	High Street, Chasetown, Burntwood, Staffordshire, WS7 3XH
24. Bury Walk-in Centre	Moorgate Primary Care Centre, 22 Derby Way, Bury, BL9 0NJ
25. Calder Community Practice	82 Halifax Road, Lower George Street, Todmorden, OL14 5RN
26. Camphill GP Led Health Centre	Ramsden Avenue, Camphill, Nuneaton, CV10 9EB
27. Cardrew Health Centre	60 Cardrew Industrial Estate, Cardrew Industrial Estate, Redruth, TR15 1SS
28. Carfax NHS Medical Centre	Swindon Health Centre, Carfax Street, Swindon, SN1 1ED
29. Castle Health Centre	3-4 York Place, Scarborough, North Yorkshire, YO11 2NP
30. Cator Medical Centre	Beckenham Beacon, 379 Croydon Road, Beckenham, Kent, BR3 3FD
31. Chester Walk-in Centre	Countess of Cheshire Hospital, Countess of Chester Health Park, Liverpool Road, Chester, CH2 1UL
32. City Health Centre	32 Market Street, Manchester, Lancashire, M1 1PL
33. City of Coventry NHS Walk-in and Healthcare Centre	Stoney Stanton Road, Coventry, CV1 4FS
34. Clifton Nurse Access Point	Clifton Cornerstone, Southchurch Drive, Nottingham, NG11 8EW

35. Clover Health Centre	Equitable House, 10 Woolwich New Road, London, SE18 6AB
36. Crawley Health Centre	Cross Keys House, 14 Haslett Avenue West, Crawley, West Sussex, RH10 1HS
37. Cricklewood GP Health Centre	Barnet Hospital A&E, Britannia Business Village, Cricklewood, Barnet, NW2 1DZ
38. Darwen Health Centre	James St West, Darwen, BB3 1PY
39. Derby NHS Walk-in Centre	Entrance C, London Road Community Hospital, Osmaston Road, Derby, Derbyshire, DE1 2GD
40. Derby Open Access Centre	Lister House, 207 St Thomas Road, Derby, DE23 8RJ
41. Doncaster 8-8 Health Centre	The Flying Scotsman Centre, St Sepulchre Gate West, Doncaster, DN1 3AP
42. Dudley Borough Walk-in Centre	Holly Hall Clinic, Stourbridge Road, Dudley, DY1 2ER
43. Earls Court Health & Wellbeing Centre	2B Hogarth Road, Earls Court, London, SW5 0PT
44. Easington Healthworks Medical Centre	Paradise Lane, Easington Colliery, Peterlee, County Durham, SR8 3EX
45. Eastbourne Station Health Centre	Eastbourne Station, Terminus Road, Eastbourne, BN21 3QJ
46. Eastham Walk-in Centre	Eastham Clinic, Eastham Rake, Wirral, Merseyside, CH62 9AN
47. Edgware NHS Walk-in Centre	Edgware Community Hospital, Burnt Oak Broadway, Edgware, Middlesex, HA8 0AD
48. Edmonton GP-led Walk-in Service	1 Smythe Close, Edmonton, Middlesex, N9 0TW
49. Edridge Road Health Centre	Impact House, 2 Edridge Road, Croydon, Surrey, CR9 1PJ
50. Encompass Health Centre	The Galleries Health Centre, Washington, Tyne and Wear, NE38 7NQ
51. Erdington GP Health and Wellbeing Walk In Centre	196 High Street Erdington, Erdington, B23 6SJ

52. Eston Grange NHS Health Care Centre	Low Grange Health Village, Normanby Road, Middlesbrough, TS6 6TD
53. Featherstone Road Health Centre	Hartington Road, Southall, Middlesex, UB2 5BQ
54. Fellview Medical Practice	Cleator Moor Health Centre, Birks Road, Cleator Moor, Cumbria, CA25 5HP
55. Finchley NHS Walk-in Centre	Finchley Memorial Hospital, Granville Road, London, N12 0JE
56. Folkestone Walk-in Centre	Royal Victoria Hospital, Radnor Park Avenue, Folkestone, Kent, CT19 5BN
57. Fulham Centre for Health	Charing Cross Hospital, Fulham Palace Road, London, W6 8RF
58. Fylde and Wyre Same Day Health Centre	Same Day Health Centre, Fleetwood Health & Wellbeing Centre, Dock Street, Fleetwood, Lancashire, FY7 6HP
59. Gateshead Walk-in Service	Queen Elizabeth Hospital, Gateshead, NE9 6SX
60. Gloucester Health Access Centre	Eastgate House, 121-131 Eastgate Street, Gloucester, Gloucestershire, GL1 1PX
61. Gosbury Hill GP Clinic	Orchard Gardens, Chessington, Surrey, KT9 1AG
62. Gracefield Gardens GP Centre	2-8 Gracefield Gardens, Streatham, London, SW16 2ST
63. Greyfriars Health Centre	Phoenix House, Howard Street South, Great Yarmouth, Norfolk, NR30 2PT
64. Grindon Lane Minor Injury and Illness Unit	Grindon Lane Primary Care Centre, Grindon Lane, Sunderland, SR3 4DE
65. Guildhall Walk Healthcare Centre	27 Guildhall Walk, Portsmouth, PO1 2DD
66. Halewood Walk in Centre	The Halewood Centre, Roseheath Drive, Halewood, Liverpool, L26 9UH
67. Half Penny Steps Health Centre	427-429 Harrow Road, London, W10 4RE
68. Hammersmith Centre for Health	Hammersmith Hospital, Du Cane Road, W12 0HS

69. Hanley Health and Wellbeing Centre	Potteries Shopping Centre, 69/71 Stafford Street, Hanley, Stoke-on-Trent, ST1 1LW
70. Harold Wood GP Walk in Centre	St Clements Avenue, Off Gubbins Lane, Harold Wood, RM3 0FE
71. Hartlepool NHS Healthcare Centre	One Life Hartlepool, Park Road, Hartlepool, TS24 7PW
72. Hastings Medical Practice & Walk-in Centre	Station Plaza Health Centre, Station Approach, Hastings, TN34 1BA
73. Hawthorn Medical Centre	Unit K, Fallowfield Retail Park, Birchfields Road, Levenshulme, M14 6FS
74. Hayes Town Medical Centre	52 Station Road, Hayes, Middlesex, UB3 4DD
75. Haywood Community Hospital Walk-in Centre	Haywood Hospital, High Lane, Burslem, ST6 7AG
76. Herefordshire GP Access Centre	ASDA Building, Belmont Road, Hereford, HR2 7JE
77. Hillside Bridge Health Centre	Hillside Bridge Health Centre, 4 Butler Street, Bradford, BD3 0BS
78. Huyton Walk in Centre	Nutgrove Villa, Westmoreland Road, Huyton, L36 6GA
79. Jarrow Health Centre	Palmer Community Hospital, Wear Street, Jarrow, NE32 3UX
80. John Radcliffe Hospital GP-led walk-in centre	John Radcliffe Hospital, Headley Way, Headington, Oxford, OX3 9DU
81. King Street Health Centre	47 King Street, Wakefield, WF1 2SN
82. Kirkby Walk in Centre	St Chads Clinic, St Chads Drive, Kirkby, L32 8RE
83. Langbaugh Medical Centre	Coatham Health Village, Coatham Road, Redcar, TS10 1SR
84. Leigh Walk-in Centre	Leigh Health Centre, The Avenue, Leigh, Lancashire, WN7 1HR
85. Lincoln Walk-in centre	63 Monks Road, Lincoln, LN2 5HP
86. Lindley Medical Practice	Integrated Care Centre, New Radcliffe Street, Oldham, Lancashire, OL1 1NL

87. Litherland Town Hall Health Centre	Hatton Hill Road, Litherland, Liverpool, L21 9JN
88. Liverpool City Centre NHS Walk-in Centre	52 Great Charlotte Street, Liverpool, L1 1HU
89. Locala Walk in Centre	Dewsbury & District Hospital, Halifax Road, Dewsbury, West Yorkshire, WF13 4HS
90. Malling Health Telford	39-41 Sherwood Row, Town Centre, Telford, Shropshire, TF3 4DZ
91. Malling Health Wrekin	Princess Royal Hospital, Apley Castle, Apley, Telford, Shropshire, TF1 6WL
92. Market Hill 8 to 8 Health Centre	The Ironstone Centre, West Street, Scunthorpe, North Lincolnshire, DN15 6HX
93. Medway NHS Healthcare Centre	547 - 553 Canterbury Street Gillingham, Kent, ME7 5LF
94. Middleton Health Centre	Middleton Shopping Centre, Middleton, Greater Manchester, M24 4EL
95. Midway Medical and Walk-in Centre	Morton House, The Midway, Newcastle-under-Lyme, ST5 1QG
96. Molineux Street Walk-in Centre	Molineaux NHS Centre, Off Shields Road, Byker, NE6 1SG
97. New Cross GP Walk-in Centre	Suite 3 Waldron Health Centre, Amersham Vale, London, SE14 6LD
98. NHS Parsonage Street Health Centre	Parsonage Street, West Bromwich, West Midlands, B71 4DL
99. NHS Sheffield Walk-in Centre	Rockingham House, 75 Broad Lane, Sheffield, S1 3PB
100. NHS Walk-in Centre Widnes	Health Care Resource Centre, Oaks Place, Caldwell Road, Widnes, Cheshire, WA8 7GD
101. North Chelmsford NHS Healthcare Centre	Sainsbury's, 2 White Hart LANE, Chelmsford, Essex, CM2 5EF
102. North Colchester Healthcare Centre	Colchester Primary Care Centre, Turner Road, Colchester, Essex, CO4 5JR
103. North West London Medical Centre	56 Maida Vale, London, W9 1PP

104. Northumberland Health Medical Centre	Hind Crescent, Erith, Kent, DA8 3DB
105. Oadby and Wigston Walk-in Centre	18 The Parade, Oadby, Leicestershire, LE2 5BJ
106. Old Swan Walk-in Centre	Crystal Close, St Oswald St, Liverpool, L13 2GA
107. Oliver Road Polyclinic	Oliver Road Polyclinic Walk-in Service, 75 Oliver Road, Leyton, E10 5LG
108. Orchard Village Walk in Centre	2 Roman House, Roman Close, Rainham, RM13 8QA
109. Park Community Practice	Horne Street Medical Centre, Hanson Lane, Halifax, HX1 5UA
110. Parsons Green NHS Walk-in Centre	5-7 Parsons Green, London, SW6 4UL
111. Peckham GP Walk in Centre	Lister Health Centre, 101 Peckham Road, London, SE15 5LJ
112. Peterborough Walk-in Centre	City Care Centre, Thorpe Road, Peterborough, PE3 6DB
113. Phoenix Centre	Phoenix Centre, Parkfield Road, Wolverhampton, WV4 6ED
114. Ponteland Road Health Centre	169 Ponteland Road, Newcastle upon Tyne, NE5 3AE
115. Prestwich Walk-in Centre	Fairfax Road, Prestwich, Manchester, Lancashire, M25 1BT
116. Primary Care Emergency Centre	Manchester Royal Infirmary, Oxford Road/Upper Brook Street, Manchester, M13 9WL
117. Putnoe Medical Centre	93 Queen's Drive, Bedford, MK41 9JE
118. Quayside Medical Centre	76b Cleethorpe Road, Grimsby, Lincolnshire, DN31 3EF
119. Reading Walk-in Health Centre	1st Floor 103-105 Broad St Mall, Reading, RG1 7QA
120. Resolution Health Centre	11 Trinity Mews, North Ormesby, Middlesbrough, Cleveland, TS3 6AL
121. Rotherham NHS Walk-in Centre	Rotherham Community Health Centre, Greasbrough Road, Rotherham , S60 1RY

122. Royal Devon & Exeter Walk-in Centre	Royal Devon and Exeter Hospital, Barrack Road, Exeter, EX2 5DW
123. Rugby Walk-in Centre	Rugby Urgent Care Centre, Hospital of St Cross, Barby Road, Rugby, CV22 5PX
124. Salisbury Walk-in Health Centre	Avon Approach, Salisbury, Wiltshire, SP1 3SL
125. School House Practice	Dewsbury Health Centre, Wellington Rd, WF13 1HN
126. Shakespear Medical Practice	Burmantofts medical centre, Cromwell Mount, Leeds , LS9 7TA
127. Sheppey NHS Healthcare Centre	Sheppey Community Hospital, Plover Road, Minster-on-Sea, Sheerness, ME12 3LT
128. Shiremoor Health Resource Centre	Earsdon Road, Shiremoor, Newcastle Upon Tyne, Tyne And Wear, NE27 0HJ
129. Showell Park Health and Walk In Centre	Fifth Avenue, Showell Park, Wolverhampton, West Midlands, WV10 9ST
130. Shrewsbury Walk-in Health Centre	Whitehall, Monkmoor Road, Shrewsbury, Shropshire, SY2 5AP
131. Sidwell Street Walk-in Centre	31 Sidwell Street, Exeter, Devon, EX4 6NN
132. Skelmersdale NHS Walk-in Centre	116-118 The Concourse, Skelmersdale, WN8 6LJ
133. Slough Walk-in Health Centre	Upton Hospital, Albert Street, Slough, SL1 2BJ
134. Soho Walk-in Centre	1 Frith Street, London, W1D 3HZ
135. Solihull Healthcare and Walk in centre	Solihull hospital, Lode Lane, B91 2AE
136. South Birmingham GP Walk-in Centre	15 Katie Rd, Birmingham, B29 6JG
137. South Liverpool NHS Walk-in Centre	Church Road, Garston, L19 2LW
138. Spring House Medical Centre	Ascots Lane, Welwyn Garden City, Hertfordshire, AL7 4HL

139. SSAFA Care CIC Health and Walk In Centre	1 Spinney Hill Road, Leicester, Leicestershire, LE5 3GH
140. St Andrews Health Centre	2 Hannaford Walk, Bow, London, E3 3FF
141. St Helens Minor Injuries Unit and Walk in Centre	The Millennium Centre, Corporation Street, St Helens , WA10 1HJ
142. St Luke's Health Centre	Pantile Avenue, Southend on Sea, Essex, SS2 4BD
143. St Neot's Health Centre	24 Moores Walk, St Neots, Cambridgeshire, PE19 1AG
144. St Oswald's Hospital Walk-in Centre	St Oswald's Hospital, Clifton Road, Ashbourne, Derbyshire , DE6 1DR
145. Stockton NHS Healthcare Centre	Tithebarn House, High Newham Road, Hardwick Estate, Stockton-on-Tees, TS19 8RH
146. Story Street Medical Practice and Walk-in Centre	Wilberforce Centre, 6-10 Story Street, Hull, HU1 3SA
147. Summerfield GP and Urgent Care Centre	Summerfield Primary Care Centre, 134 Heath Street, Winson Green, Birmingham, B18 7AL
148. Teddington Walk-in Centre	Teddington Memorial Hospital, Hampton Road, Teddington, Middlesex, TW11 0JL
149. Thamesmead NHS Health Centre	4 - 5 Thames Reach, London, SE28 0NY
150. The Beacon Health Centre	St Mary's Hospital, Parkhurst Road, Newport, Isle of Wight, PO30 5TG
151. The Connaught Square Practice	41 Connaught Square, London, W2 2HL
152. The Hill General Practice and Urgent Care Centre	Sparkhill Primary Care Centre, 856 Stratford Road, Sparkhill, Birmingham, B11 4BW
153. The Junction Health Centre	Arches 5-8 , Clapham Junction Station, SW11 2NU
154. The Nottingham NHS Walk-In Centre	Seaton House, London Road, Nottingham, Nottinghamshire, NG2 4LA
155. The Orchard Medical Centre	Macdonald Walk, Kingswood, Bristol, BS15 8NJ
156. The Pinn Medical Centre	37 Love Lane, Pinner, Middlesex, HA5 3EE

157. The Practice Loxford, Loxford Polyclinic	Loxford Polyclinic, 417 Ilford Lane, Ilford, Essex, IG1 2SN
158. The Ridgeway Surgery	Alexandra Avenue Health and Social Care Centre, 275 Alexandra Avenue, Rayners Lane, Harrow, HA2 9DX
159. The Skelton Medical Centre	Byland Road, Skelton-in-Cleveland, North Yorkshire, TS12 2NN
160. The Wilson Health Centre	Cranmer Road, Mitcham, Surrey, CR4 4TP
161. Thurrock Health Centre	57 High Street, Grays, Essex, RM17 6NJ
162. Timber Hill Health Centre	Level 4, 115-117 The Castle Mall, Norwich, NR1 3DD
163. Tollgate Lodge Healthcare Centre	57 Stamford Hill, Stoke Newington, N16 5SR
164. Town Centre GP Surgery	14-16 Chapel Street, Luton, LU1 2SE
165. Trafford Health Centre	Trafford general hospital, Moorside Road, Davyhulme, Manchester, M41 5SL
166. Upney Lane Walk-in Centre	Barking Community Hospital, 132 Upney Lane, Barking, IG11 9LX
167. Urgent Care Centre, Guy's Hospital	Guy's Hospital, Great Maze Pond, SE1 9RT
168. Vicarage Lane Health Centre	10 Vicarage Lane, Stratford, E15 4ES
169. Victoria Central Walk-in Centre	Mill Lane, Wallasey, Wirral, CH44 5UF
170. Walsall Walk-in-Health Centre	19-21 Digbeth, Market Square, Walsall, West Midlands, WS1 1QZ
171. Wansbeck Primary Care Access Centre	Wansbeck General Hospital, Woodhorn Lane, Ashington, Northumberland, NE63 9JJ
172. Warren Farm Urgent Care Centre	Warren Farm Rd, Kingstanding, B44 0PU
173. Washwood Heath Urgent Care Centre	Washwood Heath Health and Wellbeing Centre, Clodeshall Rd, Saltley, B8 3SN
174. West Herts Medical Centre	Hemel Hempsted Hospital, Hillfield Rd, Hemel Hempstead, Hertfordshire, HP2 4AD

175. West Lancashire Health Centre	Ormskirk & District Hospital, Wigan Road, Ormskirk, Lancashire, L39 2AZ
176. Westgate Walk in Centre	Westgate Road, Newcastle-upon-Tyne, NE4 6BE
177. Westminster & Pimlico Health Centre	15 Denbigh Street, London, SW1V 2HF
178. Westwood 8 to 8 Primary Care Centre	Pelham Street, Worksop, S80 2TR
179. Weybridge Walk-in Centre	Weybridge Community Hospital, 22 Church Street, Weybridge, KT13 8DY
180. Weymouth GP-led Walk In Centre	Weymouth Community Hospital, 3 Melcombe Avenue, Weymouth, Dorset, DT4 7TB
181. White Horse Surgery & Walk-in Centre	Vale Rd, Northfleet, Gravesend, Kent, DA11 8BZ
182. Woking Walk-in Centre	Woking Hospital, Heathside Road, Woking, GU22 7HS
183. Wolds View Primary Care Centre	Bridlington and District Hospital, Bessingby Road, Bridlington, YO16 4QP
184. Worcester Walk-In Health Centre	Farrier House, Farrier Street, Worcester, WR1 3BH
185. Yeovil Health Centre	37 Middle Street, Yeovil, BA20 1SB

Annex 3: List of closed walk-in centres

Name	Address
1. Alma Road Primary Care Centre	Central Peterborough, PE1 3FG
2. Ancoats Walk-in Centre	Old Mill Street, Ancoats, M4 6HH
3. Ashfield Walk-in Centre	Kirkby-in-Ashfield, NG17 7AE
4. Bexley North Health Centre	Crayford Road, Bexley, DA1 4ER
5. Blackpool NHS Walk-in Centre	26, Talbot Road, Blackpool, Lancashire, FY1 1LF
6. Bolton Walk-in Centre	Lever Chambers, Bolton, BL1 1SQ
7. Bristol City Gate Walk-in Centre	Broad Street, Bristol, BS1 2EZ
8. Canalside Medical Centre	Monton, Greater Manchester, M30 8AR
9. Canary Wharf NHS Walk-in Centre	30 Marsh Wall, Isle of Dogs, London , E14 9TP
10. Crown Health Centre	Withersfield Road, Haverhill, CB9 9LA
11. Croydon Walk-in Centre	45 High Street, Croydon, Surrey, CR0 1QD
12. Darlington Urgent Care Centre (Dr Piper House)	King Street, Darlington, DL3 6JL
13. Forum Health Walk-in Service	Forum Square, Wythenshawe, M22 5RX
14. Hampshire Healthcare Centre	Basingstoke and North Hampshire Hospital, Basingstoke, RG24 9NA
15. Harlow Walk-in Centre	1a Wych Elm, Harlow, Essex, CM20 1QP
16. Harness Harrow Walk in Centre	46 South Parade, Mollison Way, Edgware, HA8 5QL
17. Headrow NHS Walk-in Centre	Balcony Level 7, The Light, The Headrow, Leeds, LS1 8TL
18. Hornsey Central Walk-in Clinic	Park Road, London, N8 8JD
19. Ilford Walk-in Centre	201-205 Cranbrook Road, Ilford, Essex, IG1 4TD
20. Ilkeston Family Practice and Walk-in Centre	Ilkeston Community Hospital, Derbyshire, DE7 8LN

21. Lakeside Plus/Corby Urgent Care Centre	Corby, NN17 2UR
22. Laurels Neighbourhood Practice	Haringey, North London, N15 5AZ
23. Leighton Hospital Walk-in Centre	Leighton Hospital, Crewe, CW1 4QJ
24. Little Hulton Walk-in-Centre	Haysbrook Avenue, Worsley, Manchester, M28 0AY
25. Liverpool Street NHS Walk-in Centre	Exchange Arcade, 175 Bishopsgate, London, EC2M 3WA
26. Loughborough Walk-in Centre	Pinfold Gate, Loughborough, Leicestershire, LE11 1BE
27. Manchester Picadilly Walk-in Centre	1st Floor Gateway House, Station Approach, Piccadilly South, M1 2GH
28. Mersey View GP Access Centre	Everton Road, Liverpool, L6 2EH
29. Milton Keynes Walk-in Centre	Hospital Campus, Standing Way, Eaglestone, Milton Keynes , MK6 5NG
30. Monkgate Walk-in Centre	Monkgate Health Centre, 31-33 Monkgate, York, YO31 7WA
31. Mount Gould Local Care Centre	Plymouth, PL4 7QD
32. Newcastle Central Walk-In Centre	Unit 5, The Bar (Jury's Inn) Newcastle, NE1 4BH
33. NHS Barnsley Health Centre	Unit 1, Gateway Plaza , Sackville Street, Barnsley, South Yorkshire , S70 2RD
34. Pendleton Walk-in-Centre	Rear of Pendleton House, Off Broughton Road, Salford , M6 6LS
35. Rochdale Walk-in Centre	Rochdale Infirmary, 90 Whitehall Street, Rochdale , OL12 0ND
36. Royal Surrey County Hospital Walk-in Centre	Royal Surrey County Hospital, Egerton Road, Guildford, GU2 7XX
37. Shirley NHS Walk-in Centre	1a Howards Grove, Southampton, Hampshire, SO15 5PR
38. South Bristol Walk-in Centre	Knowle West, Bristol, BS4 1WH

39. Stapleford Walk-in Centre	Church Street, Stapleford, NG9 8DA
40. Stockport Health Centre (Walk-In Centre)	Wellington Road, Stockport, SK2 6NW
41. The Bay Health Centre	Torbay Hospital, Newton Road, Torquay, Devon, TQ2 7AA
42. The Practice Heart Of Hounslow NHS Walk In Centre	92 Bath Road, Hounslow, Middlesex, TW3 3LN
43. Tooting Walk-in Centre	A&E department, St George's Hospital, Blackshaw Road, Tooting, London, SW17 0QT
44. Victoria NHS Walk-in Centre	63 Buckingham Gate, SW1E 6AT
45. Wakefield NHS Walk-in Centre	Thornhill Street, Wakefield, West Yorkshire, WF1 1PG
46. Walk in Centre	Royal Hallamshire Hospital, S10 2TB
47. Warrington GP Health Centre	Sankey Street, Warrington, WA1 1TD
48. Weston Urgent Care Service	Weston General Hospital, Somerset, BS23 4TQ
49. Whitechapel Walk-in Centre	174 Whitechapel Road, London, E1 1BZ
50. Withington Walk-in Centre	Withington Community Hospital, Manchester, M20 2LR
51. Wycombe GP Health Centre	Queen Alexandra Road, High Wycombe, Buckinghamshire, HP11 2TT



Making the health sector
work for patients

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