



Making the health sector
work for patients

**Advice and
recommendations
for commissioners:
deciding the future
of walk-in centres**



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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Introduction

Across England, many contracts for walk-in centres, including GP-led health centres, are due to expire in 2014 or 2015.¹ Commissioners need to decide whether or not to continue to procure walk-in centre services for patients in their local areas. In some cases, commissioners are making this decision in the context of developing a wider urgent care strategy.

This document, developed from research on walk-in centre provision in England, contains advice and recommendations that aim to help commissioners who are reviewing or preparing to review walk-in centre services reach decisions in a manner that will achieve the best results for local patients.

Monitor researched walk-in centre provision in England during the second half of 2013. Our purpose was to understand why local commissioners in many cases had decided to close walk-in centres during the previous three years. We also wanted to understand the possible impact of closures on patients, how well commissioning arrangements for walk-in centres are working for patients, and whether payment mechanisms for walk-centres and general practice services are leading to benefits for patients.

Our research was wide-ranging, including a survey of almost 2,000 patients using walk-in centres. We also spoke to stakeholders throughout the sector, including commissioners, providers, and health and wellbeing boards.

We have based the advice and recommendations in this document on the findings of our research.

Section 1 sets out the factors that commissioners should consider when deciding the future of a walk-in centre. These factors are reflected in commissioners' obligations under the Procurement, Patient Choice and Competition Regulations. Those most likely to be relevant to decisions about walk-in centres include:

- assessing the needs of patients in the local area and understanding what role the walk-in centre may play in meeting them;
- deciding what services to continue to procure, if any, 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 any conflicts of interest; and

¹ GP-led health centres (sometimes referred to as “Darzi centres” or “equitable access centres”) offer a walk-in service for non-registered patients as well as an option for patients to register with a GP practice at the centre. For more information, see our [final report](#).

- ensuring transparency in decision making.

Section 2 of this document recommends steps that commissioners can take now to address the findings of our review that:

- in some cases, walk-in centre closures may adversely affect some patients' access to primary care; and
- the split in commissioning responsibilities between NHS England and clinical commissioning groups (CCGs) is causing confusion about walk-in centres and creating a risk that commissioning decisions do not take into account the potential impact of closing or changing walk-in centre services across primary and secondary care.

The main goal of the recommendations in this section is to encourage NHS England and CCGs to consider jointly the future of walk-in centres in their areas. It is up to commissioners to decide whether to adopt these recommendations or to take a different approach. However, on the basis of our review, we believe that these recommendations will help commissioners make the best decisions for patients.

Section 3 describes how our findings about walk-in centres fit into a larger context of work to improve services.

This document is an excerpt from Monitor's *Walk-in centre review: final report and recommendations*. The final report, available at www.monitor.gov.uk/WIC, provides information and data about walk-in centre provision across England, and sets out the key findings of our review. We invite you to read the report in full, and send any questions or comments to cooperationandcompetition@monitor.gov.uk.

We also encourage you to refer to our [Substantive Guidance on the Procurement, Patient Choice and Competition Regulations](#), which offers more information about how the regulations apply in practice and provides [Hypothetical Case Scenarios](#), which set out how the regulations might apply in six hypothetical cases.

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

Our review 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 needed them, 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 Regulations² provide the framework for taking decisions about what services to procure and how to procure them. Monitor has published guidance to help the sector understand the regulations.³

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.⁴

The purpose of our review was not to investigate whether individual commissioners' decisions were consistent with the Procurement, Patient Choice and Competition Regulations. If stakeholders have concerns that a regulation may have been breached, they may make a formal complaint to Monitor.⁵

² 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.

³ See Monitor, *Substantive guidance on the Procurement, Patient Choice and Competition Regulations*, available at <http://monitor.gov.uk/s75>.

⁴ See Monitor, *Substantive guidance on the Procurement, Patient Choice and Competition Regulations*, available at <http://monitor.gov.uk/s75>.

⁵ 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.

1.1. 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.⁶

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.⁷ 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.⁸ Commissioners may have to consider in particular:

⁶ 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.

⁷ 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%).

⁸ 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.⁹ Local Healthwatch organisations may be able to help

⁹ 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.¹⁰ 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.

1.2. 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 the assessment has identified.¹¹

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 1.3);

¹⁰ See West Midlands Ambulance Service NHS Foundation Trust submission to Monitor's walk-in centre review, p.1.

¹¹ 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 should also examine the impact of any potential changes to walk-in centre services on other services. This might involve:

- 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.¹² 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

¹² See footnote 9 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 offer 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 on 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.

1.3. 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.¹³

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 of our full [report](#)).

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

¹³ 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.

1.4. 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.¹⁴

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).

¹⁴ 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 made accessible to the public on request).¹⁵

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 the conflicts.¹⁶

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,

¹⁵ 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.

¹⁶ 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* and NHS England's guidance for CCGs on managing conflicts of interest.¹⁷

1.5. 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 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.

¹⁷ NHS Commissioning Board (NHS England), [Managing conflicts of interest: guidance for clinical commissioning groups](#), 28 March 2013.

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 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 the next section).

2. 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.

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

In Section 7.2 of our full [report](#), 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 CCGs publish information on their websites by 31 March 2014 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 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 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.

2.2. 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 may also 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.¹⁸ 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 may also 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.

2.3. 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

¹⁸ 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 of our full [report](#) 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.¹⁹ Most have produced joint strategic needs assessments and joint health and wellbeing strategies.²⁰

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.²¹ 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.²² NHS England also must have regard to them when commissioning services;²³ however, NHS England local area teams are not required to have regular

¹⁹ See section 195 of the Health and Social Care Act 2012.

²⁰ 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.

²¹ See section 14Z13 of the Health and Social Care Act 2012.

²² 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.

²³ See section 116B of the Local Government and Public Involvement in Health Act 2007.

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.

2.4. 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 of our full [report](#), 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.

2.5. 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.

3. 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.²⁴
- 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;

²⁴ 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 of our full [report](#), 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.²⁵ 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

²⁵ 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”.²⁶

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

Under the Health and Social Care Act 2012, 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.²⁷ This is an issue that we will continue to consider with NHS England as we develop our long-term strategy for the payment system.

²⁶ NHS England, [Everyone Counts: Planning Patients 2014/15 to 2018/19](#), p.30.

²⁷ See [The 2014/15 National Tariff Payment System](#), p.8.

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