

Walk-in centre review: responses to our preliminary report



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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Responses to our preliminary report

This document contains non-confidential responses to our publication [Walk-in centre review: preliminary report](#) (November 2013).

We have published these responses with permission but have removed text which was identified as being confidential. We have also removed names where the author wished to remain anonymous. Removal of content is indicated by this sign: [X]

Please click on items in the list below to jump to the submission(s) you require:

- [Named short submissions \(alphabetically\)](#)
- [Anonymous short submissions](#)
- [British Medical Association](#)
- [Celesio UK](#)
- [East Anglia Area Team](#)
- [Luton walk-in Centre \(two submissions\)](#)
- [The Practice](#)
- [West Midlands Ambulance Service NHS Foundation Trust](#)

You can view all the [documents related this walk-in centre work](#), including the final report (February 2014), on our website.

From: John Dale, Ideas 4 Use

I believe this is another labour bashing move by the government.

Walk in Centres do a wonderful job and closing them will have another unwelcome impact on A&E. A&E figures are still rising and they are under strain as we go into the most busy time of year. Closing WIC's will impact on this to the detriment of the hospitals.

From: Brenda Dawson

How is it that some walk in centres are only open when the gp surgery is open and not weekends at all

From: Jayne Heaney [speaking in a personal capacity]

Dear Sir/Madam

As a patient, a carer and a healthcare professional I cannot stress too strongly how important walk in centres are to the effective provision of healthcare in the Merseyside area.

As a service user they are my first choice because they are perfect for my needs and those of my family and are open and happy to receive us and treat us in a timely and caring fashion when we have urgent unplanned needs for advice, investigation and treatment - which GPs are often not, and attendance at A&E is unnecessary (and the wait is usually too long and staff too stressed).

As the Emergency Planning and Business Continuity Manager for a large DGH and Burn Unit I know that coordinated planning with the local walk in centres provides the Trust with effective back up and resilience in times of crisis and excessive pressures and helps to keep A&E/ hospital attendances on a normal day a lot lower than they would otherwise be.

Without the walk in centres there will be no contingency back up or resilience in the whole healthcare economy when pressures increase or a major emergency incident occurs. (e.g. They take our minor injuries when we receive Major Incident casualties and stay open longer and run Radiology longer in coordination with us when there is a problem with utility failure, etc).

GPs cannot take any more pressure and commissioners will overload them if they stop funding and close walk in centres which are run very effectively by Community Health Service Trusts. I know there is a shortage of funding but I really feel from

every aspect the walk in centres are the solution and not the problem. It is not duplication it is health provision the way it should be.

[✂]

From: Ken Holton, Holbrooks Health Team (1)

Sir,

Monitor press release is not accurate about cost-effectiveness in the NHS.

Walk in centres were supposed to cost £13 per contact when they were set up in 2004, in fact the lowest cost per contact was double that, with the highest costs around £62 per contact. From the start they were costing more per contact than GP surgery contacts with GPs (£19) and nurses (£14), despite taking the easiest cases. Patients with long-term conditions, or requiring referral, take about 70% more time than people walking in with minor infections and injuries. The operational brief for walk-in centres when faced with a complex patient was simply to redirect them to somebody else. So they were, and are, doing easier work for double the price. Exactly the same scenario occurred with the removal of out of hours care from GPs. The costs doubled.

If, instead of investing in yet more infrastructure, the additional staff were simply seconded into existing facilities, the NHS would have saved some of the cost. This argument is still true. I agree that the funding needs to be revised to make walk-in-centres operate on the same level as general practice. The walk-in-centres would not receive QOF, or DES, since that is voluntary and in any case relates to long-term-conditions (which walk-in-centres do not treat) so the average funding available to walk-in-centres would halve, and that would be much more fair.

Monitor research does not account for selection bias and response bias in the reported user responses.

Our practice has analysed responses from service users of emergency departments and walk-in-centres. If you ask these users WHY they attended when they are attending, they will report that it is because of difficult access to primary care. However, if you contact them from the practice, explaining that the enquiry is from the practice, they do not give this answer. I attach the latest analysis from our practice (we have been doing these every few years since 1989) and on page 5 you will find a chart relating to WIC attendance for the year. At any one hour, this equates to approximately one attendance every 6 months. The idea that this is caused by poor access to primary care is preposterous. On page 7 we analysed how many days of the entire year it had not been possible to obtain an appointment AFTER attendance at ED, and on weekdays this was only bank holiday Mondays. On page 8 there is a chart showing how long a patient would have had to wait for the

next available appointment in GP after they walked in to WIC or ED – for the majority it is less than an hour – the longest waits relate to attendance between mid-night and 07:00. On page 9 there is a chart showing attendances out-of-hours, which you can see amounts to approximately 1 per hour over the year. It is not economically feasible to open a general practice for that sort of number. Undoubtedly more than 1 per hour would attend, but this does not equate to need, and therefore one should question if this is good expenditure of limited resources simply to provide convenience. It is the long-term-sick who are disadvantaged by dilution of the service.

I hope you find this helpful. We do have a vast amount more information if you would like to see it (for example, that walk-in-centres only attract users from the immediate vicinity, but the rate of ED use in that vicinity is not reduced by the presence of the walk-in-centre).

From: Ken Holton, Holbrooks Health Team (2)

As promised, here is the analysis we did a couple of years ago [Monitor note: this is inserted below]. The walk-in-centre is shown schematically on pages 8 and 9 for the self-referrals to ED and the discharges without treatment from ED.

In both cases you will note that the take up of ED services is actually higher from residents around the walk-in-centre than from some areas that are equidistant from the emergency department.

The schematic does show some areas with very high use of ED and these are mainly those closest to ED.

I have asked [X] if he can find the analysis we did of actual WIC attendance, however this shows an uptake almost exclusively along the North-South road on which the centre is based. The uptake from areas which also use the ED excessively are generally lower than districts that are equidistant from the walk-in-centre. This shows that whatever market the WIC is supplying, it is not based on acute medical need, nor is it reducing misuse of the Emergency Department.

In Healthcare we have a paradigm of demand for services compromising the ability of the service to meet the need of those who have greatest need for medical care. Walk-in services do not appear to mitigate the effect of demand, and because they cost more and are generally not well situated for the benefit of most of the population, they are not a good solution.

We currently have a secretary of state who appears to be unable to distinguish between need and want, and cannot comprehend how diluting the available resources over even more hours is detrimental to continuity of care for those who actually need it most. It is not unreasonable to propose that walk-in services could solve the problem of demand, but to my way of thinking, the provision of walk-in

access needs to be a parochial solution, not an institutional provision such as walk-in centres.

If I can get hold of the actual attendance data for the WIC, I will send that too.

Unscheduled attendance

An analysis of current patterns

January 2011

K M Holton & J Clinton

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Acknowledgements

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Introduction

In the year 2009-10 there were 20,511,908 unscheduled care attendances of which 15,489,615 were to accident and emergency departmentsⁱ. Of these attendances, approximately 80% were deemed to be inappropriate, indeed 3% of attendees leave without being seenⁱⁱ.

Men account for 52% of attendancesⁱⁱⁱ, compared to appointments in primary care for which they account for only 31%^{iv}.

NHS Coventry has an attendance rate slightly above the regional average and considerably below the national average. The patterns of attendance are similar in Coventry to the patterns nationally.

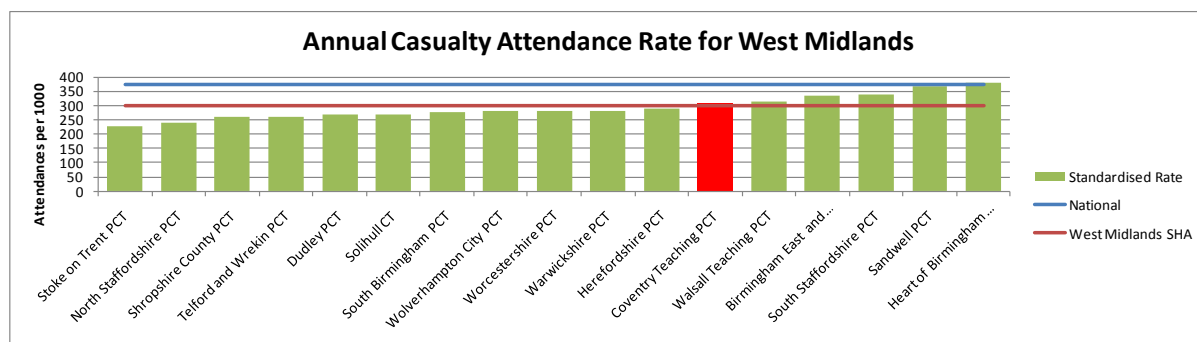


Figure 1 Casualty attendance Coventry compared to West Midlands

Peak attendance is on Monday mornings at 10:00 a.m.

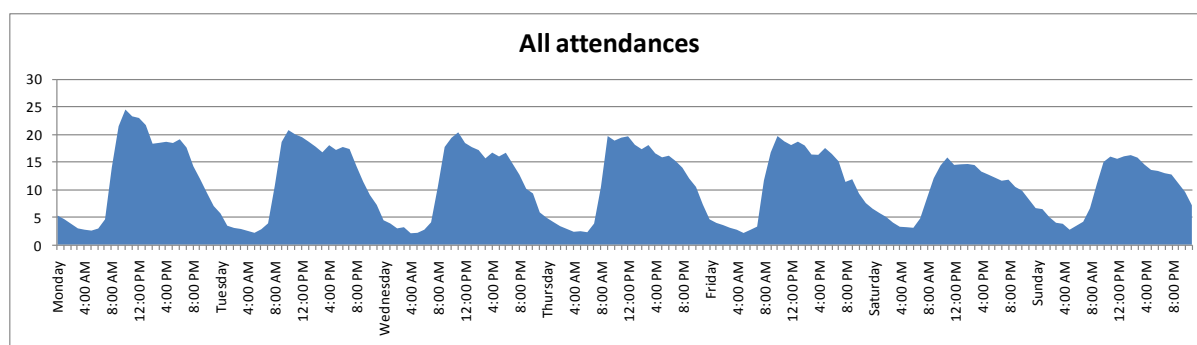


Figure 2 Casualty attendance pattern by day and hour

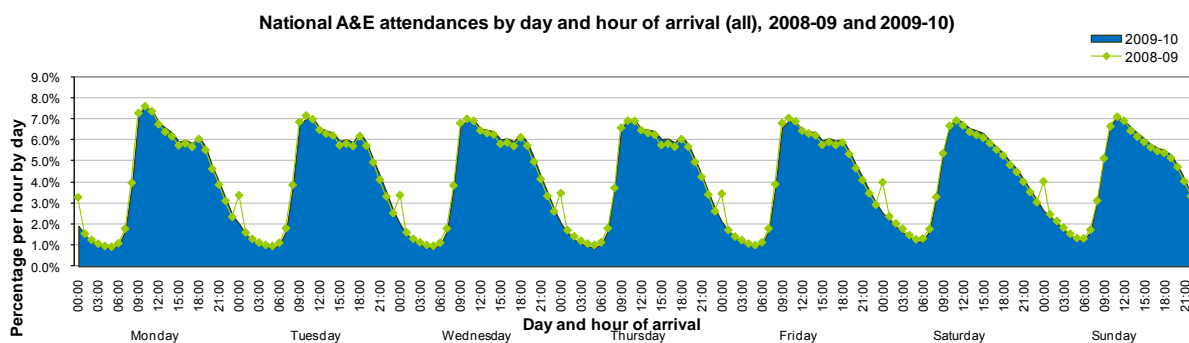


Figure 3 HES data for National Casualty Attendance pattern

There is a different pattern at weekends with fewer attendances overall.

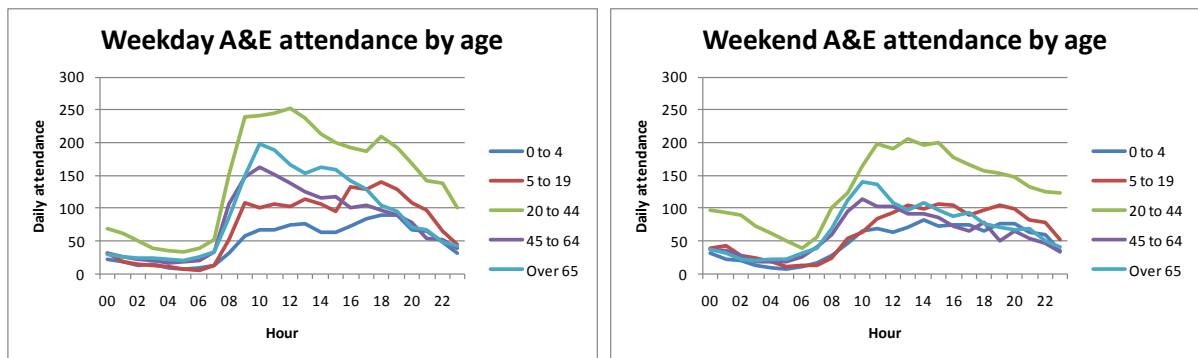


Figure 4 Comparing weekday and weekend attendance by age

Note that children show a peak in the late afternoon on weekdays and all other age groups show a peak in the morning, with the 20-44 age group also showing a relative increase between 9 and 11.

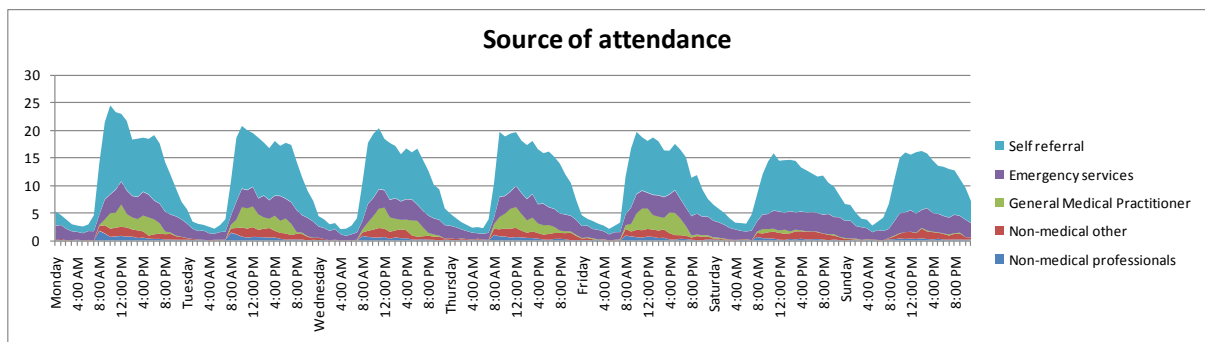


Figure 5 Source of attendance by hour and day

The cause of the increased attendance on weekdays and particularly in the morning appears to be partly GPs and partly self-referral.

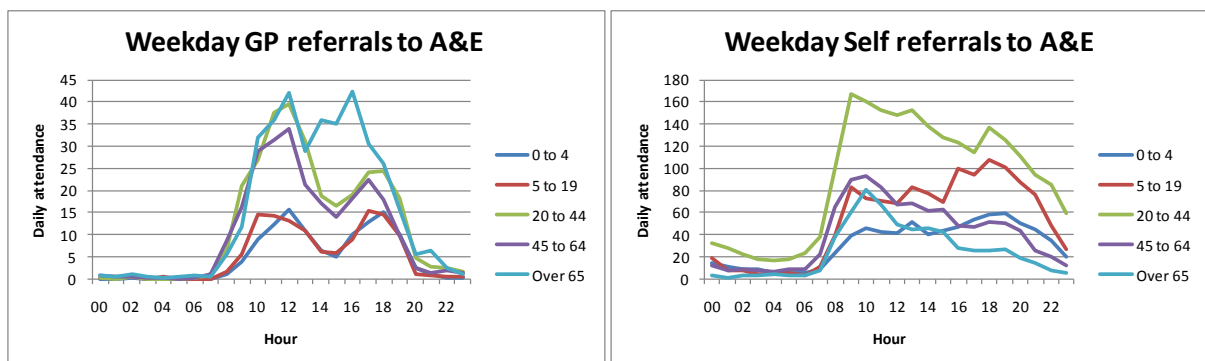


Figure 6 Pattern of GP and self initiated weekday A&E attendances

Both GP initiated and self-initiated child attendances increase in the afternoon. The rise is less at weekends. This may be due to the ability to obtain an immediate GP opinion.

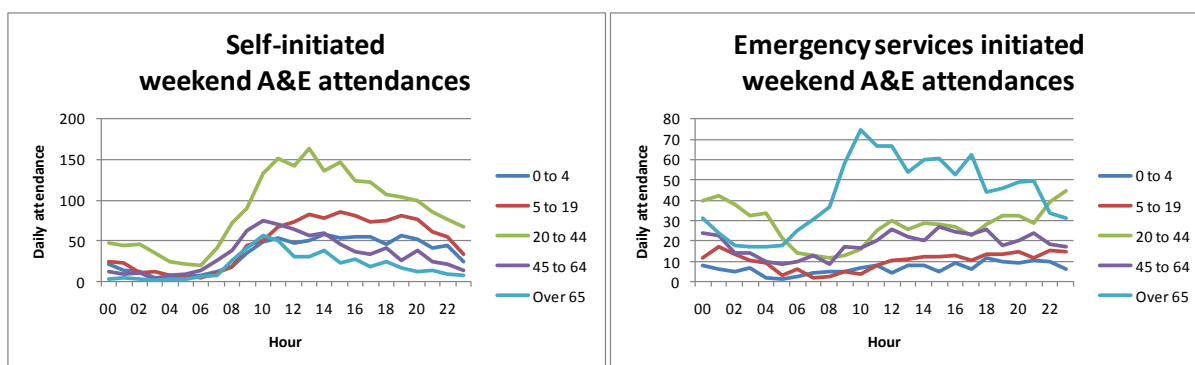


Figure 7 Weekend attendances by hour and source

The absolute number and proportion of all groups except over 65 rises with time for emergency service initiated referrals, however this is less than the fall with time of self-initiated referrals. The pattern for all groups except children is similar to weekend self-referrals and with the exception of 20-44 year group is also of the same magnitude on average. It may be that the relative rise in self-initiated childhood attendance on weekdays is related to the availability of primary care services.

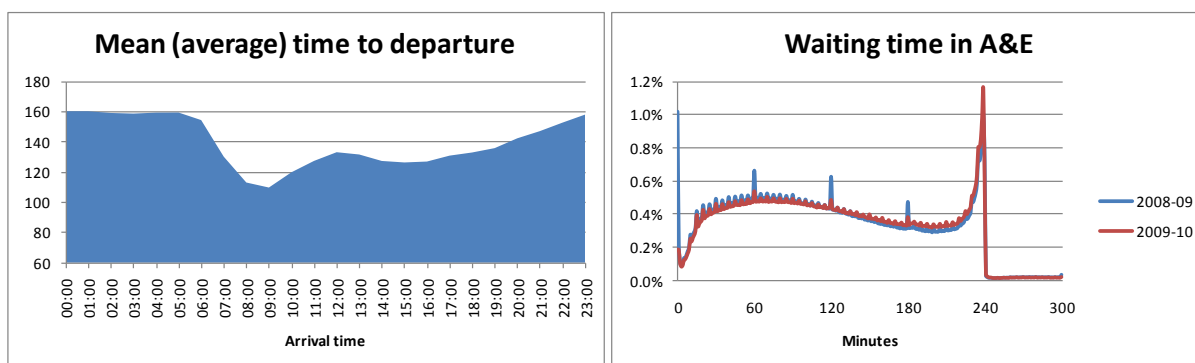


Figure 8 Waiting time in A&E^v

The peak activity in A&E coincides with the shortest average waiting time, although this is still around 2 hours^{vi}. From midnight until 06:00 the average waiting time is 4 hours. The waiting time does relate in part to the disposal with non-treated patients leaving earlier.

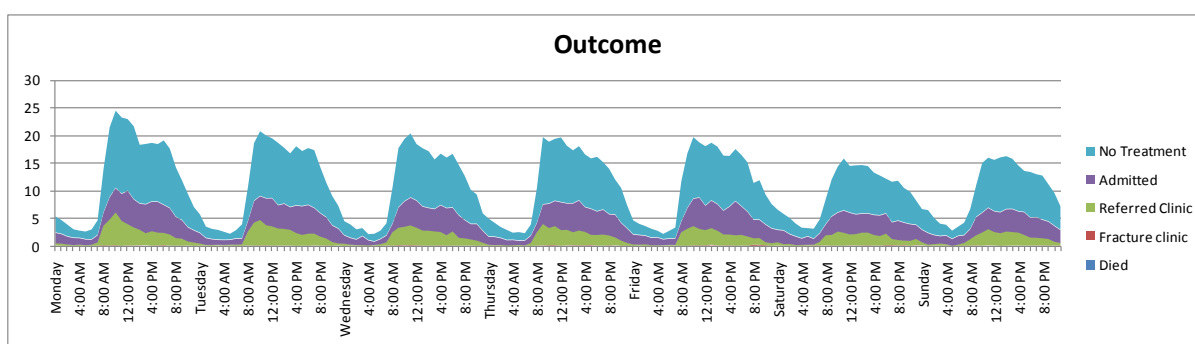


Figure 9 Outcome of A&E attendance

Admissions occur at a relatively even rate through 24 hours.

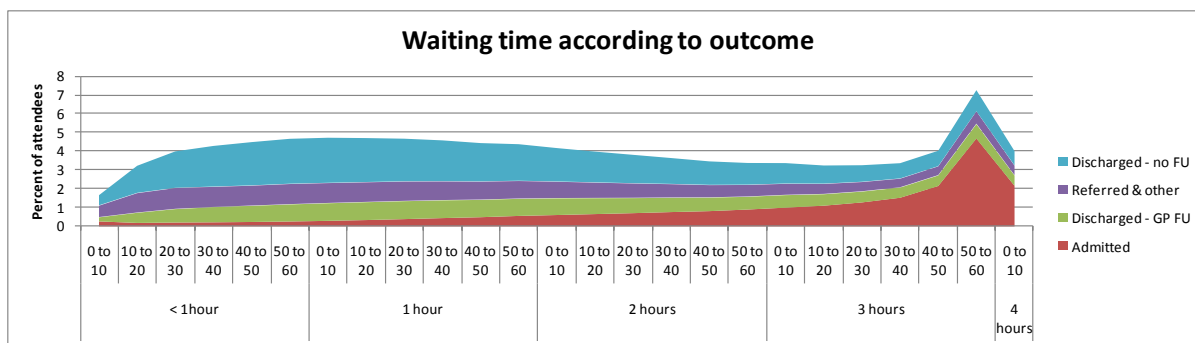


Figure 10 Waiting time according to outcome

This illustrates what may be a problem: patients are able to get an opinion in less than an hour and if this also requires investigations, the waiting time is usually less than two hours. Providing a rapid assessment, even if this is to advise that no medical treatment is required, may be stimulating further attendance.

Mode of attendance

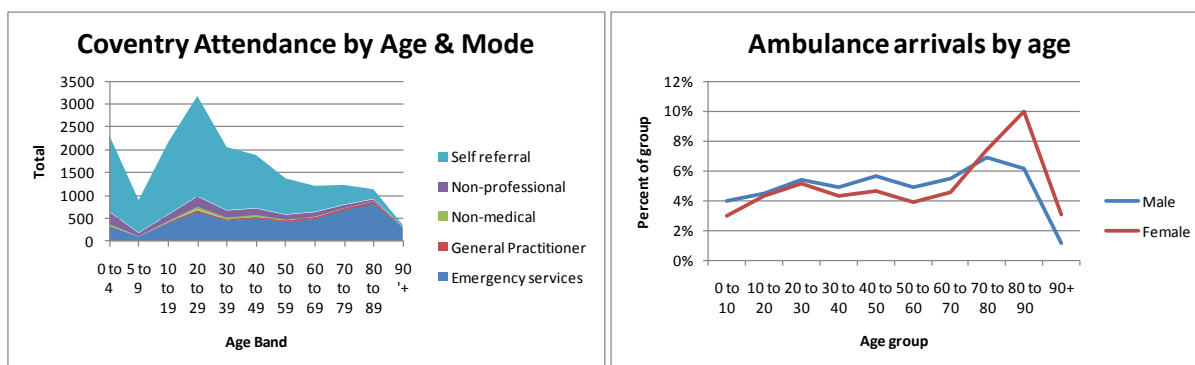
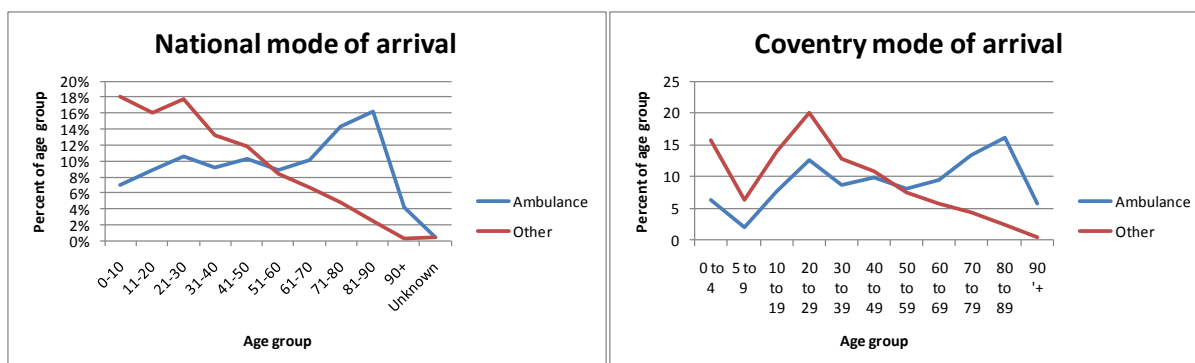


Figure 11 Attendance pattern by age and mode of arrival

Figure 12 Comparing mode of arrival by age^{vii}

Outcomes

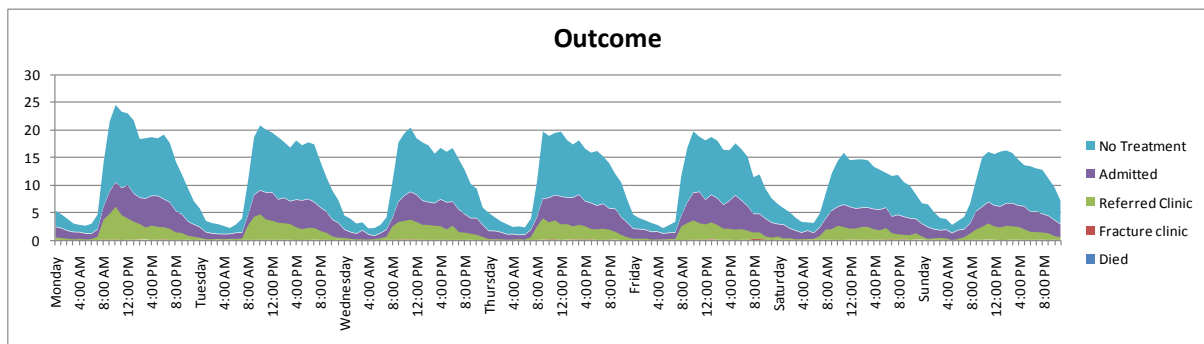


Figure 13 Outcome according to day and hour

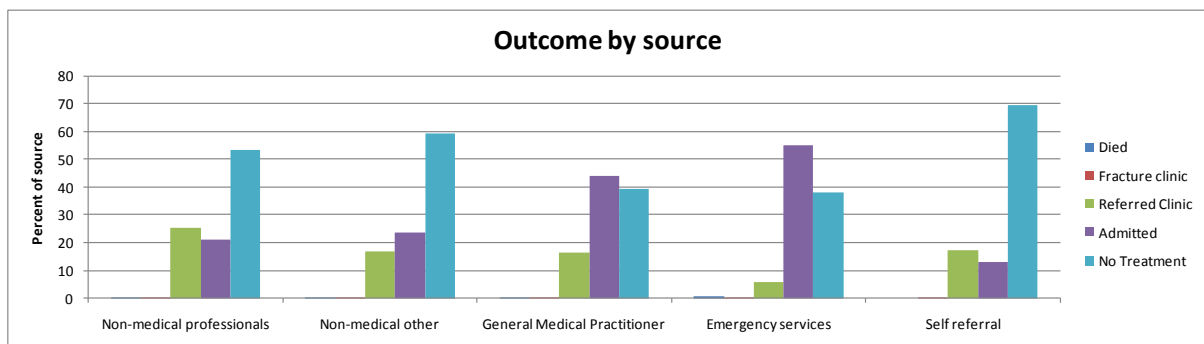


Figure 14 Outcome according to source

Treatments

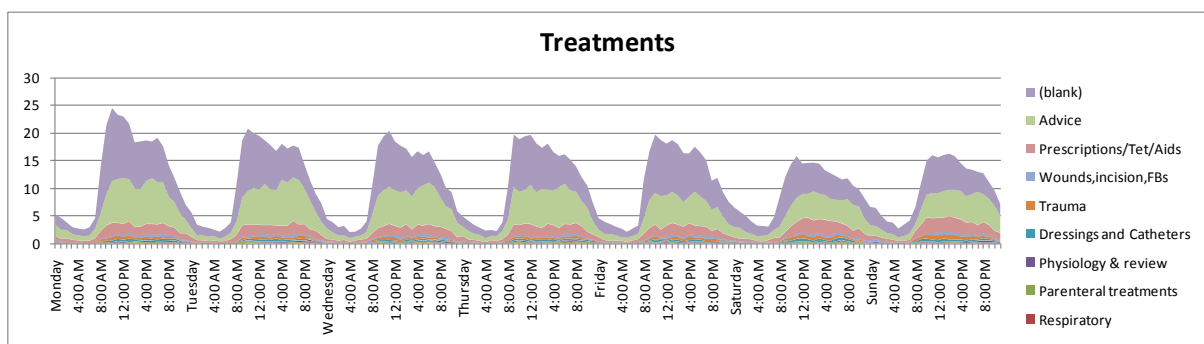


Figure 15 Treatments according to time of day

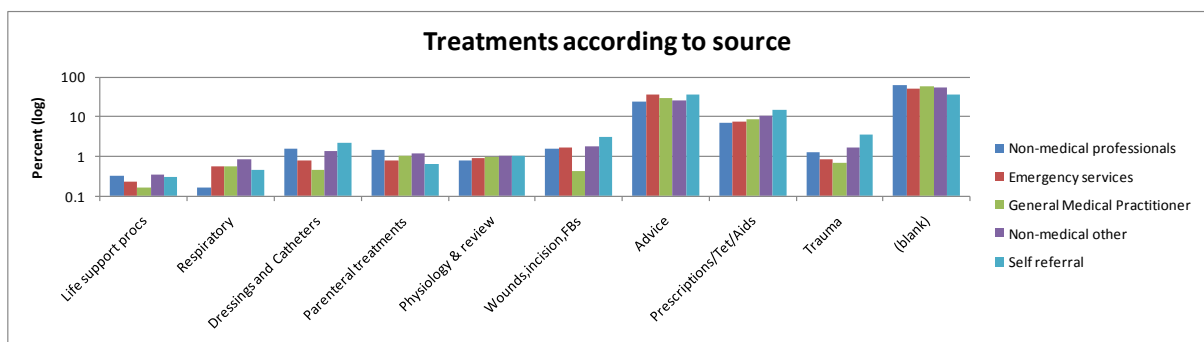


Figure 16 Treatments according to source

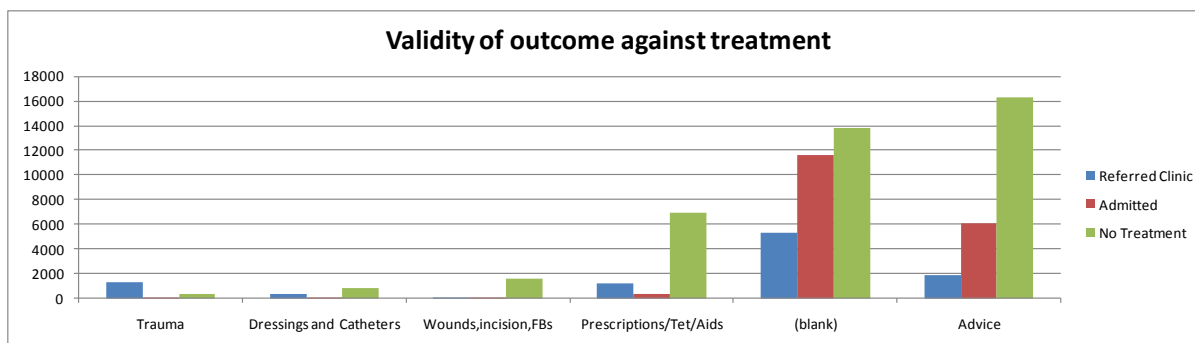


Figure 17 Comparing reported treatment against outcome

GP and demographic factors

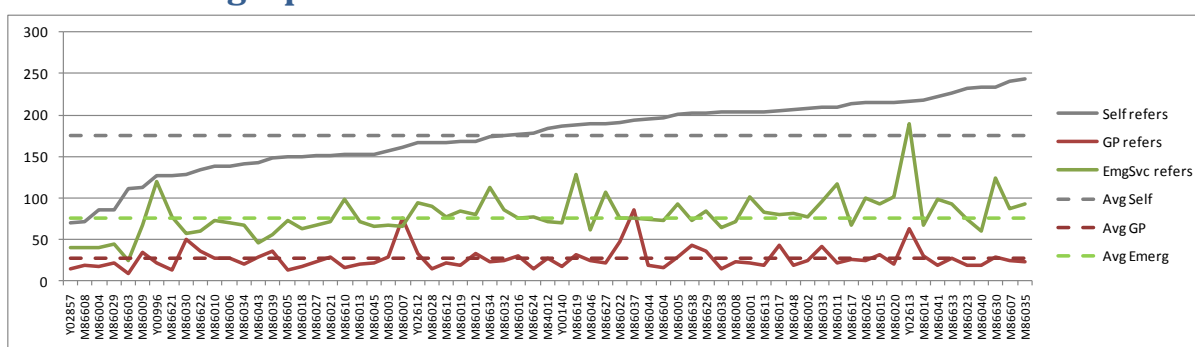


Figure 18 Patterns of referral by practice

Note the red line is GP initiated referrals. The 3 high referring practices are also visible in the following charts.

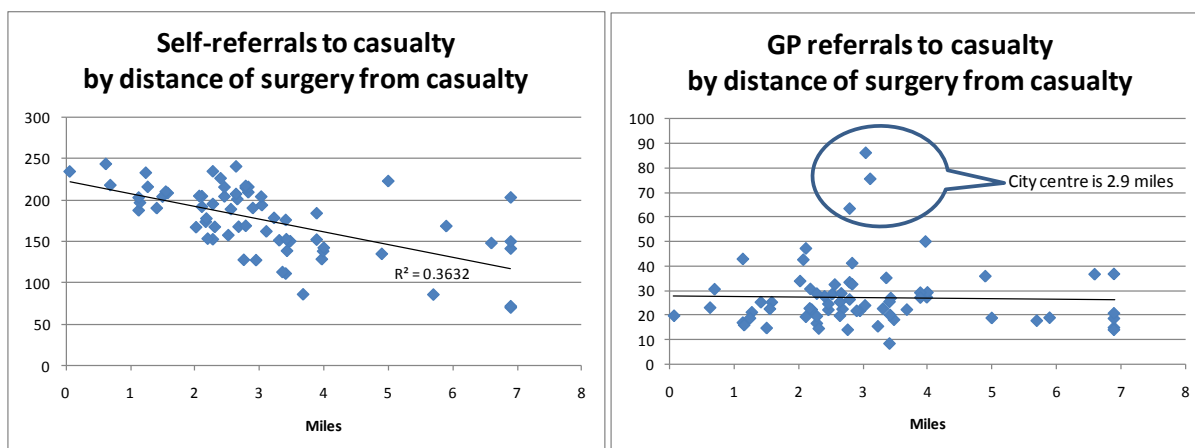


Figure 19 Self referrals and GP referrals according to distance from casualty

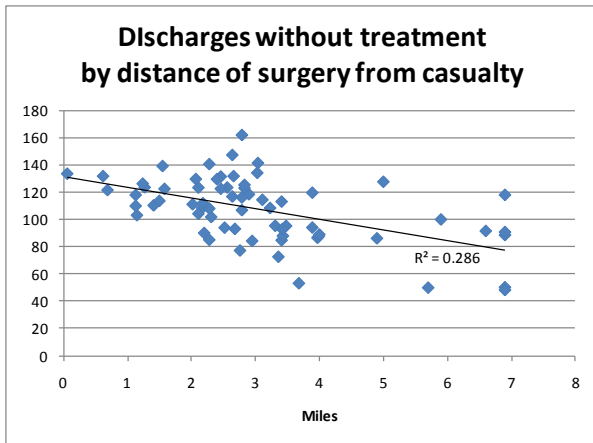


Figure 20 Discharge without treatment by distance from casualty

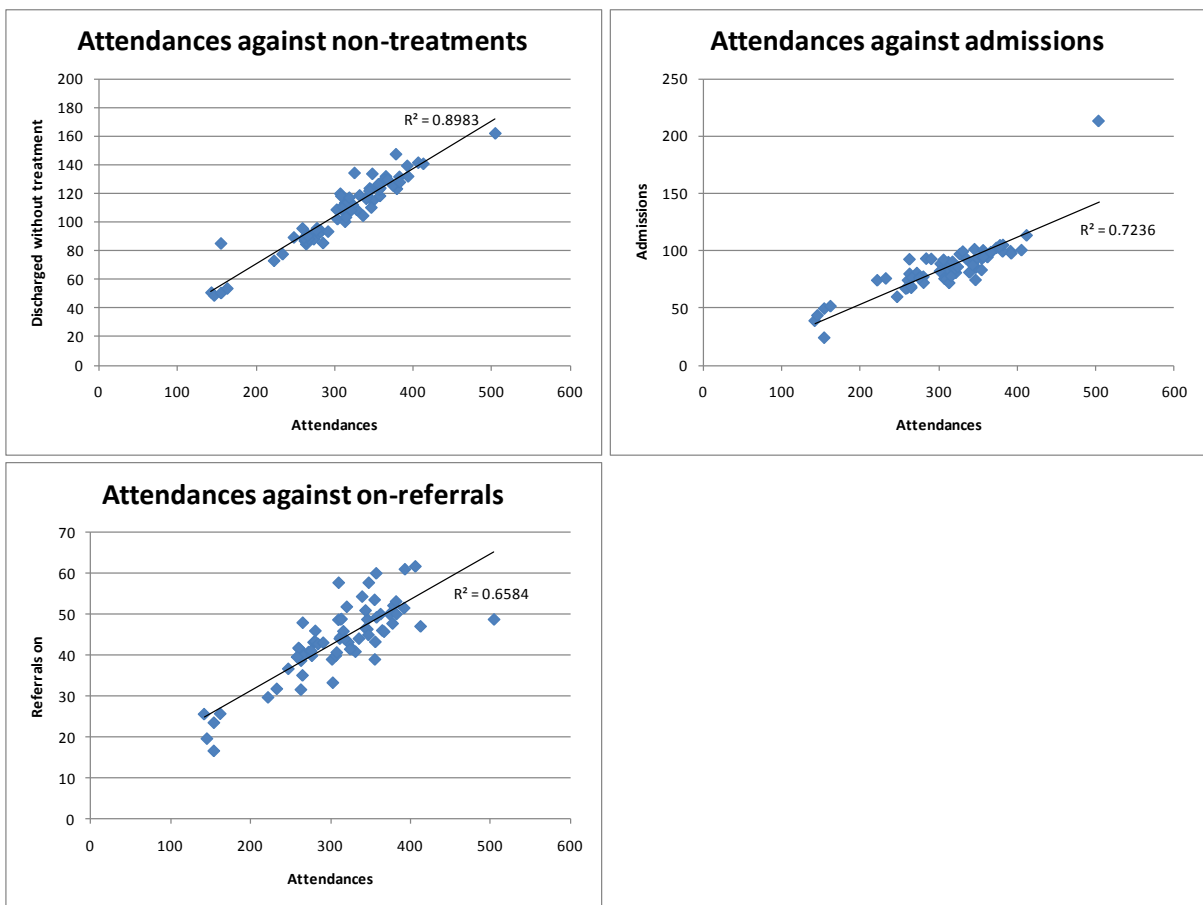


Figure 21 Practice level outcomes against attendance rate

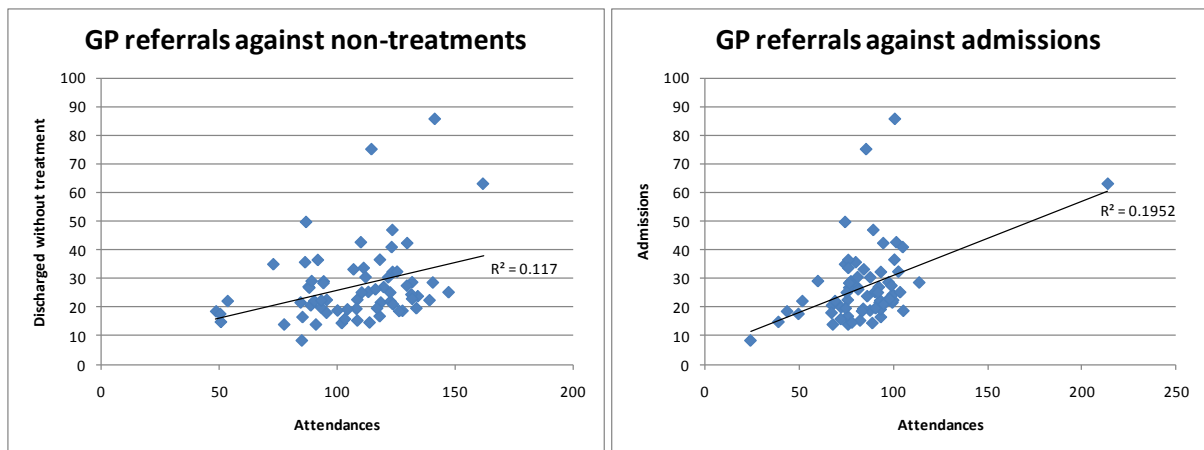


Figure 22 Admissions and non-treatments for GP initiated attendance

Thematic analysis

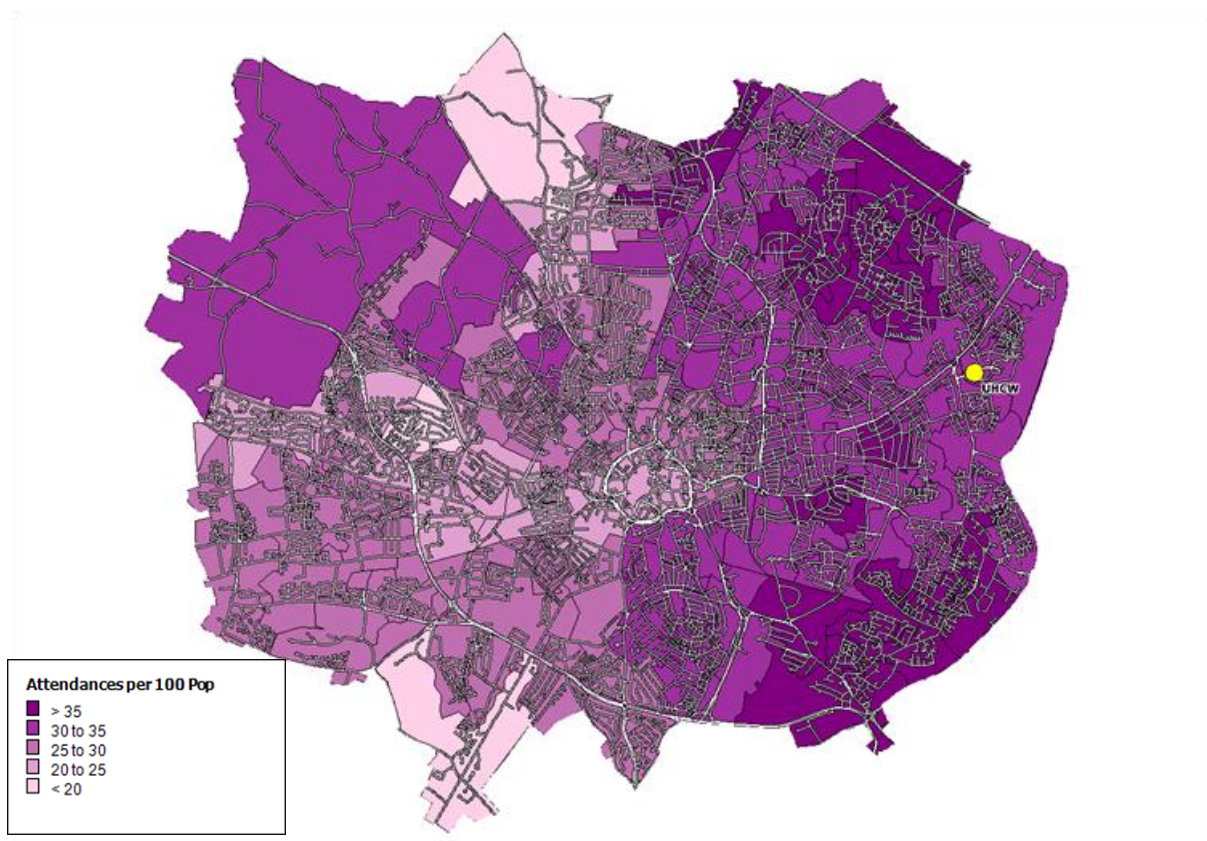


Figure 23 Casualty attendance by ward of residence

Contains Ordnance Survey Data © Crown Copyright and Database Right 2010. Contains Royal Mail Data © Royal Mail Copyright and Database Right 2010

Figure 24 Self referrals by ward of residence

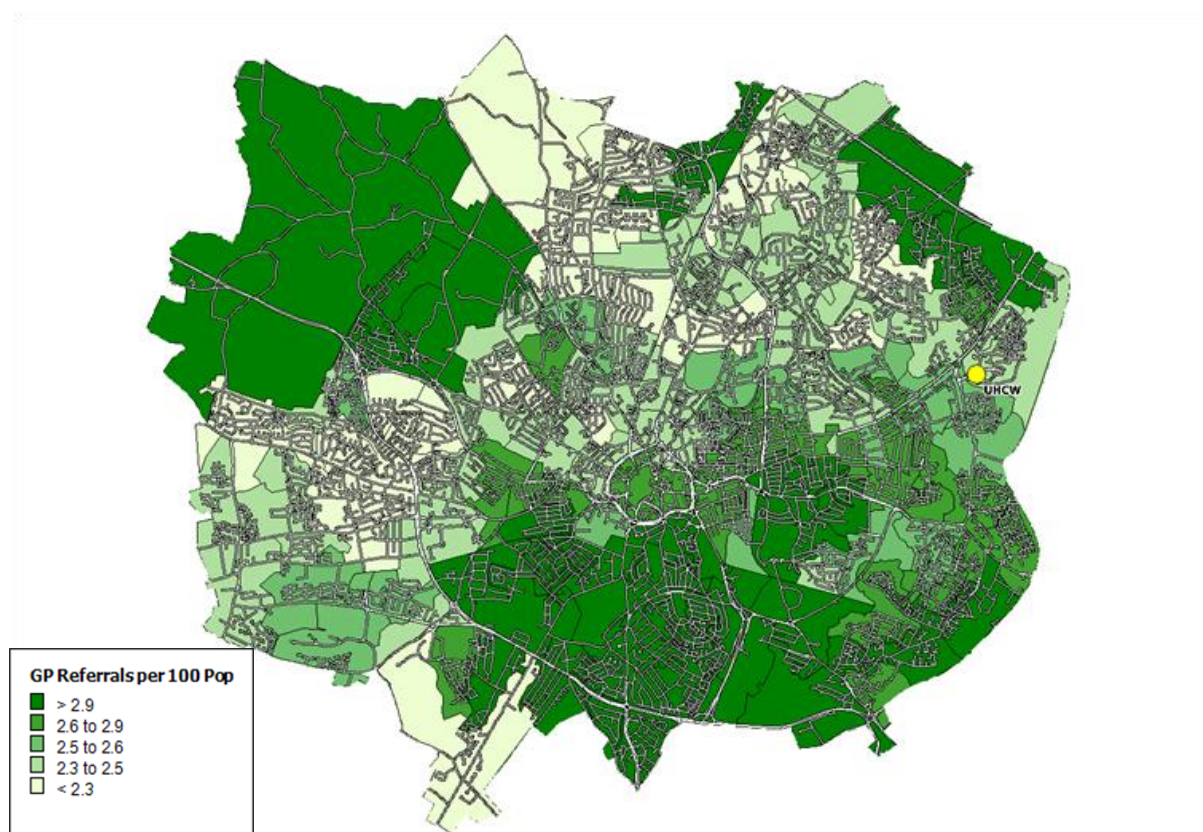
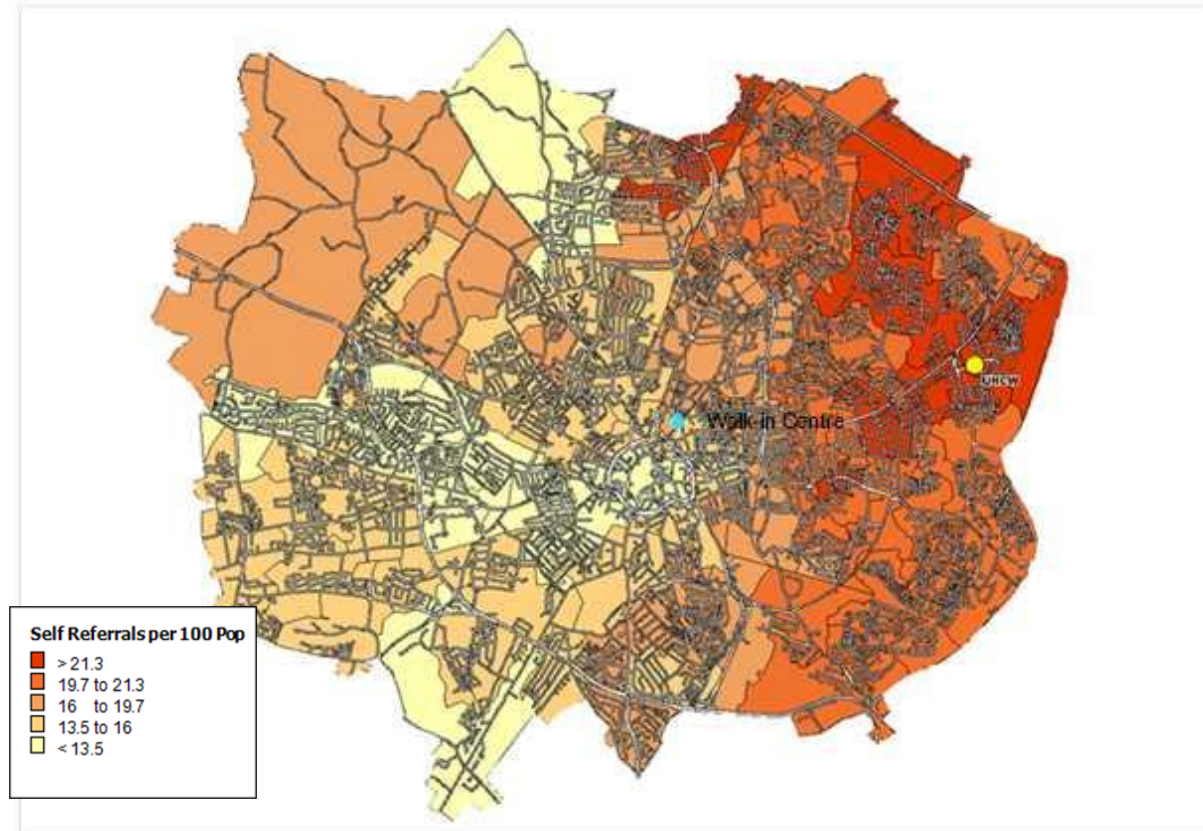
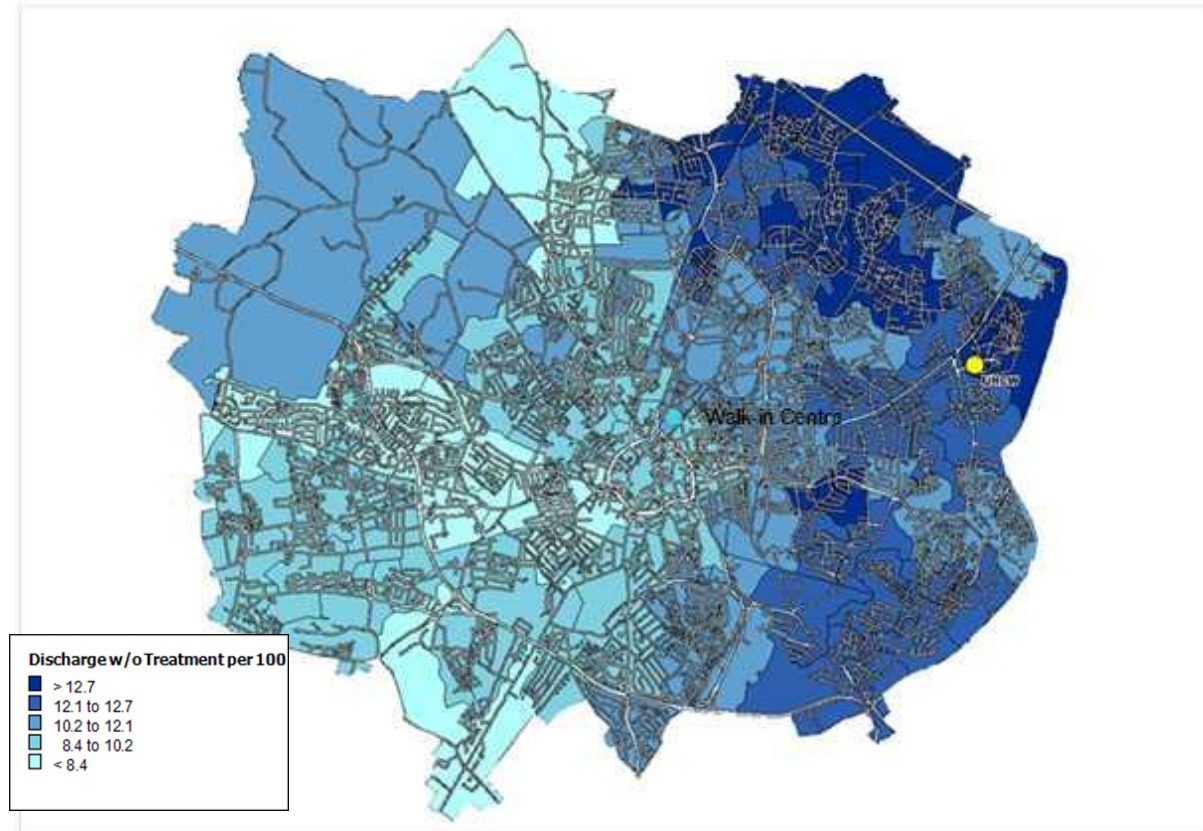


Figure 25 GP referrals by ward of residence

Figure 26 Discharge without treatment by ward of residence



Sources not referenced within text.

All other sources are those compiled by Jon Clinton and Ken Holton

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- | | |
|-----|--------------------------------|
| i | Source The Information Centre. |
| ii | Source HES-on-line |
| iii | Source HES-on-line |
| iv | Source Holbrooks-Health-Team |
| v | Source HES-on-line |
| vi | Source HES-on-line |
| vii | Source HES-on-line |

From: NHS England Midlands and East Regional Commissioning

NHS England Midlands and East Region welcomes the excellent and comprehensive Monitor Walk in Centre Preliminary Report which captures the many and complex issues and challenges involved in commissioning and reconfiguring these services. We also recognize the value that the report has in engaging stakeholders in the debate and potentially involving stakeholders in solutions to these challenges.

We particularly recognise and agree with the advice for commissioners to:

- Assess and consider the needs of vulnerable patients when considering reconfiguring these services
- Ensure an integrated approach to Urgent Care so that any WiC reconfiguration does not destabilise other part of the system
- Take an approach that is transparent particularly where there may be conflicts of interest

However, we also consider that the primary payment mechanisms for WiC arrangements do lead to duplication of payment for some primary care services and we are repeatedly informed by Patients that the combination of Out of Hours, Walk in Centre, GP Services and Accident and Emergency leads to Patients being confused where to attend and when. Therefore, as and when these service contracts are reviewed these issues as well as the wider health inequalities must also be considered by Commissioners.

In particular, NHS England Midlands and East Region would wish to continue engaging with Monitor in understanding the views it has independently received so we can achieve the best solutions to the challenges outlined in this report.

Once again thank you for producing a first-rate report which will help guide Commissioners in their decision making.

From: John Noton

With regard to the comments about your report some observations from a practice manager

1. Men of a working age seem to use these more frequently possibly as they have to get advice when they are not working
2. Convenience, people some times use these as they are more convenient but it does duplicate provision

3. Being too easily available means people may not choose advice from pharmacies regarding viral illnesses and IT INCREASES THE DEPENDENCY CULTURE
4. They struggle to staff them and often end up using many different locums, this sometimes means the quality of the care and safety can be in deficit
5. We need to encourage individuals to take ownership of their health and increase the focus on prevention not availability

There is a role for these but not so if we move to 7 day 12 hour availability of primary care as being sought by the government, they may be better for big cities or something equivalent in primary care

From: Helen Osborn

Comments on re view of WIC

- 1- Reasons for closing WIC usually pragmatic and based on VFM and avoiding duplication of services. Walk in centres were initially centrally funded and were set up in parallel to other services as a “must-do”
- 2- Wider issues of primary care funding and contracting are touched on, but without reference to the need to plan ahead for our increasing elderly population with many LTC including dementia. Managing appropriately people with LTC and urgent is a high priority in sharp contrast to current role of WIC dealing on the whole with minor self- limiting illness.
- 3- CCG best placed to manage future of WIC in order to make better use of them and ensure address high priority needs of local population with input from AT for those WIC providing predominantly primary care service for registered population
- 4- Payment mechanisms for WIC and primary care do not currently work- Primary care is becoming overloaded with the need to address LTC and Urgent but with no additional investment. WIC currently dealing with low priority work which does not represent good value for money
- 5- Current work carried out in our local WIC is if low value and would be better managed by self-management , community pharmacist or primary care
- 6- Ease of access of WIC valued by those attending but in these days of austerity this seems a luxury which can no longer be afforded.
- 7- WIC could be re-commissioned by CCG to provide services which help to meet the high priority needs of the population eg urgent care and LTC

- 8- Priority should be to develop good supporting services to manage our elderly population with LTC, improving communication between services and avoiding fragmentation
 - 9- I am not convinced that market forces have a part to play in the current economic climate with reduced opportunities for profit margins
 - 10-Procurement, Patient choice and Competition regulations are cumbersome. This has fostered fragmentation of services rather than integration as parts of services are put out to tender. Procurements exercises are also very time consuming and expensive with the added complication of seeking more expensive legal advice about how to avoid a possible challenge- Not the way to go if we are looking to develop integrated services
 - 11-In terms of patient choice- when are we going to have an open public debate about how much can we afford to spend on health care? And what is the NHS going to stop providing?
-

From: Malathi Reddy

The findings of the review was informative. Service configurations have become so complex that the only thing which appears to be functioning for the convenience of the patient are the walkin centres. It would be useful however to have some accountability and to continue to support these services.

From: Zena Wigram

Dear Sir

It seems that commissioners / DoH / NHS England / whoever is in charge (who is in charge?) aren't at all sure what the NHS is for, let alone what walk-in centres are for. If the NHS is to treat people's health, to make people who are ill better and people who are well stay well, then it's very odd that a walk-in centre should be closed because it's too popular: too many people are getting the health treatment that the NHS was set up to offer. What? While others are closing because not enough people use them (was there really no demand at all in that area or are the people in that area just going to A&E? Just spreading TB or AIDS or whatever because they can't get treatment at all? Or they're all super-healthy there?). It's much cheaper if people who are disempowered and not registered with a GP are sick outside in cardboard boxes and don't have any access to healthcare, rather than paying to have a centre where they could be treated.

This seems symptomatic of the whole problem with the new-look NHS: no-one is sure what should be done, let alone who should be doing it. Dividing things up into little bits (commissioners, providers, GPs, Monitor, CQC, NHS England, CSUs) means that everyone wants to meet their own separate targets, in the short term, and no-one is taking the longer-term whole population view. It used to be that there was a battle between social services and the NHS over who should pay the bills to support very elderly people who needed support to stay healthy at home. Now we have battles between all the divided up NHS people over whose responsibility those elderly people are. Is it Monitor's fault, or CQC's fault, or NHS England's fault, or the CCG's fault if they're sick in hospital and don't get proper care? Or perhaps the nurses' fault - but there are so few nurses with so many posts unfilled, that makes it no-one's fault. Someone, somewhere will do an inspection and write a report sometime. So that's OK then - tough luck on old Mrs X, of course, but no-one's fault or responsibility.

And if a mother with a child sick on a Sunday goes to A&E instead of a walk-in centre, that's A&E's problem not the CCG's problem, or the local authority's problem, and she could just sit in A&E for six hours among the drunks, but that's not their fault or their problem, so that's OK then.

I suggest the solution is to fire all the politicians and fat-cats making a mint out of the health service and bring back a single commissioning and providing group, which is paid on the basis of how many people are healthy, not how many people are sick and seek treatment. I'm currently well and healthy, but I despair of what will happen if I get run over in the street, let alone get a major long-term condition, because the NHS is crashing down about our ears, and all we get are reams of reports and a lot of political hot air about what great improvements have been made and how good the system now is.

From: Babs Williams

Invest in WICs, allow CCGs to own and commission them to fit with local needs.
Allow CCGs to develop services offered in them.

Give them **time** to get established and work.

From: [✂]

Hello

Please don't close the Shrewsbury WIC. In my previous job I had to start living away during the week. I left home at 6am on Monday and returned late on Friday evening, which was an incredibly stressful arrangement. It was such a relief that I could become a registered patient at the WIC (I don't know if all WIC's are also a normal GP practice). Without this service which has weekend opening I would literally not have ever been able to go to the GP without taking a whole day's annual leave on a Monday or Friday. Patients are not allowed to register at two GP surgeries, so I couldn't even have registered with one at home and one where I worked.

Thankfully I now work in Shrewsbury but work is stressful enough without trying to fit in GP appointments during work time, so it is such a relief to be able to go in the evenings and weekends.

Why close WICs at the same time as suggesting 7 day GP opening? The idea for 7 day GP opening will not be an effective substitute for WICs - it's only a pilot and it won't end up being widespread due to lack of GPs, lack of money, etc.

From: [✂]

Walk in centres deal with two ends of the population spectrum - those who work hard, and pay most of the taxes in this country, but who do not have the time to spend all day on a phone trying to get a GP appointment, and those at the other end, often vulnerable people whose more chaotic lifestyle prevents them from making and keeping appointments, but who need good primary care more than many who take up most of the GP appointments.

Visit any GP surgery and see who is sitting there waiting for the appointment that they had the time to make - the elderly (but not the ones that are causing the ED pressure) and middle class mothers with young children - both groups probably need care, but possibly not as much as they get.

What do GPs do all day - measure BP and cholesterol, tick boxes for their QOF points, but does that activity actually give improved outcomes - not as much as are needed? They are not addressing the inequalities in outcomes that are widening in the UK, or preventing the relentless rise in ED attendance and hospital admission.

The system must change if the NHS is to survive, we must address inequalities and GPs and walk in centres can both be part of that solution, but it needs to be properly planned, with service provision based on population need and not demand.

Having moved Public Health away from the NHS, I'm not convinced they can influence commissioners as they need to. Commissioners are led by GPs who have a vested interest in keeping general practice as it is. Public health consultants have no axe to grind and are trained to assess population need, evidence of effectiveness and to evaluate outcomes of services, but are rarely allowed to follow through such a cycle to help us ensure that we have the effective services that are based on need not demand, and are delivering improved outcomes wherever they are delivered.

I am an ex-GP and semi-retired public health consultant, so you may think I also have an axe to grind. I may do, but it's my tax payer axe that wants to see public money spent on needed, effective services that will deliver better outcomes and reduced inequalities. Fiddling about while the NHS burns won't do this.

From: [✕]

The general opinion of my colleagues and of friends and family in Bolton is the closure of the WIC 2 years ago has been a great loss. Politics should not come into delivery of primary care, there are all sorts of positive ripple effects from having the convenience of a late and weekend opening WIC, not to mention potential cost savings and general feeling of being 'valued' and 'cared for' by the general public. Had a chat with my team and they all agreed:

- WIC's are convenient and accessible as long as they're situated in a central position in town for general public, in particular the young, the old and the Mums & toddlers who I'm sure are probably the most prolific users of GP's surgeries
- Speed – No capacity at GP or A&E
- Potential for further development, i.e. offering smears, flu jab, imms & vaccs etc... Could use as a public health promotion and advice centre as well as healthcare

Thank you for the opportunity to share our views.

From: [✕]

Dear Sir/Madam

I just felt I needed to pen some words on behalf of the great treatment I received from my walk in centre in Stockport (before it closed). I struggled with a series of UTI's and diabetes for a number of months while my walk in centre was still open. My flare ups always co- in sided with my gp surgery being closed on Wednesday afternoons, Saturday mornings or late at night, without my walk in centre I would

have had to use my local hospital. Staff were kind, helpful and always gave me the antibiotics I needed to get me through till I could see my gp.

From: [✂]

Dear Sir or Madam,

I am responding to the helpful report by Monitor on walk in centres. I am responding in a personal capacity but unusually over the years of the policy I have had a number of roles, these included being the medical director of a private health company bidding for contracts, as a clinical GP who worked in one for over 6 months and then as a medical director and director of a PCT with responsibility to oversee one. This included efforts to change the model that was commissioned.

I come from the backdrop that there is an issue of access to primary care and general practice in particular in many areas. There are many factors to this, but there are many constraints on the general practice workforce and the way it works, not least the overall demand for primary care. Some surgeries (such as mine) have changed their appointment system to Doctor First, whereby we now offer most consultations on the telephone. Whilst there are risks with this approach and it does not suit everyone, in a session we will now manage 30+ patients as compared to a routine 18-20. This is a significant increase in productivity and we have reduced our A & E attendances (which were not high by local comparison by 20%. A major constraint though is the number of GPs in particular and the funding, not for doctors for ancillary and nursing staff and this is to a degree hampering developments in the out of hours time frames.

To turn to the walk-in centre, the view [✂] in particular is that this was the solution to a "London problem" rolled out nationally. Actually what we wanted to do (and were not able to) is to open one of our larger surgeries in the county as an urgent care centre after 630pm and at weekends. This would have been considerably cheaper than the [✂] current spend or we could have replicated the system in the major towns locally for the same money. It would also have increased access and in our opinion reduced A & E attendance. As it is the local walk-in-centre whilst liked by patients has stimulated supply side demand as there is evidence that 80% of patients who attend as walk in patients are registered with local practices. Whilst they can always do better, the county ranks as one of the best for the provision of general practice in the UK when measured by QOF etc. So overall I think the walk in centre policy has been a missed opportunity to actually increase access to general practice generally. It might work in the conurbations where there is generally poor access to general practice, but if allowed, we could have commissioned things a very different way that benefitted many more patients.

To turn to your specific questions...

1. What are your views on the reasons that commissioners have given for closing walk-in centres?

Too expensive, increases supply side demand, capacity already present in other practices

2. Has Monitor sufficiently captured the concerns of commissioners related to walk-in centres? What additional information or evidence should we consider?

Yes

3. What are your views on Monitor's analysis and preliminary findings related to the potential impact of walk-in centre closures on patients?

Probably right, but specific contracts for hostels, homeless etc can be delivered under specific contracts by other providers. We used to do this with a specific surgery and there is no reason why this cannot work if correctly commissioned.

[✂]

4. What are your views of our analysis and preliminary findings on how divisions in responsibility for the commissioning of walk-in centres may result in drawbacks for patients?

The current "mess" of division between commissioning by CCGs and NHS England needs to change. There needs to be absolute clarity on where the responsibility lies.

[✂]

5. What changes would you recommend to the way the commissioning of walk-in centres is organised? For example, should one commissioning body take the lead in decisions about walk-in centres while ensuring that decisions take into account the potential impact of a closure across primary and secondary care? If so, which body and why?

Recommend place with CCGs. This is very important as they need to find local solutions to their difficulties, rather than a "one size fits all" policy.

6. What are your views about our analysis and findings on how the payment mechanism for GP practices and walk-in centre services may not be working in the best interests of patients?

Monitor (understandably) is coming from the perspective that competition will improve standards. The evidence base for this is very marginal at best and my contention is that better value and quality can be achieved by sensible commissioning.

[✂]

7. Do you believe including in the payment mechanisms stronger incentives for GP practices and walk-in centres to improve quality and efficiency could benefit patients?

Yes

8. How do you think the payment mechanisms should be adjusted to increase patient benefits within the limits of NHS funding?

Look at the barriers to why GP practices do not open at weekends now. These revolve around nursing and ancillary staff, availability of buildings and availability of GPs. I would contract these separately to the GP contract.

9. Is the description of the key factors that commissioners are likely to need to consider under the Procurement, Patient Choice and Competition Regulations when taking decisions about the future of a walk-in centre helpful?

Would further advice or guidance be helpful?

As mentioned the procurement and competition rules are frequently barriers to what we need to do. They often ensure a "race to the bottom" and prevent integration. They also drive unhelpful behaviours from individuals and organisations.

I trust that these comments are helpful. If I can be of further assistance, please let me know.

From: [✉]

Would like to know where the 50 WIC are that have been closed.... obviously these are going to be in remote areas and not busy residential areas. Also will I get an appointment at my GPs within a next day or two of feeling unwell or will I have to wait at week like I did two weeks ago!!!! And when I did complain I got an appoint 3 days later!!! With a nurse clinician (same as the WIC nurses) and not my GP.

Are the general public being asked for their comments on this subject, because the positive feedback we receive in our WIC regarding the service the people of Halewood are receiving, I think there will be quite lot of resistance to closing any WIC.

From: [✉]

Hello, there is confusion in the urgent care system and partly that is why so many patients attend A&E.

There is also confusion around terminology:

Walk in Centres in the context of recent news, I believe refers to “Darzi” practices. We obviously have more conventional WICs which treat minor injuries and minor illness and are usually nurse led. However, I would consider closing the majority and concentrate those resources and skills in one place....currently A&E.

They could be renamed, but the important point is that the service would be offered (majors, minors, primary care, diagnostics etc) in one place – which is exactly where patients currently go!! The 24 hour supermarket mentality. People do not want to wait too long and certainly don’t wish to passed from pillar to post.

This model I simplistically describe is one I have been pushing in my area for years – a lone voice in this area!! However, perhaps one day it will come to fruition.

“Radical” is the order of the day, otherwise we will contine to go round and round in circles reinventing what has gone before! I am now in the closing months of my 40 year NHS career and after working in the majority of clinical areas over the years feel totally dismayed and tired of hearing “review” this, “monitor” that, gain “assurance” etc etc, without actually getting on with the job and delivering the superb care the NHS is capable of!!

[X]

From: [X]

Dear Sirs,

[X] I felt obliged to respond to the questions raised in your report. The report seems fair and balanced and raises the most relevant questions.

I think one of the major difficulties is that Walk-in Centres are so diverse that it is difficult to generalise. Our contract is coming up for review and the process has been long and drawn-out and largely unsatisfactory. Despite the fact that [X] was one of the first wave it is clear that staff at our CCG and LAT really have only limited comprehension of what we do here. This is compounded by the fact that our LAT includes few if any staff that previously worked for our local PCT, and they have minimal knowledge of the local health community.

We provide many services that other local providers have been reluctant to provide or fail to appreciate. We offer extended hours and flexibility to increase access for the sizeable local population of difficult-to-reach patients including the homeless, substance misusers, the seriously mentally ill, those recently released from prison, asylum seekers etc. We are one of only two local organisations prepared to accept designated violent patients. We have public health responsibilities, providing TB screening, diagnostic and follow-up services and BCG vaccination in an area that is seeing a rapidly rising incidence of TB.

The GP practice element of our organisation has over 10,000 registered patients, which would appear to be larger by far than the list size figures given in your report. Should our organisation be allowed to fail this would have serious implications for the local health community, when other local practices are bordering on failure and applying to close lists. Our WIC clearly copes with the overflow from a number of local practices which would be in danger of failing should our service be withdrawn abruptly. I understand the argument that this is paying twice for primary care services which other practices should be providing but WICs should not be made scapegoats for the chronic under-funding and over-working of primary care in the UK.

It seems clear that local commissioners seem to be motivated only by the opportunity to save funds by closing services, rather than considering the wider implications. I note that your report makes no mention of the wider professional environment. Our organisation has sponsored the extended training of a number of nurses which has added to the value and quality of the local pool of nurses with extended skills. Our GP arm is a training practice which has been earmarked for expansion of training numbers as part of the national expansion of GP training. We have one extant educational supervisor and three other GPs in training to be educational or clinical supervisors. This activity has not been factored into anyone's calculations because service budget holders have no interest in it. We also have a training department which provides clinical skills and theory and safeguarding training to the local health economy. Activities such as these appear to be beyond the view of those commissioning and assessing clinical services and yet have importance to the wider professional environment.

In terms of our clinical activities we have generally performed very well against contractual targets, and we believe that we provide an efficient service in terms of both quality of activity and financial value. Our integral place in the local area is attested to by our place in the emergency planning arrangements and the on-going pilot by which we are taking ambulance cases from South-Western Ambulance Service to reduce ED attendances and provide appropriate one site medical care.

We can only foresee a future in which we will not exist and this change needs to be planned and handled carefully to avoid major adverse effects on the local healthcare environment.

BMA response to Monitor's Walk-in centre review preliminary report

The BMA responded to Monitor's initial review of the provision of walk-in centre services in England¹, and we welcome the opportunity to respond to the report into preliminary findings. We have restricted our response to areas of particular pertinence for the BMA.

Following Lord Darzi's Next Stage Review report of October 2007,² it became Department of Health policy that every PCT should commission at least one walk in centre. The result was that walk-in centres were created without regard to existing local services or gaps in provision. It is unsurprising, therefore, that in some areas; local commissioners have taken the decision that to continue walk-in centre contracts is not the most appropriate use of resources. The roll-out and subsequent decommissioning of walk-in centres in some areas shows that a blanket, top down approach is not appropriate and commissioners must be able to take account of existing local provision and local need when commissioning services.

1. What are your views on the reasons that commissioners have given for closing walk-in centres?

In many areas there is no clear evidence that walk-in centres are meeting unmet need, and in some cases they are duplicating services^a. There is a compelling case, therefore, to invest resources more efficiently to reduce pressures on other parts of the system, such as general practice and accident and emergency services.

We strongly believe that any service closures should be clinically led and based on good clinical evidence. We agree that decisions relating to walk-in centre closures should be done in a transparent and open fashion^b, taking a holistic view of healthcare provision within a local health economy. We believe that the closure or reconfiguration, or commissioning of any service should occur as a result of a thorough needs and impact assessment.

We were concerned by Monitor's finding that no follow up studies had been done to analyse the impact of walk-in centre closures on patients^c; this may, however, be due to the short time-scales since walk-in centres have been closed. It would be helpful if such a study could be undertaken, to better understand the impact of closure in those areas.

3. What are your views on Monitor's analysis and preliminary findings related to the potential impact of walk-in centre closures on patients?

Monitor expresses concerns that walk-in centre closures may restrict access to primary care services. However, where local commissioners have identified that their local walk-in centres are an inefficient use of resources and/or are creating demand as opposed to relieving pressure³, this resource could be used to improve access to GP services.

^a "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"." – page 47 Monitors walk-in centre review preliminary report

^b "We also saw examples in which commissioners appeared to have decided to close walk-in centres without setting out their reasons for doing so and explaining the process they followed to reach their decisions." – Page 71 Monitors walk-in centre review preliminary report

^c "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." – page 54 Monitors walk-in centre review preliminary report

The BMA agrees with some of the analysis presented by Monitor, such as the emphasis placed on the impact on health inequalities^d. It is important that all stakeholders in local healthcare keep health inequalities in mind when taking decisions which impact on the wider healthcare economy.

There is a general principle underlying Monitor's analysis^e that speed of access is always clinically necessary and desirable. GPs are adept at managing risk, prioritising urgent patients and supporting patients to self-care where possible. Many GP practices offer telephone consultations with a nurse or a doctor and this may mean that there is less need for a face to face consultation.

4. What are your views of our analysis and preliminary findings on how divisions in responsibility for the commissioning of walk-in centres may result in drawbacks for patients? What other information or evidence related to this topic should Monitor consider? and;

5. What changes would you recommend to the way the commissioning of walk-in centres is organised? For example, should one commissioning body take the lead in decisions about walk-in centres while ensuring that decisions take into account the potential impact of a closure across primary and secondary care?

The BMA notes that Monitor has taken on board the points made in the BMA's initial submission concerning the confusion that has arisen regarding commissioning responsibility for walk-in centres. The current division (the practice-list based elements commissioned by Area Teams and the 'walk-in' elements commissioned by CCGs) should be retained, in order to prevent conflicts of interest arising. We would welcome, instead, clear guidance on who has responsibility for which elements, with guidance that sets out how Area Teams and CCGs can best work together to make decisions.

6. What are your views about our analysis and findings on how the payment mechanism for GP practices and walk-in centre services may not be working in the best interests of patients? What other information or evidence related to this topic should Monitor consider?

Monitor states^f that current payment mechanisms 'do not strengthen incentives for GP practices to improve quality and efficiency of their services so that their patients are more likely to choose their services instead of using a walk-in centre'. This statement misconstrues the purpose of walk-in centres. At present, although there is some concern over the duplication of services, the walk-in centre model is not designed to stimulate competition with general practices. If improvements are needed in general practice then appropriate steps should be taken to support practices to improve quality and efficiency.

There are significant assumptions that redesigning payment mechanisms to stimulate competition between walk-in centres and GP practices would 'drive GP practices and walk-in

^d "people from lower socio-economic groups tend to be the most common users of walk-in centres" –page 38

^e "of those that were able to get an appointment (87% of all respondents), only about half were able to get an appointment either on the same day or on the next working day (49%); 33% had to wait a few days and 15% had to wait a week or more." – page 51 Monitors walk-in centre review preliminary report

^f "the current payment mechanisms 'do not strengthen incentives for GP practices to improve quality and efficiency of their services so that their patients are more likely to choose their services instead of using a walk-in centre". – page 61 Monitors walk-in centre review preliminary report

centres to continually improve their own services’⁹. These assumptions lack a clear evidence base.

Furthermore, walk-in centres are designed to treat minor ailments and isolated illnesses requiring medical attention, which as mentioned above can include creating excess demand. GP practices provide long term coordinated care for chronic illnesses, as well as acute presentations and minor ailments. There is a risk in creating competition for funding from the same pot between walk-in centres and GP practices, in that they are different types of providers with potentially different groups of patients.

Incentivising providers to ‘encourage patients to use their services’, as suggested on page 64, may not lead to well designed services tailored to patient need, but could create a perverse incentive for providers to encourage patient attendances. In the current financial climate, commissioners should be focussing attention on how to create responsive and easily accessible services, whilst also promoting self care and preventative measures to try and reduce pressures on existing services.

8. How do you think the payment mechanisms should be adjusted to increase patient benefits within the limits of NHS funding?

The GP contract changes for 2014-15 included initiatives to improve access, including giving practices the option to work with other practices across a locality to provide extended hours. We welcome the changes which we believe will refocus GP time on treating patients in a holistic manner. It is changes like these that will help deliver patient benefits and ensure best use of NHS funding⁴.

In addition, enhanced services are a valuable lever for commissioners to use to improve quality and create locally responsive services. CCGs need to be encouraged to use these levers to improve local services, for example by providing clear guidance about how to manage conflicts when commissioning services from member practices.

9. Is the description of the key factors that commissioners are likely to need to consider under the Procurement, Patient Choice and Competition Regulations when taking decisions about the future of a walk-in centre helpful? Would further advice or guidance be helpful?

The BMA would welcome further guidance for commissioners on the commissioning and closure of walk-in centres⁵⁶. This review, whilst helpful in clarifying certain issues surrounding the application of the regulations to walk-in centre closures, still leaves unanswered questions for commissioners. We would welcome greater clarity concerning the commissioning requirements for walk-in centres.

Endnotes

¹ British Medical Association (2013). BMA response to Monitor's review of walk-in centres. London, BMA.

² Health, D. o. (2007). Our NHS Our future: NHS next stage review - interim report.

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.” – page 64 Monitors walk-in centre review preliminary report

³ Smith, J., H. Holder, et al. (2013). Securing the future of general practice: new models of primary care, The King's Fund & Nuffield Trust.

⁴ Doran, T., E. Kontopantelis, et al. (2011). "Effect of financial incentives on incentivised and non-incentivised clinical activities: longitudinal analysis of data from the UK Quality and Outcomes Framework." *BMJ* **342**:: d3590.

⁵ British Medical Association (2013). BMA written evidence for the 2013 Accountability Hearing with Monitor.

⁶ British Medical Association (2013). BMA response to the statutory consultation on the 2014/15 National Tariff Payment System.

Review of the provision of walk-in centre services in England November 2013

About Celesio UK

Celesio UK is a leading provider of integrated healthcare services to the NHS specialising in medicines, pharmaceutical care and primary care patient services.

With almost 20,000 employees, over 1,500 community pharmacies, a UK-wide logistics network and dispensing in excess of 150 million items a year, we work in partnership with the NHS, community pharmacies and medicines manufacturers to help UK citizens live longer, healthier and more positive lives. We provide our customers, the NHS and patients with high levels of service, value, efficiency and innovation.

Celesio UK comprises Lloydspharmacy, AAH Pharmaceuticals, Evolution Homecare, Wilkinsons Healthcare, Dr Thom and Betterlife. Celesio UK is part of Celesio: a leading international trading company and provider of logistics and services in the pharmaceutical and healthcare sector. Celesio takes a proactive and preventive approach to ensuring that patients receive the products and support that they require for optimum care. We operate in 16 countries around the world and have about 38,000 employees.

Every day, we serve over 2 million customers – at 1,500 pharmacies of our own and 4,100 participants in our brand partnership schemes. With around 130 wholesale branches, we supply approximately 65,000 pharmacies and hospitals every day with up to 130,000 pharmaceutical products. Our services benefit a patient pool of about 15 million per day.

Celesio UK response

1. What are your views on the reasons that commissioners have given for closing walk-in centres?

2. Has Monitor sufficiently captured the concerns of commissioners related to walk-in centres? What additional information or evidence should we consider?

The concerns listed are, in our view, comprehensive. They highlight the tension between the convenience of multiple access points and patient choice on the one hand and the most efficient use of resources on the other.

That should not detract from the broad consensus that if the nation is to address the healthcare challenges it faces then the NHS needs to improve patient access to primary healthcare advice, support and treatment.

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That in turn means the NHS needs to consider a range of primary care providers in local communities which complement and supplement the role of GP surgeries and A&E departments.

The range and volume of patient demand is too great to funnel all needs towards GP surgeries and there is ample evidence that for a variety of reasons, such as convenient access during working hours, patients want advice, support and treatment in care settings outside of GP surgeries.

Commissioners therefore need to consider what existing community healthcare assets could be used to achieve improved access and outcomes for patients, in particular community pharmacies.

The report listed the main reasons why patients have presented at WICs – including coughs, colds and flu-like symptoms; skin conditions or skin infections; stomach upset or pain; breathing problems (such as asthma): these are conditions which could and should be treated at community pharmacies.

Therefore, when commissioners are considering reducing access and choice by closing WICs they should think about replacing that access and maintaining choice through service provision in community pharmacies.

Much more effort needs to be undertaken to help educate the public when it is most appropriate to self-care, go to their local pharmacy or their GP practice.

3. What are your views on Monitor's analysis and preliminary findings related to the potential impact of walk-in centre closures on patients? What additional information or evidence should Monitor consider?

We agree with the view that commissioners need to have in place alternative routes to advice, support and treatment for patients who commonly use WICs: in the absence of a WIC patients who use those centres may not necessarily refer themselves to their GP surgery even if they are registered with one. Those that do will add to the demand pressures which many GP surgeries are already facing and some may present at A&E departments thereby increasing pressure there.

We think Monitor needs to assess what other routes to care already exist in local communities and could provide the kind of support, advice and treatment commonly made available at WICs and which therefore avoid adding demand pressures to GP surgeries and A&E departments.

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We contend that community pharmacies are best placed to provide a route to primary care which complements and supplements the role of the GP.

4. What are your views on our analysis and preliminary findings on how divisions in responsibility for the commissioning of walk-in centres may result in drawbacks for patients? What other information or evidence related to this topic should Monitor consider?

5. What changes would you recommend to the way the commissioning of walk-in centres is organised? For example, should one commissioning body take the lead in decisions about walk-in centres while ensuring that decisions take into account the potential impact of a closure across primary and secondary care?

If so, which body and why?

Celesio UK supports the concept of patient-centric care pathways: service provision should be built around the needs of individual patients.

However, commissioning and funding silos make that concept difficult to realize in practice.

One lead commissioning body could help join up service provision better than is currently the case.

That would allow a comprehensive analysis of primary care needs and how best those needs can be met from a range of providers.

This would also help patients to understand better the care choices they have: when is it most appropriate to seek advice from a community pharmacist as opposed to a GP? If we help people make informed choices then we drive a more efficient NHS and achieve better outcomes for patients.

6. What are your views about our analysis and findings on how the payment mechanism for GP practices and walk-in centre services may not be working in the best interests of patients? What other information or evidence related to this topic should Monitor consider?

7. Do you believe including in the payment mechanisms stronger incentives for GP practices and walk-in centres to improve quality and efficiency could benefit patients?

8. How do you think the payment mechanisms should be adjusted to increase patient benefits within the limits of NHS funding?

We believe there is a need to align how the GP and community pharmacy contracts are funded to drive cross-professional working.

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We also reiterate the point that many of the services which patients want and use in WIC setting are available or could be made available in community pharmacies.

For example, it is estimated that the cost to the NHS of a pharmacy-led minor ailment intervention is half of the cost of a GP-led intervention and yet 40% or more of GPs' time is spent on minor ailments (which in most cases lead to a prescription which is fulfilled at a community pharmacy).

This is neither economically or clinically efficient and it does not offer easy, convenient access to healthcare for patients.

In the new NHS commissioners need to think beyond the default position of "how do we get GPs to do more and therefore how do we use funding to incentivize them?"

Instead commissioners need to consider and assess carefully from the outset care pathways which include at their core community pharmacy as that can offer access and outcomes at a lower cost.

9. Is the description of the key factors that commissioners are likely to need to consider under the Procurement, Patient Choice and Competition Regulations when taking decisions about the future of a walk-in centre helpful?

Conclusion

Celesio UK acknowledges the concerns of commissioners highlighted in the report in relation to the provision of walk-in centres, and we believe that community pharmacy has a significant role to play, especially in increasing access to primary care and releasing capacity in other, oversubscribed areas of the NHS such as GP surgeries and A & E, given the readymade network in the heart of local communities.

We would welcome the opportunity to work with Monitor to demonstrate how Celesio UK can help deliver solutions in an effective and cost efficient way.

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NHS England, East Anglia Area Team Response to Monitor Walk in Centre Report

Question	Response
Reasons given by Commissioners for closing Walk-in-Centres? Has Monitor sufficiently captured the concerns of Commissioners related to WiC?	<p>We are not surprised that there are different reasons offered for local decisions, the key issue is that Commissioners can demonstrate that the decision can be justified in the context of local need, ensuring best use of limited resources and that the decision has been taken openly and transparently. It is for local commissioners to be held to account for their decisions and the rationale.</p> <p>It is regrettable that the report appears to focus on the fact that there have been closures of Walk in Centres, rather than assessing whether the commissioning decisions that have been made and implemented have been progressed in an appropriate manner in the context of the role and remit of Monitor. This is of particular concern given the media focus has now been given to “closure” of WiCs, rather than welcoming the fact that commissioners are critically reviewing how they improve access to high quality services within the resources available.</p> <p>We would suggest that it is unhelpful to suggest that Commissioners have concerns with regard to Walk in Centres – Commissioners have a duty to look at all services and, with stakeholders, critically review services to ensure that they are achieving the outcomes required and offering best value.</p>
What are your views on Monitors analysis and preliminary findings related to the potential impact of WiC closures on patients? What additional information or evidence should Monitor consider	The report highlights the variation that exists nationally, thus making any generalised statements unhelpful, reinforcing potential perceptions that do not reflect local circumstances. It is the responsibility of all Commissioners to understand local needs, undertake Equality Impact Assessments and ensure transparency in decision making.
What are your views of our analysis and preliminary findings on how divisions in responsibility for the commissioning of WiCs may result in drawbacks for patients?	We are confident that Area Teams and CCGs are able to work jointly to support strategic reviews of local services and develop appropriate commissioning strategies to meet local needs, recognising that currently the majority of WiC play a role in delivering “essential” primary care services and as part of an integrated urgent care system. Further change in commissioning responsibility would be extremely unhelpful as the key to delivering for patients will be the building of strong partnership arrangements

<p>What other information of evidence should be considered?</p> <p>What changes would you recommend to the commissioning of WiCs?</p>	<p>and trust between commissioners which requires a period of stability. We would strongly urge that there is no centrally driven directive on which body should be responsible, but rather this should be for local determination to meet local circumstances. The current arrangements facilitate this.</p>
<p>What are your views about our analysis and findings on how the payment mechanism for GP practices and WiCs may not be working in the best interests of patients?</p> <p>What other information or evidence should be considered?</p> <p>Should there be strong incentives for GP practices and WiC to improve quality and efficiency?</p> <p>How could payment mechanisms be adjusted?</p>	<p>We recognise the risks associated with perverse incentives impacting across the health and care system and therefore this issue cannot be considered in isolation and therefore any changes must be considered as part of a whole system review of financial flows.</p> <p>All commissioners should be expected to demonstrate best use of limited resources and be held accountable for this through effective contract management against agreed outcomes to drive quality and efficiency.</p>
<p>Is the description of the key factors that commissioners are likely to need to consider under the PPC&C Regulations helpful? What further advice would be helpful?</p>	<p>The steps set out are appropriate and would be expected as best practice in relation to any service.</p>

[Luton Walk-in Centre: response 1]

2nd December 2013

Corporation and Competition Directorate Monitor
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SE1 8UG

Re: Review of the provision Walk In Centre Services in England – Our suggestions and comments

Thank you for allowing us this opportunity to comment on the provision of Walk In Centres and just to note that we were not aware that this review was currently being undertaken but we commend you for having carried out this excellent review and analysis. Local Healthcare Solutions Ltd (LHS) is the provider of the Town Centre GP Surgery, the Luton Walk in Centre and of course we are sorry that you did not choose us as one of the review centres for your analysis but hope we can complement some of the excellent work that has already been completed. Attached is our 2010/11 Annual Report which has covered many of the areas already carried out in your review but just to update; the numbers attending the Walk In Centre and registrations have continued to rise with the numbers seen during 2012/13 was 44,399. We currently are on a par with last year's number but the number of registered patients stands at just over 5000, having started off as zero in 2009.

Below we provide you with some suggestions and comments on the questions raised in the 'Walk In Centre Review Preliminary Report':

Section 6, Page 49

During the past year and with the removal of PCTs and the introduction of the CCG and the NHS England Local Area Teams (LAT) there has been a complete absence of communications with any commissioners in respect of the Town Centre GP (TCGP) Walk In Centre.

As a general overview, however, we feel that commissioners may have a point but the issue is not so much with Walk In Centres as with general practice and the variability of General Practice. At a local level here in Luton we collect the information about the GP registration of the patients who attend the Walk In Centre and can report that the pattern is constantly repeated, week on week. We are unclear as to what the concerns of commissioners nationally are as none has been raised. We have seen no evidence that it is the Walk In Centres that are having a negative effect on access to primary care. Our experience taken from patient word of mouth is that it is the other way around. The patients can't get access to their own GP. We can further evidence that on a number of occasions GP practices have been closed with the sign on their door advising all patients to go to the Walk In Centre. As a provider we had notified the PCT about such incidents but of course the throughput of commissioning staff means that none of these staff are still around and records are scanty.

Section 7, Page 58

Our experience from running the Luton Walk In Centre for the past 5 years is that, had the Walk In Centre not been open then between 35 and 50% of the non-registered patients seen would have turned up at the Accident and Emergency Department. A considerable number of the patients who use the Walk In Centre live in the more deprived areas where the population operate from the old fashioned perspective that they want to see a clinical person; in addition many of them have been referred to the Walk In Centre by local chemists, voluntary sector and an array of statutory service providers. It's as if everyone wants to safety net their decision these days, eg, the pharmacist thinks it's a benign rash but it might be meningitis so the parent is advised to have it checked out at the WIC or the Health Visitor wants the burn on a child's arm seen by a GP. It is our opinion that the numbers attending have been compounded by the introduction of fear factors which has come via:

- the media
- 111 or NHS Direct Service who contribute about 10% of the number of patients sent
- a complicated mix of lack of access in primary care; experience of friends and family who have already used the Walk In Centre
- Added to this the fact that we have noticed a change in the case mix with sicker people now attending the Walk In Centre as non-registered patients requiring same day care.

A recent survey has calculated that 10% of such patients would need to be seen at A&E if the Walk In Centre was not able to cater for them. We would further like to inform this review that during the recent **swine flu epidemic** we were a centre for dealing with swine flu, especially for the children. We were able to respond very quickly especially in the unusual circumstances where the swine flu telephone service was not dealing with children under 16 years; the local A&E Department was not see anyone with swine flu; resulting in the Luton Walk In Centre being turned in to a Tamiflu Centre. Do to the experience and skills mix of the workforce and us being a local provider we were able to cope with extraordinary large numbers of people attending, all of whom were dealt with on site.

Monitor's analysis is a good understanding of the potential impact of Walk In Centre closures on patients but also needs to be aware that during the past 5 years, (the life span of Walk In Centres) GP practices' have come under further pressure with the growth in long term conditions and GP practices having to make decision as to whether they concentrate on same day demand hence reducing resources for specialised clinic run in the main by experienced GPs or reduce capacity for long term condition and meet the demand for same day appointments especially in the afternoons. It is also worth noting that any extra funding that came into General Practice has been earmarked for long term conditions.

Locally our experience has been that few GP practices offer same day appointments in the afternoons, with most same day patient attending the Walk In Centre from approximately 3.30 onwards stating that they couldn't get an appointment with their own GP practice. On a number of occasions when we were full to capacity and rang such surgeries we were either not able to access the surgery by phone or when we did were informed by the receptionist that no further appointments were available on the day and yes the patients had been advised to attend the WIC

We consider that Monitors' unique positions in spanning the spectrum between the Walk In Centres: General Practice and A& E departments will give this final report a powerful voice in an otherwise silo orientated NHS Service planning structure with ring-fenced resources & accountability disjointed.

Section 7.2, Page 61

Agree entirely with your conclusion that the division in responsibility for the commissioning of Walk In Centres (WIC's) has resulted in confusion and may in time result in draw backs for patients. The experience on the ground is that the CCGs are local organisation elected from amongst local independent providers, GPs and chemists, hold open board meetings and are ultimately accountable to its constituents. The status and role not dissimilar to the previous PCTs with local CCGs accountable to local practices to the local population; in turn local GP practices are accountable to the CCG, all of whom have an overarching responsibility for the population health as a whole.

Whilst the CCG have responsibility for urgent care we would propose that Walk In Centres are a key and significant contributor to the overall management of same day conditions and same day urgent care. Removing the contribution of Walk In Centres from the overall provision of urgent care is somewhat illogical and in our experience is not working. For instance, should decision be made to close the Luton Walk In Centre then that decision needs to be made from an evidence base and with those responsible for the provision of urgent care taking responsibility for the decision including the impact and the consequences should this provision no longer be available to the people of Luton.

The experience from the Luton Walk In Centre is unsustainable in so far as that:

1. The commissioning of the WIC & GP Registered patient service is the responsibility of the NHS England LAT.
2. Some of the services carried out here such as LES's, contraception and HIV services are the responsibility of the Public Health Department for Luton Borough Council.
3. Responsibility for the premises, including facilitating extra capacity rests with the NHS Property Company (Prop Co)
4. Responsibility for services such as drugs; access to secondary care: DES's, NES's are the responsibility of the local CCG.

Our experience of having tried unsuccessfully to get the simplest of issues resolved between these four organisations has been that it doesn't work for the provider or for the patients.

It is our considered opinion that the future commissioning of Walk In Centres should be the responsibility of the local CCGs. The Luton Walk In Centre contract is due to expire at the end of February 2014 and we have not had any commissioning meetings during the past year and are totally unaware of the intention of or whether or not the NHS England LAT team are planning to continue; close or re-commission by public procurement this services. If, a decision has or will be made to close the WIC then the Luton CCG will of course feel the impact as will the other local providers of primary and urgent care services.

Section 7.3.2, Page 65

In our opinion the difficulties lie with the variability in GP practice quality and the lack of any performance management carried out to any of the GP contracts, GMS, PMS, or APMS. The payment mechanism in General Practice in there totality doesn't reflect quality and performance. There needs to be much more transparency and a levelling of the playing fields between General practice and Walk In Centres. It could be argued that what is needed is dis-incentives to practices that are not offering the full range of primary care, especially same day urgent patient care and hence the patients having to use Walk In Centres, this would then free up resources. An important point missing from your analysis and findings is the role that the Immediately Necessary Treatment (INT) played in general practice with the pre new GMS contracts rewarding GP practices for seeing immediately necessary treatment patients under the red book item of service arrangements. The need for immediately necessary treatment has increased in many areas

especially an area such as Luton with a transient population, the majority of who have no experience of using the NHS. If the payment options were adjusted in general practice, regular general practice may be more flexible to see INT patients who at the moment are all referred to the Walk In Centres. There is a strong case especially in an area such as Luton to adjust the award or payment structure to GPs who are operating in a deprived area where demand for same day appointments is disproportionately high and in many cases the per capita funding is disproportionately low.

We consider that this monitor review is an ideal umbrella for considering and making recommendations about inequitable but fair tariffs for patients using Walk In Centres, GP Surgeries and patients attending A&E with a primary care condition. Should such a tariff be identified and a market created linked to quality and performance then this may introduce some competition, choice and subsequently some redistribution into the many services currently providing; or not providing; same day urgent care.

Section 8.5, Acting Transparently, Page 71

There is only one pot of money in the NHS and if a Walk In Centre is currently operating well on a value for money basis delivering good quality care to the local people and to the local health economy then there is little cause for going through the process of re-procurement at open tender. If the current Walk In Centre is providing a good service then there should be no need to destabilise a good system which is working well for local populations. If, it is not broken then why fix it but if however there are performance issues with the current service provision this is an ideal opportunity for the commissioners to proactively performance manage these centres.

As a local provider we would value and welcome some performance management as we feel confident that we can demonstrate:

- what does work well
- the opportunities for profiling some of the services
- varying capacity
- changing case mix and incorporating or integrating some of the same day urgent care services.

As an experienced NHS provider we would recommend that this style of performance and contract management based on cooperation and collaborative working would produce a much better outcome if measured by quality performance and patient experience than what spending money by going out to re-procurement by open tender.

However, as already stated we do not think that poor performance should be tolerated and that this should extend across the whole of primary care including GP practices, Walk In Centres or Out of Hours care provision. Where contract management has not achieved an improvement in quality and productivity then such centres should or could go out to external procurement using the open tender system.

In summary and as number; 164 in Appendix 2 on your List of current Walk In Centres, we are pleased to have this opportunity to comment and make our suggestions.

These comments are based on our experience of providing the service during the past 5 years during a period of significant growth seeing same day urgent care patients who are often sicker than those seen in regular general practice.

We have responded positively to the swine flu; have seen peak performance with the attendance last Sunday of 200 patients within the 12 hour period.

Look after many very needy people including the homeless which we are able to provide long term care for

We have received visits from a number of overseas commissioners or providers: a visit from the UK Treasury Office assessing if we were meeting our objectives to reduce inequalities: in the last month we received a visit from the Cabinet Office who were carrying out a deep dive of urgent same day services in a number of areas across the country.

Please feel free to make contact if you require any further information and I look forward to reading the final report.

Yours sincerely

Bernie Naughton
Director and Management
Luton Walk In Centre.



Town Centre GP Surgery

Annual Report 2010-2011

Local Healthcare Solutions Ltd.

Foreword

Convenient, clinically effective and easily accessible health and care services can have tremendous impacts upon how people best manage and cope with illness and disease. The Luton Town Centre GP Walk in Service has firmly established these benefits for local people. Complementing other primary care led services across the town, the service provides these accessible services 12 hours a day 365 days of the year. I am impressed how the staff make sure they offer a fully flexible appointment system which in turn is especially helping young people to seek and be provided with the treatment and advice they need.

If we are to help people take greater control and responsibility for their own health, we have to make sure that they can receive the right support and back up when they need it. The Town Centre GP Walk in Centre is a growing and developing example as to how this partnership provides exactly the right sort of support in ways that people easily engage with, whether they need to see either a doctor or a nurse. This is helping more and more people to lead healthier lives. I am sure the service will grow and flourish as the team continues to learn and develop what is already a successful resource for local people.

Dr Steve Feast
Deputy CEO and Director of Transformation
NHS Luton

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Executive Summary

In 2008 NHS Luton commissioned (by open tender) Local Healthcare Solutions Ltd. (LHS Ltd.) to deliver a primary care resource for walk-in patients without an appointment and registered patients at the Luton Walk in Centre, 14-16, Chapel Street, Luton.

“The NHS Luton and Luton Borough Council, Annual Public Health Report 2010-2011, describes Luton as a multicultural urban town; with an estimated population size 194,300; younger than that in the East of England and England; approximately 32% of Luton’s population is from Black and Minority Ethnic (BME) communities and with 25.9% of Luton residents who are in the worst national quintile of deprivation.”

This is the second Annual report which sets out to examine how this Town Centre GP Surgery (TCGPS) is performing including meeting its objectives: foremost of which is providing access to primary care services 8am-8pm, 365 days a year. This service has been operating for over two years, has grown in clinical capacity and reputation and reports the following:

- During the period April 2010 until March 2011 the TCGPS saw and treated 27,302 walk in patients: 42% more than in the same period the previous year.
- Peak demand is in the middle of the day with a similar but delayed pattern at weekends but near full capacity throughout the day.
- Those who attend the walk in service come from across Luton with more residents from LU1 and LU2: which includes areas of highest deprivation
- During weekdays Monday to Friday 11.5% and 14.5% at weekends of users live outside of Luton
- Children 0-15 years are the highest age group users of the walk in service at 26% compared to 21% which is the number of 0-15 year olds in Luton.
- A detailed breakdown of presenting conditions is included but the most common clinical condition at 24% is respiratory distress, especially in children

The reasons why people use the walk in service are varied but in summary **the key factors** include ease of access to primary care: location of the building in central Luton: convenience for those working in Luton: shoppers and visitors to Luton including those using the airport: referrals made from other statutory and voluntary agencies: word of mouth from previous users and the reputation for quality, speed and choice. However, of equal importance why people use this service is that it meets the previously unmet needs of the people who tell us that in the absence of this service they would have attended the Accident and Emergency service as they had no other access to primary care in Luton.

This report also provides a profile of the patients who are on the TCGPS’s list of registered patients and shows that 98.5% of those registered are under 65 years of age compared to 88% for the population of Luton or 83% for the rest of the East of England.

This report contains details of what the users of the Walk in centre think of this service for both walk in and registered patients including the results of the national MORI 'GP Patient Survey' and some direct feedback received from patients and their families.

This second Annual Report has sought to focus on activity and service performance and we believe it shows that this service is performing well, has an excellent reputation and meets the needs of the people of Luton and surrounding areas. However, as a leading edge primary care service the TCGPS needs to remain vigilant and respond to the many changing economic and technological forces, patterns of health care especially the desire for individual self care and well being and how we can better target health programmes towards the most disadvantaged in Luton in order to encourage positive lifestyle and behaviour change as an enabler for raising their life chances.

Annual Report 2010 - 2011

1. Introduction

Since opening in February 2009, The Town Centre General Practitioner Surgery (TCGPS) has been providing healthcare services out of the Luton Walk in Centre at Chapel Street Luton. These two related Primary Care services are as follows:

- 1) A walk-in service where anyone eligible to receive NHS care can walk and be seen by a GP or Nurse whichever is most appropriate to their needs
- 2) A regular GP service for residents of Luton who want to register with a GP practice.

The walk-in service which gives access to a GP without an appointment is a new concept in primary care and was the brainchild of Lord Darzi's NHS next stage review, 'Vision for Primary and Community Care'. It was never intended to substitute for patients receiving comprehensive primary care from their own registered GP but to compliment it especially during the periods when regular GP surgeries are closed.

Open 8am-8pm on 365 days a year with at least one GP on site at all time, it is set to give patients more rights to control over their own health through greater access to primary care. The majority of patients attending the walk in centre are sick but it is important to note that the role of the walk in centre is also to give immediate access to preventative care such as contraception and providing a holistic service for self help and wellbeing. Visiting dignitaries have commented that on a number of performance and quality indicators the Luton walk-in centre is one of the most successful Darzi walk-in-centers in the country.

The Town Centre GP surgery also provides **registration for patients** who reside within the Luton Unitary Authority boundary. Based at the walk-in-centre, 14-16 Chapel Street Luton, anyone eligible to receive NHS treatment can choose to register and receive access to a comprehensive range of primary healthcare services.

1.1 Purpose

The purpose of this report is to;

- Provide an update and analysis on the performance of the Town Centre GP Surgery service for the past year and review if this new service is meeting the needs of the people of Luton with reference to inequality and public health
- Assess how it is assisting with improving access to primary care as envisaged by Lord Darzi in his founding philosophy.
- Profile in some detail, who the people are who use the walk-in centre, make comparisons with the previous year and highlight any significant changes.
- Make an informed contribution for the necessary future planning, enabling all to realize the benefits that can be extracted from having such a valuable Primary Care resource in the centre of Luton.

2. Profile of Luton

In order to fully comprehend the aims of the walk-in centre as a source of primary healthcare, it is first of all important to set it within the context of Luton as a town.

The NHS Luton Annual Public Health Report 2010 - 2011 contains the following overview of Luton:

Luton is a multicultural urban town situated approximately 30 miles north of central London, and covers an area of approximately 16 square miles. Luton has excellent communication links including its own international airport, and has recently bid for city status as part of the Queen's diamond jubilee celebrations.

Estimates of population size, obtained from the office for National Statistics (ONS), is 194,300 in 2009. However, Luton Borough Council estimates that there are approximately 204,700, that is, 10,400 higher than ONS estimate, with the difference mainly arising from migration.

In general, Luton's population is younger than that in the East of England and England see Table 1.

Age	Luton	East of England	England
Under 15 Years	21%	18%	18%
15-64	67%	65%	66%
65+	12%	17%	16%

Table 1. Displaying Age Breakdown of Luton Population

Approximately 32% of Luton's population is from BME communities, particularly the Pakistani, Bangladeshi, Indian and Caribbean communities. In recent years, the diversity of the population has increased due to an increased number of international students attending the University of Bedfordshire, and the arrival of migrants from European Union countries, notably Poland and other Eastern European countries.

Based on the Index of Multiple Deprivation (IMD), Luton's deprivation score increased from 24.73 in 2007 to 25.78 in 2010 and the rank dropped from 87 out of 354 to 60 out of 326 local authorities (with 1 indicating the most deprived authority).

Over a quarter (25.9%) of Luton residents are in the worst national **quintile** of deprivation, and 58.6% are in the worst two quintiles. Figure 1 map below shows the most- deprived areas in the Borough of Luton which corresponds to the areas with lower life expectancy.

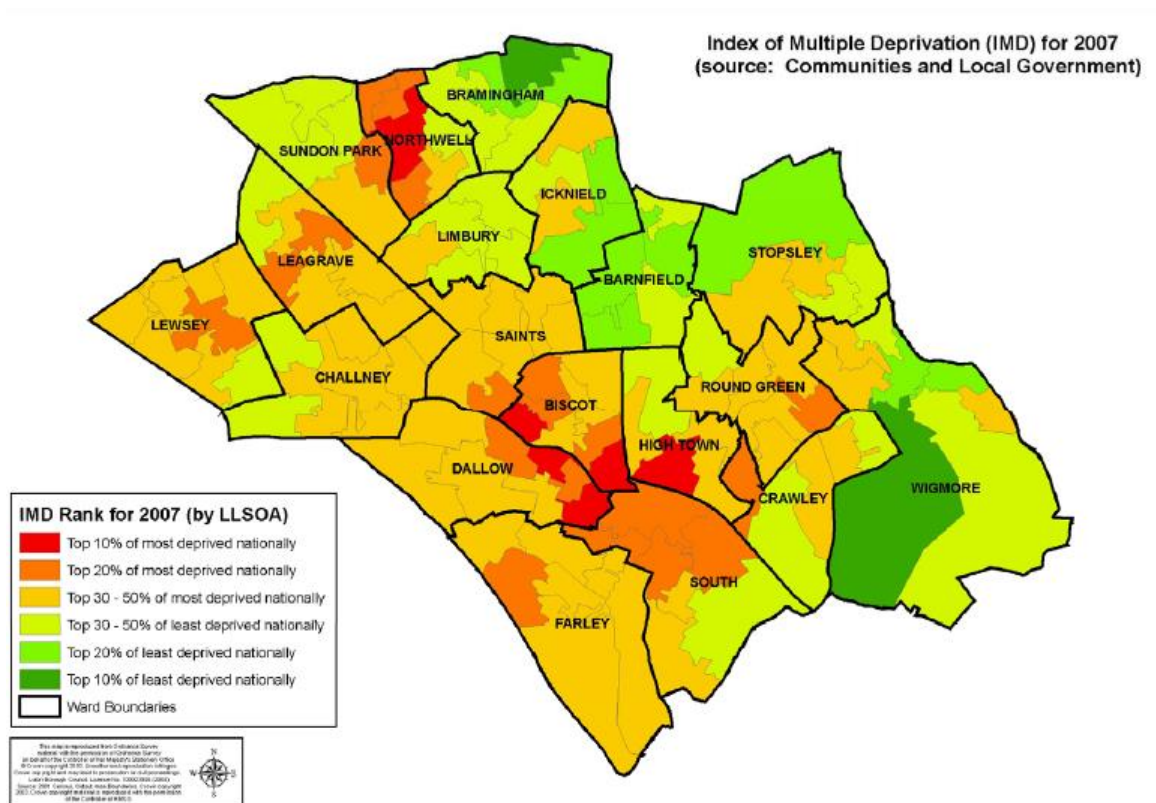


Fig.1 Map of Multiple Deprivation in Luton

3. NHS Luton Walk-in service

3.1 Demographics of Walk in Patients who use the service

The walk-in service is widely used by the population of Luton and people from the surrounding areas. In addition it is also used by people, who work in Luton during the week and due to a number of factors have difficulty in accessing their own GP practice for primary care services. Chart 1 below shows the residency of users, classified by post code, at weekends and during the week.

3.1.1 Residency of Walk in Patients Weekdays and Weekends

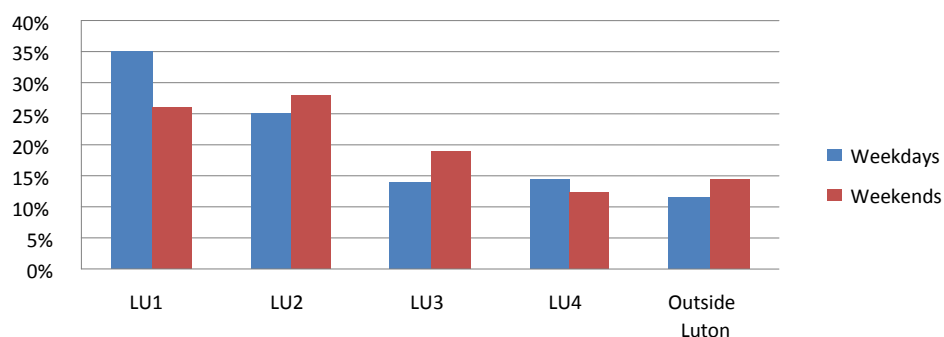


Chart1. Demonstrates the residency of walk in centre users 2010-2011

Residency of Walk in Patients who use the Centre

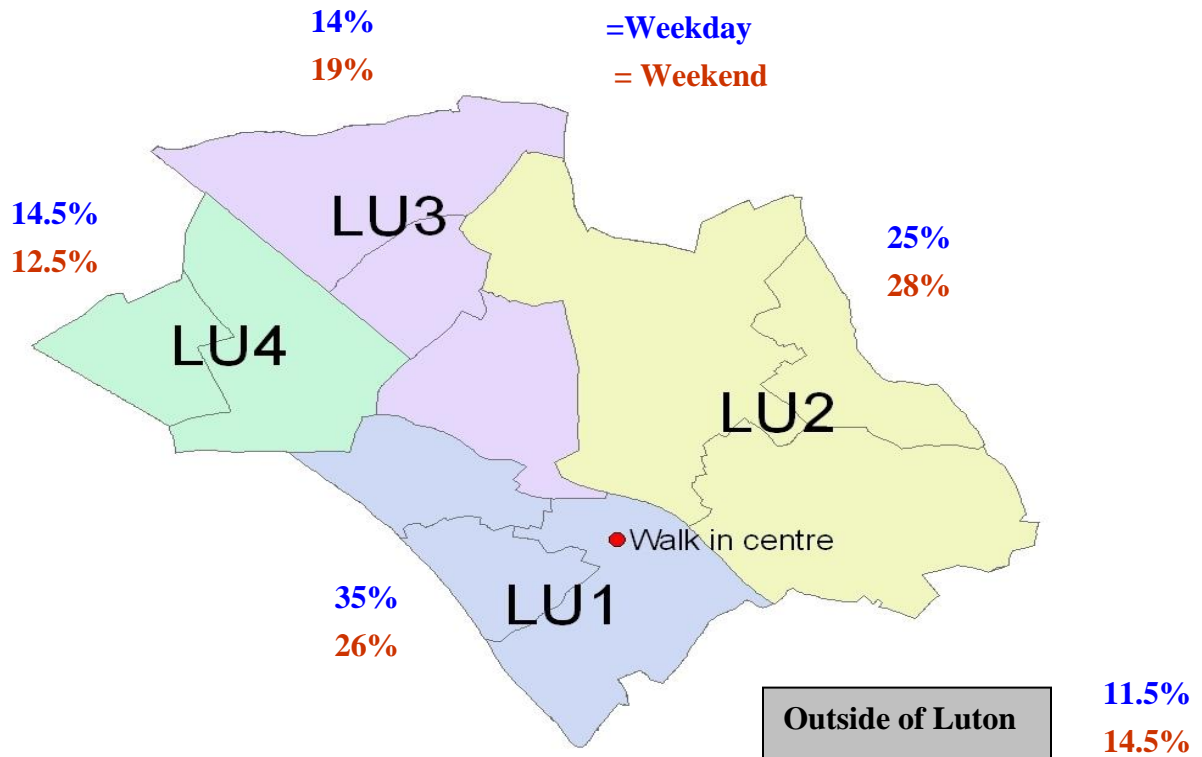


Fig.2 Map displaying the different Luton postal sectors and alongside the percentage of walk in patients who attend the TCGPS

3.1.2 Ethnicity

The Luton Annual Health Report 2010-11 further notes that some ethnic communities are more likely to live in areas which are more deprived especially the wards in and around the centre of Luton town and covering almost the whole of the LU1 postal area. Chart 2 below shows the ethnicity of the walk in patients who use the TCGPS walk in service. The large number classified as ‘undisclosed’ is due to many users not wishing to have their ethnicity recorded: many even noting that ‘the question in itself is a form of racism’

Ethnicity of Walk in Patients

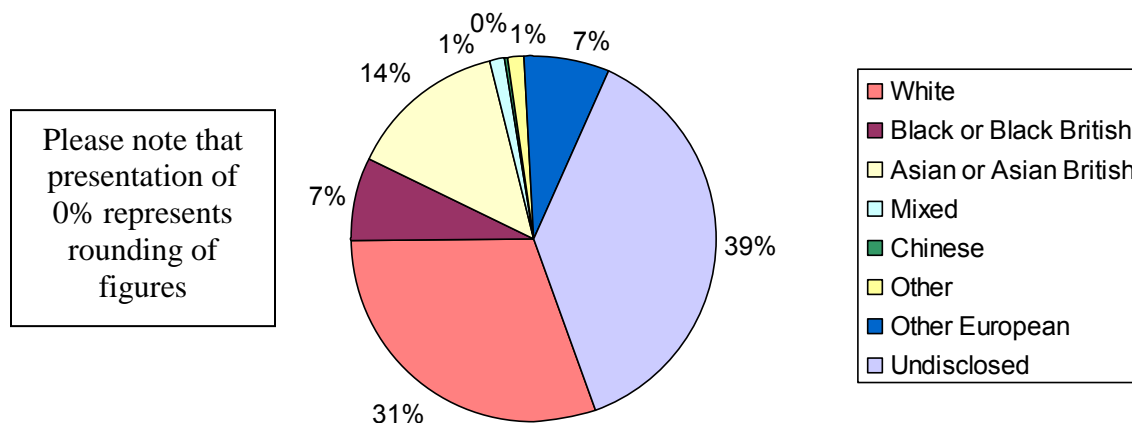


Chart 2. Pie Chart representing the ethnicity of walk-in-patients

3.1.3 Age Gender

Table 2a and 2b shows the age gender profile of those who attend for walk in health care and how these compare with the age profile of Luton generally.

Age range	Female	Male
0-15	2434 (23.2%)	2660 (30.2%)
16-25	2720 (26%)	1581 (17.9%)
26-35	2084 (19.9%)	1765 (20%)
36-45	1198 (11.4%)	1137 (12.9%)
46-55	901 (8.6%)	780 (8.9%)
56-65	588 (5.6%)	476 (5.4%)
66-75	348 (3.3%)	269 (3.1%)
76-85	168 (1.6%)	116 (1.3%)
86+	31 (0.3%)	29 (0.3%)

Age Range	Walk-in-Centre	Luton
Under 15 Years	26%	21%
15-64	69%	67%
56+	5%	12%

Table 2a (left) Showing the age gender profile of the walk in patients and

Table 2b (right) Showing the age range differences between patients using the walk in centre and the population of Luton (comparison with Table 1)

4. The staff who deliver the service at the Walk in Centre

4.1 The Clinical Team:

DR EMILIE HAWORTH B.Sc (Hons), MBChB, DFFP, MRCP

Interests in Sexual Health, Dermatology, Public Health / Tropical Medicine

DR RAMALINGAM SUGANTH MBBS, MRCP, MRCP

Interest in Diabetes.

DR RAZA ALAM MBBS, MRCP

Interests in Mental Health, Health Inequalities and Medical Ethics.

JANE MORTON RGN

Minor Illness Cert

ROSE IRESON RGN, Dip Health Education

Minor Illness Cert, Nurse Prescriber.

4.2 Operational Management Support team

Dr Peter Ward M.B., Ch.B. Medical Director to Local Healthcare Solutions Ltd.

Dr Raj Khanchandani MBBS, M.S., MRCP. Clinical Director

Mrs. Jeannie Szumski RGN. Minor Illness Cert., Nursing Director

Mrs. Bernie Naughton BA, RGN, RM, HV Cert. Management Director

Amanda Philpott On site Operational Manager

4.3 On call back up support

Experience has taught us that in addition to the regular rostered team of staff it is essential to have a back up contingency plan in the event of an unforeseen incident happening at the Walk in centre. Members of the Local Healthcare Solutions Ltd. parent company who are also clinicians provide an on call support service to the frontline staff

The Town Centre GP Surgery has been remarkably successful in recruiting and retaining good quality staff who have worked as a team to initially establish this new service and have ever since concentrated their efforts in sustaining the delivery of quality care and assisting with the development of new projects. This good team spirit has to be set against a background of difficulties with recruiting GP and nurses to work in Luton.

5. Activity and Performance

As noted earlier the initial aim of the walk in service was not to replace the need for a patient to register and attend their own GP, but to complement access to current GP services for patients wishing to see a primary care professional without an appointment. Demand for consultations at the walk in centre has been high and year on year has continues to increase. Feedback from the clinical staff based at the Walk in Centre and the reported evidence shows that most people attending are sick at the time of presenting

and there is a link between the residents of Luton many of whom are migrants and may have limited knowledge of how the standard NHS operates.

5.1 Monthly activity and compared to the previous year

Table 3 below presents the activity figures each year since the opening in 2009 until March 2011

Month	Walk in Appointments Year 1 (2009-2010)	Walk in Appointments Year 2 (2010-2011)
Apr	1248	1910
May	1356	1927
Jun	1704	1892
Jul	1986	2095
Aug	1691	1980
Sep	1393	2007
Oct	1725	2332
Nov	1569	2422
Dec	1657	2809
Jan	1611	2705
Feb	1408	2329
Mar	1914	2894
	19262	27302

Table.3 Increase in activity figures between February 2009 and March 2011

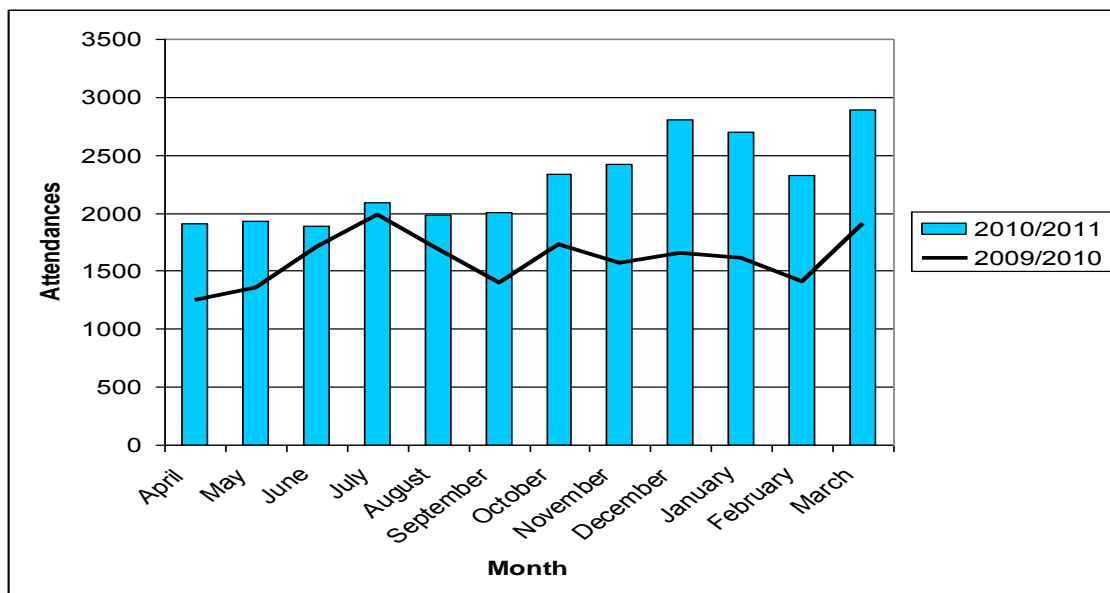


Chart.3 above displays the total number of attendances per month for both 2009/2010 and 2010/2011.

5.2 Times when people present for treatment

Chart 4 below purely gives the times of attendance but also provides a clue as to why people attend and the reasons given for not accessing their own GP surgery. It is also worth noting that these figures do not include visits made by the registered patients but taken together the walk in centre building operates at near full capacity during opening hours.

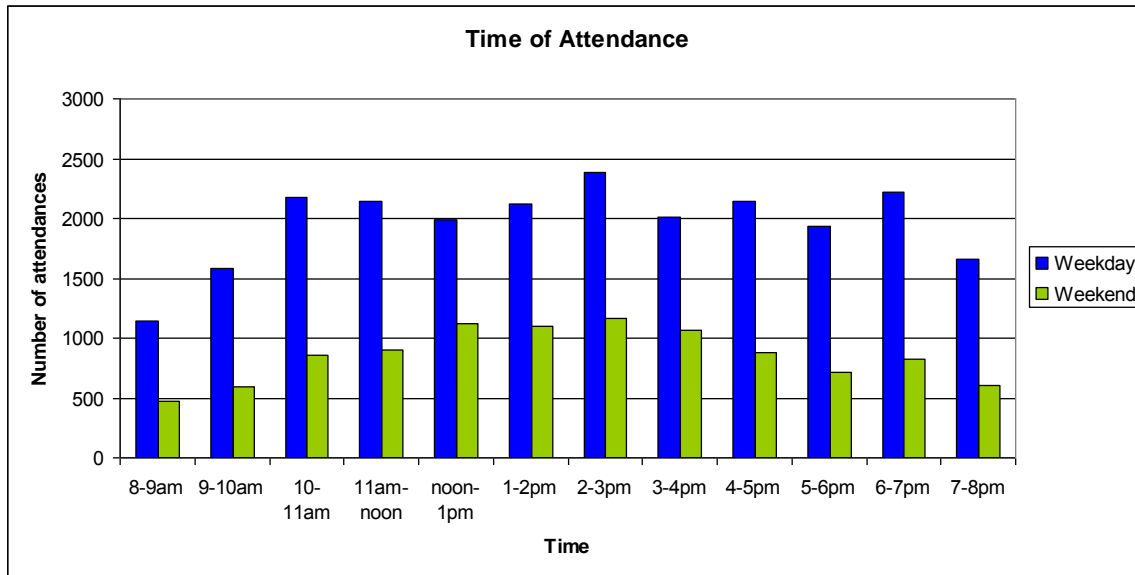


Chart.4 Representing the total number of Walk in Attendances in 2010-2011 by time

5.3 Presenting Conditions

Patients attending the Town Centre GP Surgery for walk in care without an appointment present with the usual range of conditions ordinarily seen in general practice. However, there are many more patients seen with acute minor injuries and there is also seasonal variations when, for example, there are exceptionally high numbers of respiratory distress patients both young and old attending for medical care.

Feedback from the staff on site informs us that they are now seeing and treating many more acutely ill patients who have self presented or have been referred by another community health service. The Town Centre GP Service is working closely with NHS Luton to monitor and evaluate this apparent trend but more needs to be done to address and raise awareness amongst the public, about making better usage of preventative health care rather than delaying access to healthcare until there is a crisis.

Chart 5 below shows the main presenting conditions for patients accessing walk in care in the year 2010/2011

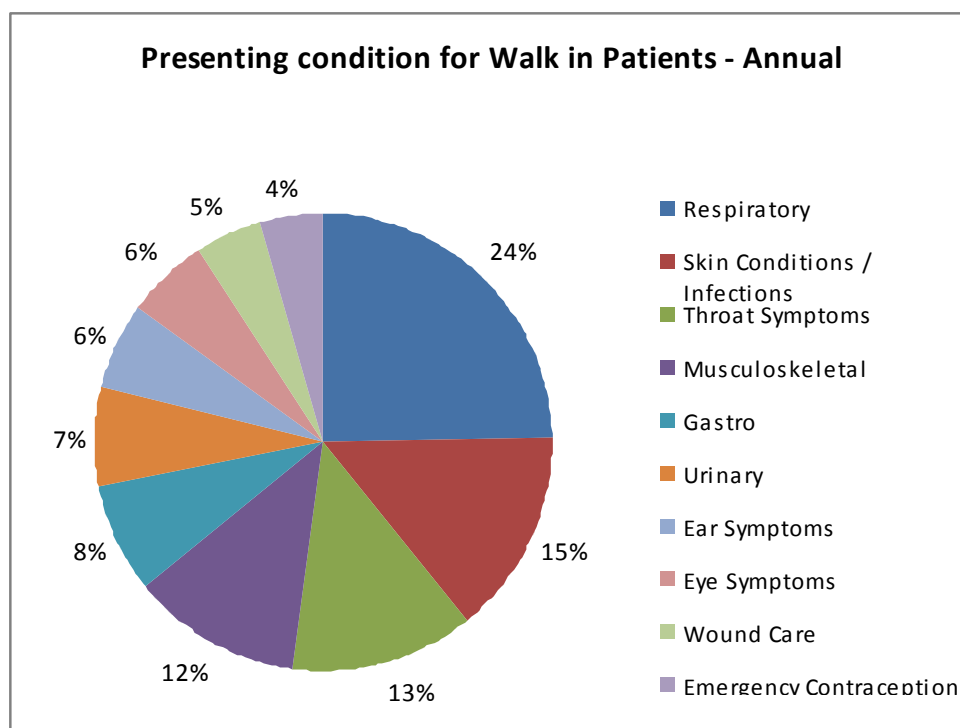


Chart. 5 Displays Presenting Conditions for year 2010/2011

5.4 Access to Contraceptive Care

Demand for emergency contraceptive care and advice, especially at the weekends, has been very high and increased overall by 301 consultations or 226% and by 358% for the age group 13-19 years, between 2009/2010 and 2010/2011

Access to contraceptive care is well provided for in central Luton but information available demonstrates that access to contraceptive care at the Walk in Centre is particularly popular with young girls due to the anonymity of the centre and the speed and ease of access. Feedback from onsite staff can quote young girls coming in with other members of their own family registering at reception with a physical ailment such as: sore ears and when in the privacy of the GP surgery requesting the 'morning after pill'

Age range	2009-2010	2010-2011
13-19	41	147
20-29	142	286
30-39	44	91
40-49	12	12
50-59	0	4
Total	239	540

Table 4: Figures for Emergency Contraception issued 2010/2011 and compared to 2009/2010

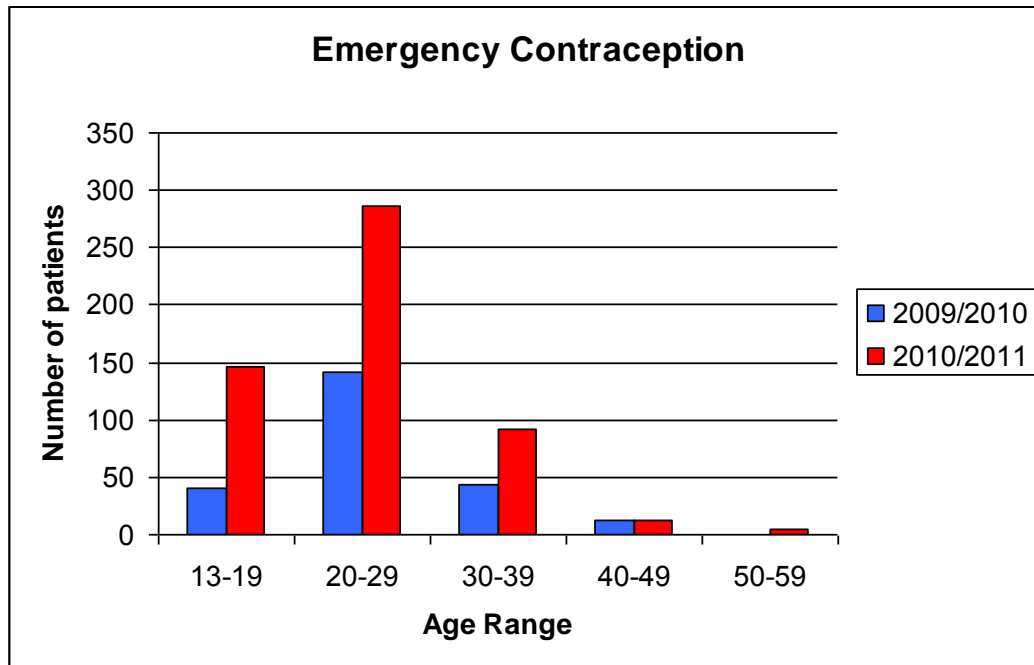


Chart.6 Displays change in Emergency Contraception between 2009/2010 and 2010/2011

5.5 Why do people use the walk-in centre?

Patients attending the town centre walk-in centre report multifactor reasons for using it, but these can be clustered into the following categories:

1. Access to the entire range of Primary Care services
2. Convenience and anonymity
3. Referral from other statutory and voluntary agency
4. Reputation

Access to Primary Care

The most frequent reason given by patients as to why they present at the Walk in Centre is because of their inability to get an appointment at their own GP's surgery or their inability to get access to the surgery due to a number of reasons. This also varies between the time of day and at weekends when most of the surgeries in Luton are closed. Patients in this category also report that had the walk in centre not been open they would have gone directly to the accident and emergency department at the Luton and Dunstable hospital.

This fact is further supported by the number of people who are resident outside of Luton but who choose to attend the walk in centre especially at the weekends. Residence from Dunstable and Houghton Regis who represent the greatest number of frequent attendees from surrounding areas have to pass the Luton & Dunstable A&E department thus dispelling the myth that people present at the accident and emergency service inappropriately because of access location.

Convenience

This is the second most frequently cited reason why patients attend for primary care and the central Luton location makes it an ideal site for people who are shopping, people who are visiting Luton and are suffering from same day or emergency illness's and people often not wanting to take time off work or out of school to go and see a Doctor. Luton's commercial and business sector have become aware of the service on their doorstep and have frequently be known to advise workers to go along and be seen on the day by a GP to reduce absenteeism from work.

Referrals from other Statutory and Voluntary Agencies.

The Luton walk in centre is becoming a 'mini primary care hub' for a number of other agencies that want a second opinion or feel it desirable to have a medical opinion for a patient they have seen.

Such agencies that make direct referrals include: community chemists, other primary care service providers including those providing contraceptive services, NHS Direct and direct referrals made through the 111 service. The walk in service now also provides an out of hours continuity of care service for patients receiving seven day a week care but when their own GP practice is closed at the weekends. Luton and other surrounding General Practitioners regularly use the TCGPS as a 'safety net' for patients who may need further advice, monitoring or treatment over the weekend when they are closed.

During the past year in particular we have become aware that other groups, especially the homeless and those that are socially excluded are able to use the walk-in centre as their main source of primary care provider. Due to the central Luton location and the ease of access, this walk in care is particularly valuable as an urgent medical support service to the voluntary sector especially NOAH who has particular expertise in caring for homeless people.

Reputation

Word of mouth has been a strong influence on how the public have heard about the Luton walk in service and has fuelled the demand for same day without an appointment access to medical care and advice. The majority of people attending the walk in service has already spoken to someone else, personal or professional, about the services and care available, opening hours and how long they are likely to wait to be seen.

As noted above, many of the Luton business and commercial sector community know of this service, its reputation for quality and speed of access, and are able to inform their employees that the service is business friendly and an asset to the Luton economy.

6 Profile of Registered Patients

In addition to the walk in service for patients without an appointment residents of Luton can also choose to register with the Town centre GP Surgery based at the Walk in Centre. During the past year 1090 patients have registered at the Town Centre GP Surgery bringing the total number of patients on the registration list to just over 2000.

6.1 Age gender of registered patients

Below in table 5 are the breakdown of the age and gender of the patients who are registered.

Age range	Female	Male
0-15	181 (17.4%)	176 (18.4%)
16-25	317 (30.4%)	189 (19.7%)
26-35	305 (29.3%)	335 (34.9%)
36-45	116 (11.1%)	131 (13.7%)
46-55	74 (7.1%)	82 (8.6%)
56-65	36 (3.5%)	34 (3.5%)
66-75	6 (0.6%)	10 (1%)
76-85	5 (0.5%)	2 (0.2%)
86+	2 (0.2%)	0 (0%)
Total	1042	959

Table 5. Breakdown of Registered Patients by Age and Gender

6.2 Residency of registered patients

Table 6 below shows the distribution of registered patients across the four Luton postal sectors.

Postcode	Number	Percentage
LU1	988	49.5%
LU2	581	29%
LU3	230	11.5%
LU4	201	10%

Table.6 Spatial distribution of registered patients

6.3 Ethnicity of registered patients

Chart.7 below shows the ethnicity of the registered patients.

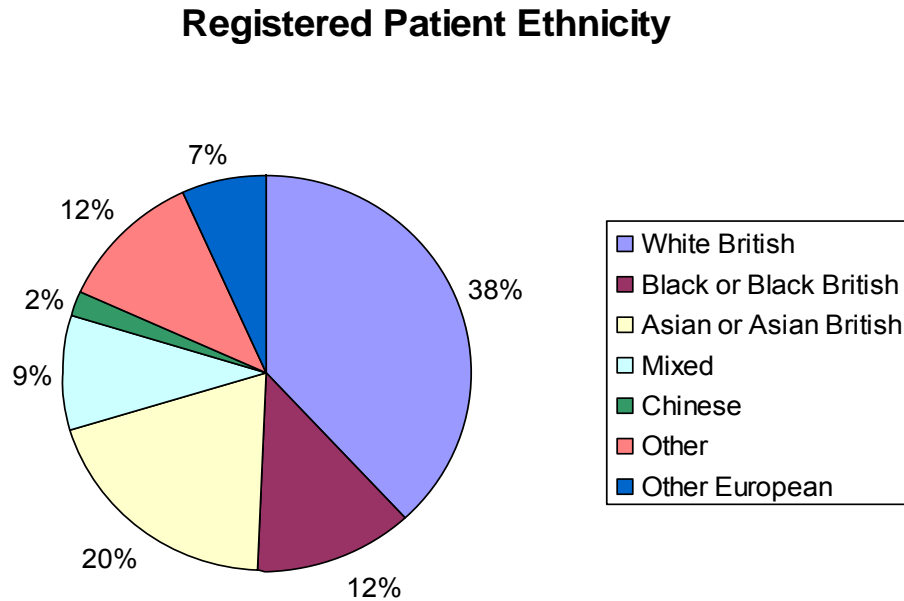


Chart.7 Registered patient ethnicity

7. Healthcare Services Provided

The Town Centre GP surgery provides a comprehensive range of Essential, Additional and Enhanced services to the registered patients.

For ease of presentation the following chart sets out to show the different services offered to registered and walk in patients as this differential in registration status is not always fully understood especially by patients who present for walk in appointments. Please note that this list is not exhaustive but a summary for example only.

Services provided to: Registered patients and Walk in patients

Service Description	Registered	Walk In
Able to book appointment with GP or GP of choice at a time of choice up to 4 weeks in advance	✓	✗
Able to speak to a healthcare professional by telephone	✓	✗
See a GP or nurse for Immediately necessary treatment	✓	✓
Consultation with a GP and, where appropriate, physical examination for purpose of identifying the need for treatment:	✓	✗
- or carry out further investigations	✓	✗
- as result of investigation results make available such treatment or further investigations as is necessary and appropriate	✓	✗
Book consultation with a GP when:		
- ill with conditions from which recovery is generally expected	✓	✗
- terminally ill	✓	✗
- suffering from a long term condition	✓	✗
Make home visits for the seriously ill and house bound	✓	✗
Prescribe clinically effective medicines for patients:		
- who are acutely ill	✓	✓
- patients with long term conditions	✓	✗
- emergency supply of drugs for long term conditions	✓	✓
- prescribe appliances and surgical equipment	✓	✗
Make referrals to intermediate and secondary care for:		
- planned secondary care	✓	✗
- urgent referrals for suspected cancer under the 2 week rule	✓	✓
- urgent referral to secondary care for acute condition	✓	✓
- Provide patient information about healthy living, health promotion and disease prevention	✓	✓
- Ensure patient with a range of long term conditions receive regular monitoring, measurements and treatment and	✓	✗
- information on effective strategies for self management of their long term conditions	✓	✗
Provide Routine Additional Services including:		
• Vaccinations and immunizations including influenza and Pneumococcal	✓	✗
• Contraceptive services and sexual health advice	✓	✗
• Maternity medical Services	✓	✗
• Child health Surveillance Services	✓	✗
• Cervical Screening Services	✓	✗
• Minor Surgery Services	✓	✗
• Childhood Immunizations and pre-school Boosters	✓	✗
Provision of Enhanced Care Services which include:		
• Sexual health and gynecological service	✓	✗
• Point of contact HIV Testing, Phlebotomy	✓	✗
• Smoking Cessation, Alcohol Reduction	✓	✗
• Learning Disabilities Health Checks	✓	✗
• Osteoporosis Diagnosis and Prevention	✓	✗

8.1 MORI survey 'Satisfaction with overall care'

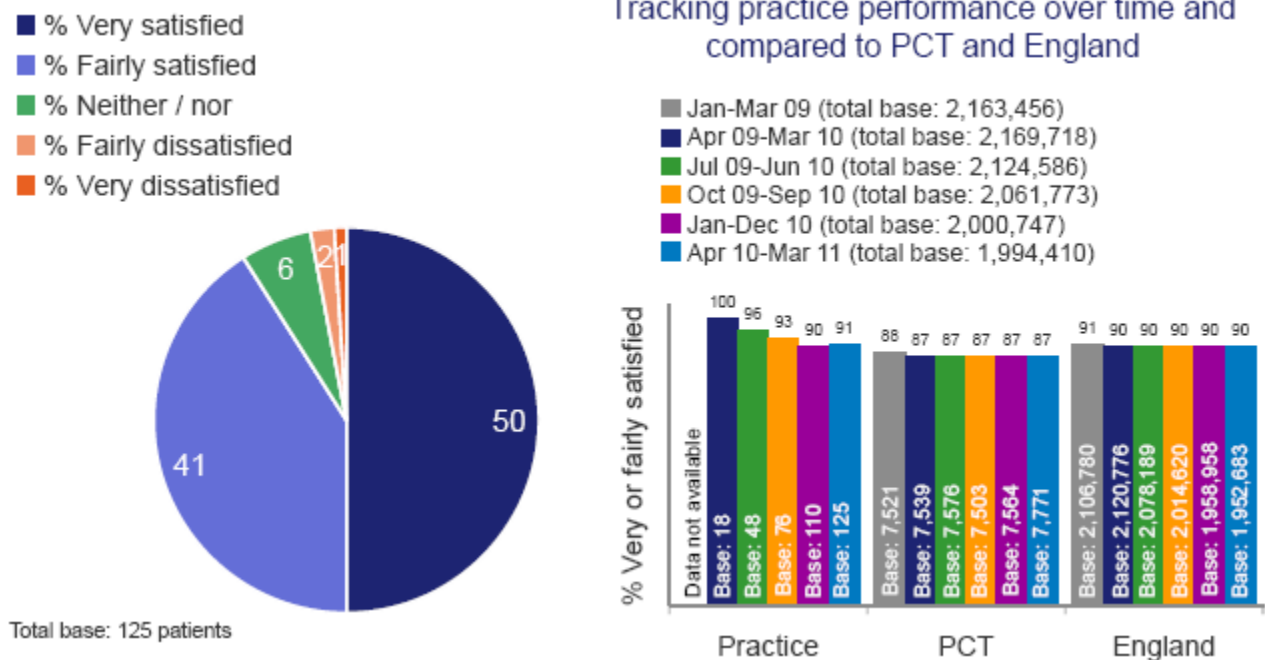


Fig.3 Patient satisfaction with overall care at the walk in centre (Obtained from Ipsos MORI)

8.2 Direct Patient feedback

In addition, the direct verbal and written feedback we have received from patients has included the following quotes:

'I was impressed by the professional, friendly and kind manner of the staff.'

'The doctor made us feel really comfortable and welcome'.

'This is a very good, quick and friendly service'.

'Lovely receptionists, very quick service, ideal for the busy women of this town'

'Surgery is very good; the staff are very helpful and friendly, the waiting time very good.'

'I am very impressed!'

'Excellent service always. Without it I knew my only other option would have been A&E on a number of occasions, so a massive saving to the NHS as well I presume

The lowest scoring area is where patients are not always able to see the same GP for each consultation: an area which presents us with a particular challenge as we aim to offer choice but have to have medical cover across the 84 hours opening hours per week.

9. Success Factors

9.1 Access

The 8 – 8pm 7 days a week opening hours are very popular with the people of Luton and the surrounding villages. The service is operated in an orderly and planned fashion which means that waiting times are minimized

The Commissioning vision present within NHS Luton during 2008 and ever since has provided the funding necessary for this enhanced Primary care health service and without which would put immense pressure on other urgent care services

9.2 The Staff

The clinical and administrative staff has a positive attitude towards working in this type of environment; we have been able to recruit quality staff and retention has been good. The GP's and Nurses are very well qualified and LHS Ltd has sought to incorporate an enriched learning and research environment into every aspect of the organization. They are also well respected by the patients both registered and people who walk in.

9.3 Location

The location in the centre of Luton close to the Arndale and main shopping area is very convenient, albeit without any on site car-parking facilities. In addition, as a very visible NHS building it carries a statement of trust and safety and as we have been informed by the users a large degree of anonymity and lack of stigma.

As shown in Figure 2 above, 14.5% of those who attend the Walk in Centre, especially at the weekends, travel in from the surrounding town and villages to receive urgent Primary Care services.

9.4 Reputation

As mentioned earlier the Town Centre GP Surgery is now highly regarded and its clinical reputation as a provider of quality primary care within Luton and the surrounding villages has increased and has become something of a local 'Primary Care Hub'

The local business community frequently remark upon its contribution to the health of the town center's economy and the Walk in Centre received a mention as a Luton asset, in Luton's bid to become a City.

9.5 General Practice model of Care

This walk-in centre is based upon the traditional general practice, easy-access model of generalist healthcare and therefore meets the needs of the people who use it. This generic holistic style of care is well regarded, represents good value for money and is appropriate for a town such as Luton that has a rich demographic mix and equally rich multiple pathology load.

10 Key areas for further development

10.1 Patient Engagement

The NHS is very keen to assist with the development of patient engagement and we are in the process of developing a patient reference group. This has also been supported by an interactive website and we are aiming to develop a number of interactive feedback sites and surveys, including the enlargement of the patient participation group. Other plans in place include the production of a monthly newsletter and a facebook page.

10.2 Managing Changes

The Town Centre GP Surgery is involved in the now nearly complete amalgamation of the two previous services; that is the nurse-led walk-in centre and the GP-led walk-in centre. This will necessitate an increase in activity but should make patient access simpler and more streamlined.

10.3 Collaborative Working

- a) The success of the walk-in service would not be complete without the excellent assistance received from a number of other care providers but in particular the work of the East of England Ambulance service. However, as medical care becomes more complex new ways of working jointly with other urgent care providers need to be designed to ensure access to primary and subsequently secondary care are as seamless and efficient as possible
- b) Information and advice from local chemists has meant that patients are properly signposted and the two services are able to compliment each other thus avoiding waste and inconvenience to patients
- c) Demand for sexual health services is high and the TCGPS has learned that by working jointly with the Brook clinic and other sexual health providers, users are able to realize benefits from both organizations.
- d) The emergence of the 111 telephone service has provided an excellent additional and easy to use telephone service to people whose condition is not serious enough for the 999 ambulance service but who still need access to advice and primary care.
- f) The drug and alcohol therapy service is also based at the walk-in centre and is a source for excellent advice and cooperation for the numerous people attending the walk-in centre with drug and alcohol problems, both acute and chronic.
- g) NOAH the homeless service who provide a range of services to the homeless and also the night shelter service during the winter months works closely with the walk-in service and both are aware that easy access to the healthcare available at the walk-in centre is often a matter of life and death to some of their most vulnerable and socially excluded clients and users.
- h) Access to Primary Care between the hours of 8pm and 8am is often necessary for some patients and the relationship that has grown between CARE UK (the current out of hours

provider) and staff at the Town Centre GP Surgery is based upon good communications, the usage of pathways which both providers are able to use for the mutual benefit of all concerned.

11 Major Challenges & Recommendations

This report has reviewed what progress has been made to date and shown what services the organization has successfully delivered and the very many benefits that have emerged since the GP Led walk in service began in February 2009. However many success's we have had there is no room for complacency or relaxing as the future speed of change and challenges appears daily more daunting. Whilst concluding this Annual Report it is nevertheless essential that the known major challenges in the coming year are highlighted and are presented for urgent attention and recommendations. Amongst the known major challenges that needs to go to the top of the urgent 'to do' list are the following:-

1. Demand management for access to walk in Primary Care in Luton.
2. Promoting and supporting the roll out of the 111 telephone health service.
3. Working with a new Out of Hours service provider and model of care provision
4. The design and delivery of primary healthcare services that better meets the needs of the 'social network generation' and the very transient Luton population with no experience of the NHS but who need access to basic health care.
5. Amending the current model of care so that the TCGPS is also synonymous with the promotion of health and wellbeing and empowering individuals to adopt healthy lifestyles for themselves, their families and their communities.
6. Piloting service delivery methods using technology and interactive healthcare for the 1 in 3 of the population who now live with a long term condition
7. The impact of the economy on people's physical & mental health: the emerging psychology distress load and the importance of working with others e.g. NOAH
8. The Care Quality Commission (CQC) registration of the Walk in Service and the subsequent revalidation of doctors.
9. Positive engagement with the Clinical Commissioning Group (CCG) to ascertain what changes they may want to make to the level or model of care at the Walk in Centre

12. Conclusion

The focus of this Annual Report has been on activity, performance and appraising if this GP Led Walk in Centre is fit for purpose and meeting the needs of the people of Luton. This is the second such report which means that we can measure progress from some of the previous benchmarks and also we have not shrunk away from highlighting some of the major challenges: one of which is the very popularity of this new service and how best to manage demand.

The NHS Luton, Annual Public Health Report 2010 – 2011 has ably demonstrated the extent of deprivation in Luton and also the relative deprivation when compared to the East of England and England. This Town Centre GP Surgery Annual Report has charted the Post Codes of users and their ethnicity and can demonstrate that by this measure the GP Led walk in service is accommodating maximum access to quality Primary Healthcare for the residents of some of the most deprived areas in this region.

By using the measure of acceptance and overall user satisfaction with the service provided, the results of the MORI ‘GP Patient Survey’ April 2010 – March 2011 has shown that satisfaction with the service is exceptionally high. This is further evidenced by the attendance from people who reside within the Luton Unitary Authority and those from the more affluent surrounding villages who value choice and articulate satisfaction.

LHS Ltd continues to work closely with NHS Luton and the wider community with the expressed intention of making a positive and significant contribution to the health of the residents of and visitors to Luton and to that end have met all our set targets and objectives and look forward to the new challenges of designing and configuring health care in the future to meet the needs of the ‘social network generation’ whilst achieving easy access to the homeless and socially excluded groups in the true and enduring fashion of NHS healthcare *to all at the point of need*.

Bernie Naughton 2011

References

Annual Public Health Report (2010-2011) “The Health of Luton’s ethnic and migrant communities” – Director of Health, NHS Luton and Luton Borough Council

[Response from The Practice]

- 1. What are your views on the reasons that commissioners have given for closing walk-in centres?**
- 2. Has Monitor sufficiently captured the concerns of commissioners related to walk-in centres? What additional information or evidence should we consider?**

The Practice understands the views that commissioners have presented in the consultation but feels that many of them may be potentially flawed as they may apply only to a locality and/or may not be based on local evidence.

They are however important and to maximise patient outputs and to minimise risk they need to form part of the pre procurement review of WICs, as part of the wider urgent care system to ensure that all relevant areas have been considered prior to procurement. This will drive up the standard of commissioning practice.

Summary of points underpinning the statement above:

- WICs have developed a bad reputation because the idea that every locality needed one was poorly thought through.
- WICs may well create a level of unnecessary demand in some areas although we see no evidence in our WICs of this. However where it occurs it can be reversed by focused commissioning to deliver specifications that clearly articulate what patients are to be seen and those that are to be redirected back into the community/Primary Care.
- The current payment mechanism means that a local health economy does not align financial incentives between different forms of provision. This is not the same as paying twice but GPs are not being paid or having to provide the resources that their patients require.
- However this is not a valid reason to stop provision. GP consultations have risen at 3.1% a year from 1995 to 2005 but funding has not. Primary care does not have the capacity to take on the current WIC workload. GPs need to focus on LTC, frail elderly and hospital admission avoidance. Other systems need to manage the on the day work.
- Primary care does not currently provide the wide access hours [up to 8pm and weekends] that the WICs do and this is an important factor in patient decisions around where to go for care. Nor are GPs often able to provide convenient access through location which WICs often do. For example our WIC in Birmingham city centre Boots.
- Paying twice only applies if the patient a) attends WIC and then the GP and/or b) if the GPs have capacity and are not using it [in areas where there is poor PC availability then WICS are a great facility for keeping patients well].
- Spending money here can save elsewhere in the system. More focus on long term conditions and better IM&T links are needed to facilitate this.
- Information about the value and impact of WICs has been unreliable. This is an absence of evidence rather than evidence of absence. Impact on AE is difficult to assess due to the fluctuations in their attendance rates.
- Local GP vested interest has impacted on the location, hours of opening, list and activity caps for WICs to protect the status quo. This potential conflict of interest needs to be understood in any decommissioning of WICs.

- The centres are very popular with patients particularly in urban areas and serve a need and segment of the population poorly served by traditional GPs. This is particularly true of the hard to reach patients.
- Properly commissioned WICS that reflect local patient need, promote integration and are a part of the local urgent care provision will deliver good quality care to patients.
- We agree that the complexity and fragmentation of services leads to confusion for patients knowing which access route to use. This affects UCC's, MIUs and ED's and is not specific to WIC provision. This can be reduced by less variability in centre provision, appropriate naming of centres and clear marketing to the general public with consistent opening times that do not change. GPs could play a major part in this.
- The in-equality of access argument can be reduced by thoughtful placement of the WICS in areas that actually require them and improve patient access.
- The WIC model in one way is similar to well delivered GP services that have access on the day for patients, a principle that is already supported, it is not replacing an ED service.

3. What are your views on Monitor's analysis and preliminary findings related to the potential impact of walk-in centre closures on patients? What additional information or evidence should Monitor consider?

The Practice agrees with the report's findings. Our experience is that WICs are very popular with patients and importantly can serve patients with many different needs [e.g. the homeless and patients with chaotic lifestyles that do not conform with the traditional primary care model] which are currently not addressed by traditional GPs.

In addition, access to traditional GPs is increasingly difficult and closing WICs will exacerbate this position and further disadvantage these patient groups, placing a further burden on local ED's. Finally patients will lose access to the much greater opening hours that WICS provide in the evenings and weekends.

4. What are your views of our analysis and preliminary findings on how divisions in responsibility for the commissioning of walk-in centres may result in drawbacks for patients? What other information or evidence related to this topic should Monitor consider?

As a provider of multi-site and multi-CCG primary and community care, we have experienced varying levels of commissioning quality both geographically and with CCGs and NHSE. To compound this further with two commissioning bodies for one contract has the potential to slow the process and increase the current quality issues. Conversely though having the two bodies working jointly may positively ensure that the potential conflict for CCG GPs is negated and the links with the urgent care system are in place/maintained.

Access for unscheduled care is a challenge and is likely to get worse, particularly in areas of expanding and transitory population with language, culture and deprivation also having a major impact. The challenge is that some areas desperately need WIC's both for patient safety and quality but also for financial reasons and this requires a whole system approach to unscheduled care. Split commissioning responsibility will encourage silo mentality and will perpetuate local self-interest.

5. What changes would you recommend to the way the commissioning of walk-in centres is organised? For example, should one commissioning body take the lead in decisions

about walk-in centres while ensuring that decisions take into account the potential impact of a closure across primary and secondary care? If so, which body and why?

Our preference would be for a single commissioner [at least until the commissioning process is stronger and can deliver this more complex system] but we do not have a particular view on which body should commission.

The most important elements are the principles they work to as commissioners. The process must be fair, equitable and transparent [negates the CCG GP conflict issue] and that the type of unit [UCC/WIC/MIU] is congruent with local needs [supporting evidenced patient need] and lies within the current/planned urgent care system in that locality with clear links to the community services, including primary care [integrated]. There needs to be consistency, regardless of the point of contact, with patients receiving the same process and quality of care. In relation to decommissioning and due to the negative patient impact any decommissioning of WIC's should be agreed by CCG and NHSE with Monitor approving the process.

Nationally we need WIC's in the right places. This needs local sensitivity as every area will have its own challenges. Our view is that WIC's offer value in unscheduled primary care, improve quality and avoid crisis through better access and reducing the ED burden and cost.

- 6. What are your views about our analysis and findings on how the payment mechanism for GP practices and walk-in centre services may not be working in the best interests of patients? What other information or evidence related to this topic should Monitor consider?**
- 7. Do you believe including in the payment mechanisms stronger incentives for GP practices and walk-in centres to improve quality and efficiency could benefit patients?**
- 8. How do you think the payment mechanisms should be adjusted to increase patient benefits within the limits of NHS funding?**

We agree with Monitor's assessment of the current payment lack of incentives for collaborative WIC and primary care working.

The current GP contract does not reflect the burden of deprivation and whilst there is an argument for financial penalties for primary care poor access, there needs to be some assessment that those surgeries have resources that reflect the real need.

Payment mechanisms are not aligned and there is no incentive for GPs to see their own patients rather than them going to a WIC or to an ED. GP funding on a capitation basis tends to lead to a management of downwards demand to their services whilst WICs are mostly funded on a cost per attendance and therefore look to drive up attendances [excepting those with activity caps]. A focus on incentivising quality and efficiency would benefit patients. In some areas a WIC will be the most efficient and cost effective way of managing the GP surgery capacity problems.

- 9. Is the description of the key factors that commissioners are likely to need to consider under the Procurement, Patient Choice and Competition Regulations when taking decisions about the future of a walk-in centre helpful? Would further advice or guidance be helpful?**

We found the report summary helpful, succinct, complete and accurate.

Commissioners should follow national guidance as suggested and merge this with an evidence based local_needs assessment taking due regard to the patient needs, hard to reach groups/needs, current level of primary care provision and access, wider urgent care service delivery/plans and current AE department performance.

Commissioners should ensure that equity, access, specific local initiatives and integration is fundamental to any new service specification, which builds upon the WIC foundation. The local community should be involved and the naming and marketing of services in the locality should be reviewed, updated and re-cascaded to ensure patients know what services are available, for what problems and when they are open. There should be real focus on services that are closer to patients [home or work], improve wellbeing and long term condition management, deliver IM&T integration and are provided in a simple way so that confusion and fragmentation is reduced.

Commissioners should drive this with payment incentives which encourage both the WIC and primary care providers to be joined up and more effective which in turn delivers improved patient outcomes. These principles need to be in place prior to procurement so that providers can respond to the service specification, contractual requirements and KPIs and design and deliver a needed and focused service that is right for commissioners and patients in the local area.



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4 December 2013

Review of The Provision of Walk-In Centre Services
Cooperation and Competition Directorate
Monitor
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SE1 8UG

Dear Sir/Madam,

Thank you for providing stakeholders with the opportunity to submit submissions to the facts, analysis and preliminary findings presented in Monitor's recently published **Walk-in Centre: preliminary report**. WMAS welcomes this report from Monitor and supports the findings and issues outlined in the report. Our specific responses to the questions posed are set out below:

Q: What are your views on the reasons that Commissioners have given for closing walk in centres?

A: Whilst WMAS recognises the reasons given for the **failure** of Walk in Centres as being accurate, these are not necessarily reasons for **closure**. WMAS believes that appropriate commissioning of Walk-in Centres, along with the matching of the needs of the local population to the capacity and capability in the Walk-in Centres would lead to better outcomes for patients and better uptake of the facilities.

Q: Has Monitor sufficiently captured the concerns of commissioners related to walk in centres? Is there any other additional information that should be considered?

A: In the West Midlands, WMAS is commissioned by CCGs to develop and maintain the Directory of Services (DoS). The DoS hold information about all Walk in Centres including the opening hours, capability and capacity of the centre. WMAS is able to provide 'gap' information for commissioners which identifies where a patient calling either 999 or 111 could be clinically appropriate to be referred to a Walk in Centre but where a Walk-in Centre is not available.

This data can be used to:

- target areas of under provision
- establish where Walk-in Centres have been commissioned inappropriately in terms of availability or services provided
- where Walk in centres are provided but not used as a result of over provision or lack of information for patients.

WMAS would therefore advise that Commissioners across the country are made aware of such initiatives and use data from the Directory of Service to inform their needs assessments.

Q: What are your views on Monitor's analysis and preliminary findings related to the impact of walk-in centre closures on patients?

A: WMAS supports and agrees with this analysis and preliminary findings. WMAS also believes that the closure of Walk in Centres in areas where patients cannot easily access other services will result in increased demand for Ambulance services.

Q: What are your views of our analysis and preliminary findings on how divisions in responsibility for the commissioning of walk-in centres may result in drawbacks for patients? What changes would you recommend to the way the commissioning of walk-in centres is organised.

A: The analysis seems accurate although WMAS knowledge of the specific commissioning arrangements is limited. WMAS has found that a number of CCGs have been active in reviewing their provision in this area and in considering options for the future. CCGs have responsibility for shaping local provision and ensuring integration of services and therefore it would seem appropriate for CCGs to have the responsibility for commissioning WICs. It would also seem appropriate for commissioners to provide incentives for Walk in Centres to work jointly with other providers to ensure an integrated service is provided for patients.

In addition to the specific responses set out above WMAS would like to see further consideration of the deployment of paramedics in walk in centres, minor injury and urgent care services. This would see paramedics in alternative locations alongside other health professionals as part of multi-disciplinary teams. Paramedics are able to triage effectively and have the skills and training to treat a wide range of illness and injury. This issue has been raised in the Keogh report and the WMAS Trust Board would like to see further consideration of:

- Review of the variability in service provision, opening hours, staff capability and clinical equipment: the current arrangements make it difficult for our paramedics to confidently refer patients to Walk-in Centres.

The specification of services could provide either a more standardised approach or a requirement for closer working and information to be provided. A further option for consideration may be centres that are jointly staffed by medical, nursing and paramedic staff. This would ensure better integration with the wider health economy and also promote skills transfer between professionals for the benefit of patients.

- Integration of the Directory of Services (or other mechanism) to support referrals to/from Walk-in Centres – WMAS feels the promotion of the DoS should be a key feature in reforming Walk-in Centre services. The preliminary report highlighted barriers to referrals between A&E departments and Walk-in Centres and the DoS could be utilised to achieve effective referrals between services.
- Paramedic access to Walk-in Centres during night-time closures: One of the issues experienced by ambulance services is the variable nature of services with variable opening and closing times. Walk-in Centres are closed are often closed at times of peak demand for ambulances but it may be possible for conveyance to A&E to be reduced if paramedics were able to use the facilities available at the Walk in Centre to treat a patient.

In summary WMAS is supportive of the findings detailed in the Preliminary Review and wishes to thank Monitor for the opportunity to submit this response. WMAS wishes to offer further support to inform the final recommendations and action as outlined in this letter.

Yours faithfully

A handwritten signature in dark ink, appearing to read 'K. Barber', with a stylized flourish at the end.

Kate Barber
Strategy and Business Development Director

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