

What is the role of walk-in centres in the NHS?

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In April 1999 the Department of Health authorised funding for a pilot scheme of 40 NHS walk-in centres in 30 towns and cities across England,¹ the first of which opened in January 2000. The overall aim of walk-in centres is to improve access to high quality health care in a manner that is both efficient and supportive of other local NHS providers. It is hoped that the centres will complement other primary care initiatives such as NHS Direct, playing a major part in the government's commitment to modernise the NHS. Key features of NHS walk-in centres are shown in the box.²

The establishment of walk-in centres within the NHS has been controversial. The claimed advantages are that centres improve access to health care through wide opening hours, a convenient location, and minimal waiting without an appointment. By using software for clinical assessment, nurses should be able to provide high quality care for patients, reducing demand on other NHS services and maximising efficiency. Such centres may also increase the appropriateness of patients' problems seen by other NHS providers by encouraging self care and helping people to identify when they need to consult a doctor.

Critics have put forward several counter-arguments.³ Walk-in centres may increase access primarily for affluent people, thus increasing health inequalities. Increased accessibility may increase total demand on the NHS, with little health gain being seen if patients primarily consult with self limiting illnesses. Diverting patients to walk-in centres is efficient only if centres provide care

Summary points

By September 2001 39 NHS walk-in centres had opened, providing health information and treatment for minor illness and injuries

The number of people visiting the centres is gradually increasing and includes a higher proportion of young adults than consult in general practice

NHS walk-in centres are highly variable in their premises, staffing, and service provision; location seems to be the most important factor determining their activities

Walk-in centres are led by nurses, supported by software for clinical assessment; the appropriate level of training of nurses for this role and the usefulness of this type of software for face to face consultations are not yet clear

Because consultations are relatively lengthy, provision of care in walk-in centres is not necessarily more economical than that in traditional settings

Key features of NHS walk-in centres

- Wide opening hours (usually 7 am to 10 pm every day)
- Walk-in access, without the need for an appointment
- Convenient location
- Provision of information and treatment for minor conditions
- Offer health promotion, supporting people in caring for themselves
- Build on, not compete with or duplicate, existing services
- Maximise the role of nurses; use of skill mix
- Nurses supported by computerised software for clinical assessment
- Good links with local general practices
- Services that meet the needs of their identified population

more cheaply than other providers, and achieving a "no wait" service may need a high level of staffing with high costs per consultation. Nurses may be no less expensive than doctors if they spend longer on consultations, and it is not certain that nurses can safely manage the wide range of problems seen in primary care. Finally, walk-in centres could undermine continuity of care, leading to duplication (people consulting different agencies about the same problem) and inappropriate care (due to lack of records about medical history).

Although walk-in centres have existed in other countries for many years, little research has been done on their impact, and the evidence that does exist from other healthcare systems may have little relevance to the NHS.⁴ The Department of Health has commissioned a comprehensive independent evaluation of NHS walk-in centres, which uses both quantitative and qualitative methods to describe the process and outcomes of care, including studies of the efficiency of walk-in centres and their impact on other NHS providers.

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Methods

This paper describes the structure and activities of NHS walk-in centres, based on several sources of information. Each walk-in centre provides monthly "monitoring returns" describing the number of visits to the centre in the previous month, waiting times, referrals, and other details. In addition, we extracted anonymised patient level data from several centres for more detailed analysis. Because of the difficulties of combining data from the wide variety of software used in different centres, we restricted this analysis to sites using Adastra software. We extracted data from the opening of each walk-in centre until 23 January 2001, by which time 36 centres had opened, 12 of which used Adastra software. Some centres did not collect complete data for all of the variables of interest. In particular, only four centres recorded sufficiently complete data about diagnoses for analysis.

As well as analysing routinely collected data, we interviewed walk-in centre managers at each centre about facilities, staffing, service provision, and use of information technology. Managers completed a questionnaire, which was followed by a semistructured interview conducted during a site visit or over the telephone. The visits enabled observation of the day to day work of the centres and were conducted when each centre had been open for between two and six months.

Results

Number of visitors

Although the number of people using walk-in centres was initially low, throughput increased with time. Monitoring returns show a gradual but steady increase in the number of visitors, with an average of 2556 visitors per centre in August 2001, equivalent to approximately 82 per day (fig 1). The monthly figure varies considerably, however, ranging from 1004 to 4041 visitors at different centres.

Who visits walk-in centres and when?

A high proportion of visitors were young adults, with relatively few elderly visitors (fig 2). Figure 3 shows the times at which people contacted centres. We found a clear relation with age, with consultations about children occurring most commonly between 1500 and 1700, those concerning young adults (17 to 35 years) peaking at lunchtime (between 1200 and 1400), and

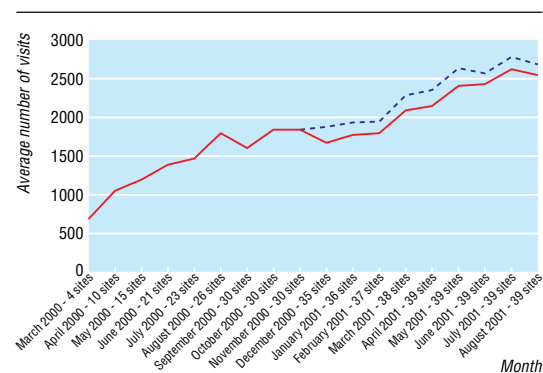


Fig 1 Number of callers per month per walk-in centre. The dotted line indicates the average number of visits per month at the 30 sites which had opened by September 2000

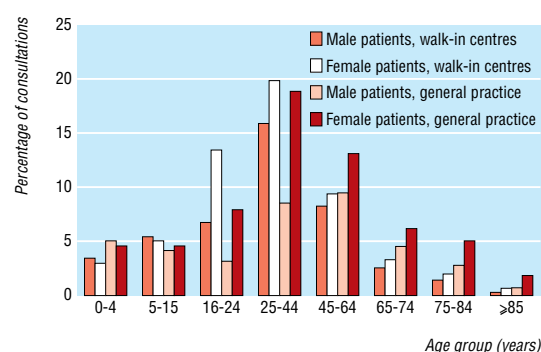


Fig 2 Age and sex of visitors to walk-in centres, compared with general practice. Proportions of walk-in centre consultations are based on data from centres using Adastra software, weighted to adjust for the length of time centres had been open. Data for general practice are from the Fourth National Morbidity Study⁵

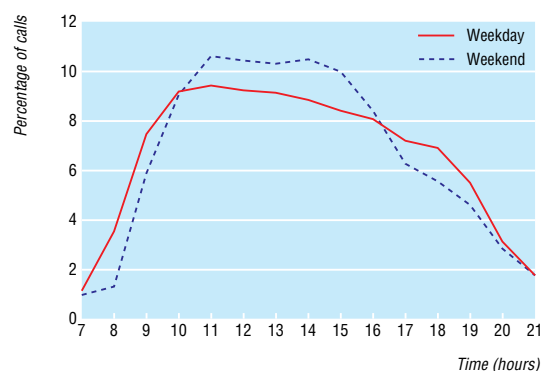


Fig 3 Times at which people contact walk-in centres. Percentage of visits is weighted to adjust for the length of time centres had been open

older people consulting mainly between 1000 and 1200. Although one feature of walk-in centres is that they have extended opening times, they received relatively few visitors outside office hours.

Consultations

The median waiting time for a consultation at the sites using Adastra was 10 (interquartile range 3 to 26) minutes, and the median length of consultation was 14 (8 to 21) minutes. The most common presenting complaints were viral illnesses, unprotected sexual intercourse (to obtain emergency contraception), minor injuries, and dressings (table). Seventy eight per cent (38076/48554) of consultations at the 22 sites reporting referral rates in May 2001 were managed entirely at the walk-in centres, without referral to any other healthcare provider.

Diversity of walk-in centres

Site visits and interviews with centre managers revealed considerable diversity between walk-in centres in terms of their size, setting, and service provision. Most centres have excellent facilities and are conveniently located. Some occupy premises in retail locations, whereas others are located close to existing healthcare providers. Although all walk-in centres are expected to deliver a range of core services, such as care for minor injuries and advice about minor illness,

Twenty most common reasons for consultations at walk-in centres (data from four centres, n=20 410). Excludes "miscellaneous," which accounts for 13% (95% CI 12.1%-14.3%) of consultations

Condition	No	Percentage of consultations* (95% CI)
Flu or systemic viral infection	578	5 (3.5 to 6.1)
Unprotected sexual intercourse	513	3 (2.8 to 3.6)
Return dressing	634	3 (2.0 to 3.4)
Other ear, nose, and throat	636	3 (2.5 to 2.9)
Common cold	391	2 (1.8 to 3.0)
Blocked ears	681	2 (2.1 to 2.6)
Other musculoskeletal condition	577	2 (2.1 to 2.7)
Non-acute wound care	326	2 (1.8 to 2.7)
Other skin conditions	667	2 (2.0 to 2.4)
Otitis media	262	2 (1.7 to 2.6)
Blood pressure check	744	2 (1.7 to 2.2)
Muscle pain	263	2 (1.4 to 2.4)
Urinary tract infection	372	2 (1.6 to 2.1)
Other eye conditions	441	2 (1.5 to 2.0)
Tonsillitis or pharyngitis	336	2 (1.4 to 2.1)
Minor head injury	240	2 (1.3 to 2.1)
Soft tissue injury of ankle, foot, or toe	289	2 (1.5 to 1.8)
Other wound, soft tissue infection, burn	249	2 (1.4 to 1.9)
Styes, conjunctivitis, blepharitis	372	2 (1.3 to 1.7)
Back pain	282	1 (1.2 to 1.7)

*Proportions weighted to adjust for the length of time centres had been open.

the extent to which centres provide these services varies considerably. This often seems to be related to previous history—for example, where a centre incorporated a pre-existing minor injuries unit. Centres are increasingly providing additional services such as phlebotomy and smoking cessation clinics, and these have often arisen in discussion with other local health services. A further important development is the use of patient group directions for the supply of prescription drugs, but the number and range of drugs supplied varies widely between centres.

Nurse led care supported by clinical assessment software

All walk-in centres are led by nurses, who conduct almost all consultations. In addition, some centres employ a range of health advisers on specialist issues such as mental health, and some employ doctors to work at particular times. The number of nurses employed in different centres at the time of our visits varied between six and 14 whole time equivalents. The centres reported wide variation in the number, grading, background, and roles of nursing staff. Some centres employed nurses with formal training as nurse practitioners, whereas others employed less highly trained nurses on the basis that their role was to assess and advise visitors (supported by clinical assessment software) rather than to make autonomous decisions about diagnosis and management. Although many centres were developing plans for the continued education of nurses, education often seemed to be ad hoc. This was mainly because of the speed with which walk-in centres were established and the difficulty of predicting in advance of centres opening the range and types of problems liable to present to them.

Many different configurations of computer software for management of patients or support of clinical decision making were used initially, and some centres had clearly experienced problems. Most commonly,

such difficulties were related to technical support by suppliers, functionality, or data extraction. Additionally, the various types of clinical assessment software implemented at different sites all seemed to have limitations for use in face to face consultations, having been adapted from software designed originally for telephone triage.

Centre management

Centres seemed to be generally well managed, and at most sites staff were well motivated and enthusiastic about their new roles. However, management structures were often extremely complex, involving several different community trusts, primary care groups, and out of hours cooperatives, which seemed to cause problems of accountability and decision making at some sites. Many centre managers believed that these problems would be resolved with the advent of primary care trusts, which would facilitate a more unified structure for management and employment.

Taking a wider view, staff at walk-in centres were optimistic about their progress and encouraged by the growing number of visitors using their service. The attitudes of other local health professionals (particularly general practitioners) were perceived as being the most important potential barrier to the success of walk-in centres, although most staff felt that these relationships were improving with time.

The place of walk-in centres within the NHS

Walk-in centres are a radical initiative within the NHS, and this report is based on an early stage of their development. Although the original health service circular set out a clear "blueprint" for walk-in centres,² their structure and role vary widely. To some extent this has arisen because of the speed of development, and it is remarkable that 36 centres were established within 20 months of the original policy announcement. The variability may also reflect some ambiguity about the place of walk-in centres in the increasingly crowded local healthcare economy, with general practice, pharmacies, out of hours primary care centres, and NHS Direct also offering to provide health care as a first point of contact.

The way in which different centres have developed has often been dictated by local circumstances, as centres attempted to achieve the original aims in very different settings. The role of a new walk-in centre in a high street may be very different from that of one which had previously existed as a minor injuries unit in a district hospital or of a centre serving a deprived housing estate. Although a key feature of walk-in centres is that they are "based on a patient/population needs assessment,"² we found only limited evidence that service delivery was planned in response to formal assessment of local needs. There is a tension between the desire for a recognisable and consistent "branding" of walk-in centres, so that people know what to expect from this new service, and designing a service that responds to local needs.

The primary aim of walk-in centres is to improve access to health care, and it does appear that they are attracting a different population from that attending general practice, especially a larger proportion of

young men (fig 2).⁵ This finding, coupled with the pattern of use by different age groups, suggests that centres are providing an accessible service to groups who find it less convenient to contact other services.

If most patients attending walk-in centres would otherwise have contacted other health professionals there is potential for reduced demand on other agencies. Whether this is more or less efficient depends on the costs of care in walk-in centres compared with the costs of alternative providers. The short waiting times and long consultations seen at walk-in centres are likely to lead to high cost care for relatively minor illnesses. As more people visit them efficiency is likely to improve, but waiting times may increase, thus reducing accessibility. Achieving a balance between accessibility and efficiency is likely to be an important issue.

One of the most radical features of walk-in centres is the use of nurses supported by clinical assessment software. Although there is evidence that nurses using similar software can safely triage telephone consultations,⁶ and that nurse practitioners working with doctors in general practice can provide acceptable care,^{7,8} the role of clinical assessment software in face to face consultations has not yet been established. Nor is it clear what level of training is necessary for nurses to work in this way, which is reflected in the variability in training and experience among nurses working in walk-in centres. The Department of Health is reviewing the experience, competencies, and training that nurses need and is also implementing a standard system of clinical assessment across all NHS walk-in centres and NHS Direct sites to replace the current programs.

NHS walk-in centres were set up as a pilot initiative and are subject to evaluation. The variability in their implementation (whether by accident or design) has led to a period of experimentation, which provides an opportunity to learn from the experience of sites providing different services in different settings. Future components of the national evaluation will provide

evidence about the impact of different types of walk-in centre on patients and other local health providers, as well as about the appropriateness, efficiency, and quality of care provided.

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Contributors: CS planned and supervised the evaluation. MC analysed the monitoring returns. CS, LM, and MC analysed the anonymised data. CP and TMS planned the interviews; TMS, CP, MC, and CS conducted them; and CP and CS analysed them. CS and MC wrote the paper, with contributions from all authors. CS is the guarantor.

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Three hundred years ago

Public health and the parish constable

The seventh edition of *The Compleat Parish Officer* was published anonymously in 1734 and reprinted by the Wiltshire Family History Society in 1996. The largest section of this manual concerns the role of the parish constable. "Men of substance, and not of the meaner sort" were elected annually by their neighbours whether they liked it or not. People refusing to serve in this unattractive office were liable to prosecution at the assizes and fines in the lord of the manor's court.

Some of the constables' many duties were designed for the public health. "Constables may command and oblige Persons infected with the plague to keep within their houses; and if after such command, they wilfully go abroad, having any infectious Sores upon them, it is felony; and if they have no Sores, they may be bound to Good Behaviour, and punished as Vagabonds, by whipping, etc." The manual also explains how to administer this particular physical therapy.

Parish constables also took part in the regulation of drugs and their prescribers. The laws of Henry VIII had empowered the Royal College of Physicians to nominate annually four censors, "who shall search Apothecaries Wares, and examine Medicines and burn or destroy those that are defective." Support and enforcement came from the primitive police force: "Constables in the City of London, and within seven miles, are to assist the President of the College of

Physicians, and such who shall have Authority from him, etc, to put the Laws in Execution concerning the said College." Neglecting to assist a censor was one way for a parish constable to commit "A Contempt of the King." Modern mechanisms with the same goals seem rather convoluted compared with when everyone knew everyone in local government.

Physicians' competition was also regulated, and there was less latitude than today for 18th century practitioners of complementary medicine: "none shall practice Physick without License of the College, on pain of forfeiting five pounds a Month, unless it be Persons having Knowledge in Herbs, etc. who may minister to outward Sores, and use Drinks for the Stone, Strangury, or Agues." Surgeons, however, were of no special concern to the parish constable.

Another duty probably had fiscal motives. "Constables etc. upon Information of Tobacco, set, sown or planted, in any Ground (except Physick Gardens) are to destroy the same within fourteen Days after receiving a Warrant from two Justices of the Peace to that Purpose, on pain of forfeiting 5 s. for every Rod unconsumed." Now there's police accountability for you.

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