

NHS Walk-in Centres in London

An initial assessment

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Executive summary

Nine NHS walk-in centre pilot sites opened in London during 2000. Six of the nine centres are located in hospital sites. The other three centres are in Soho in central London, the High Street in Croydon, and Parsons Green in Fulham. NHS walk-in centres are nurse-led and offer primary care services without an appointment. All nine centres offer assessment and treatment for minor illness and minor injuries and advice and information about other services. Additional services offered vary by walk-in centre.

This project provides a snapshot of how NHS walk-in centres are developing in London. The data were collected between February and April 2001. The focus of this study is on staffing issues, such as recruitment, training and developing the nursing role, and the interaction with other local services. Face-to-face interviews were conducted with a range of walk-in centre staff and other local stakeholders from primary care and accident and emergency (A&E) departments.

What do people come to London walk-in centres for?

Routine monitoring data were requested from the Department of Health (DoH) to describe the case mix, but access to these data was denied. However, staff described the typical problems brought by people to London walk-in centres as:

- coughs and colds
- diarrhoea and vomiting
- abdominal pain
- urinary tract infections
- earache and sore throats
- hayfever
- rashes
- minor injuries
- backache
- general health advice
- emergency contraception.

Most people attend walk-in centres with minor illnesses but the case mix is varied and some people present with complex problems. Walk-in centre staff have the philosophy that they should be able either to help people or to redirect them and did not label any users as inappropriate attenders.

Organisational issues raised for walk-in centres

Staff reported that demand for services at walk-in centres varied by time and day of the week. The busiest times were said to be Mondays and early evenings and the quietest times were very early mornings. Consultation lengths reported were longer than in 'traditional' general practice. At some walk-in centres, patients can wait up to 2 hours to see a nurse or doctor during busy times. Most walk-in centres are trying to implement a system for prioritising and redirecting people where appropriate (triage), to ensure that people are not kept waiting for services which cannot be provided at the walk-in centres.

Nursing staff at the walk-in centres use protocols called patient group directions in order to supply medication to patients. Each walk-in centre has developed their own patient group directions and this has created a large workload. Several interviewees called for national leadership in this area.

Problems with information technology have hampered the early progress of walk-in centres. For example, there was no suitable decision-support software for face-to-face use. Some walk-in centres have started off using one computer system and are now having to change to another system. Releasing staff for the time required to undergo training, while at the same time maintaining a full service, is a problem for some walk-in centres.

Staffing of walk-in centres and extending the nursing role

In the absence of central guidance on the number, grade, previous experience and initial training of walk-in centre nurses, each walk-in centre has been staffed differently. Recruiting suitable staff, particularly from community or general practice backgrounds, has generally proved to be difficult in London. The extent to which

support from general practitioners (GPs) is available in the walk-in centres also differs.

Walk-in centres provide opportunities for extending the nursing role – nursing staff said they were attracted to working in walk-in centres because they considered them to be at the forefront of nursing. The major challenges created by the new role for nurses were diagnosing and treating patients autonomously and coping with the varied case mix. Combined with a constant flow of patients, long shifts and the pressure to keep waiting times down, these new professional roles also create considerable stress. A key challenge for the future development of nurse-led primary care services in general, and walk-in centres in particular, is agreeing what training, support and experience is required to equip the nurses to do their job.

There is no standard induction course for walk-in centre nurses. Furthermore, lead nurses differ in their views about subsequent professional development and the balance needed between taught courses and supported clinical experience. At present, the generous training budgets available to the first wave of walk-in centres provide ample access to training courses, though this creates some problems with providing cover for study leave. However, it remains to be seen whether equal funding for personal development will be available if more walk-in centres are set up.

Working with other local services

Walk-in centres saw facilitating access for patients back into ‘traditional’ general practice as an important part of their role. One walk-in centre reported that 45 per cent of people attending said that they were not registered with a GP. In some centres, the location of GP ‘out of hours’ co-operatives on the same premises as the walk-in centres had the effect of encouraging informal links between the centres and local primary health care teams. All of the London walk-in centres reported that they were developing links with their local A&E departments and trying to develop two-way referral guidelines, with some centres working to develop a shared triage system. There were important issues to be resolved regarding referral direct to specialists without going via the A&E department. Interviewees recognised that referring

patients for chronic conditions or those requiring follow-up, such as back pain or breast lumps, was not appropriate and that these should be done via a GP.

Central guidance versus local control

As the NHS walk-in centres opened so far are all pilot sites, the aim is to use their experience to inform future developments. They have been given some freedom to develop differently and respond to specific local needs. However, several interviewees complained about excessive central control over the way the centres were organised and the services they offered. In contrast, there has been insufficient central guidance about issues of common importance, such as prescribing protocols. Such central–local tensions will need to be resolved if the walk-in centres are to develop in response to identified local needs and gaps in local primary care services.

The future of walk-in centres?

Not everyone we spoke to was convinced that walk-in centres represent the best use of NHS resources, and concerns were expressed about what will happen when the three years of funding come to an end. The walk-in centres set up so far are all pilot projects and as such their experience should inform future developments. If walk-in centres are to be rolled-out, the following key issues need to be considered:

- Walk-in centres need to be clear about the role they perform within their locality and to communicate this to the public, so ensuring a good match between public expectations and service provision reality. National guidance should not prevent service development being based on a thorough examination of local needs.
- Walk-in centres can offer longer consultations, at times and in locations that are convenient for patients. Explicit discussion is required on the balance between patient convenience and satisfaction, patient throughput and the opportunity cost to the NHS.
- The optimal mix of nursing grades and the roles of different grades of nurse must be clarified and the impact on other NHS services of recruiting nurses to posts in walk-in centres should be considered.
- Working in a walk-in centre is stressful and nurses are working at the limits of their clinical experience. The background, experience and core competencies

required to equip walk-in centre nurses to do their job needs to be agreed and necessary systems for supervision and training must be put in place.

- Quality assurance systems should be developed and all walk-in centre staff must be involved in auditing their activity.
- Close links between walk-in centres and other local primary care providers should be fostered, in particular regarding staff training and development, registering of unregistered patients, and a potential role in 'out-of-hours' provision.

1. Background to NHS walk-in centres

1.1 The NHS walk-in centre policy

The plan to develop primary care walk-in centres was announced by the Prime Minister, Tony Blair, on 13 April 1999. Thirty-six pilot sites were approved across the UK. Up to £30 million was made available in the first year to fund the initiative. Centres were to be nurse-led and to deliver convenient, accessible services that respond to modern lifestyles. Some of the key features required to become a pilot were described as:¹

- *A patient/population needs assessment which supports the development of an innovative primary care centre and is sensitive to age, culture and lifestyle of patients.*
- *Centres must be managed by an NHS body or a GP co-operative.*
- *Centres must have support from and/or endorsement of the local Primary Care Group/Trust, Health Authority, GP co-op and the wider local health economy. Aims must be consistent with the local Health Improvement Programme.*
- *Provision of a range of high quality minor ailment/treatment services (and possibly medical minor injuries services) to all patients.*
- *Centres should be in demonstrably convenient location to enable easy access by the target population – eg. town centres, adjacent to accident and emergency departments.*
- *Centres should have a responsive style of service, (including opening hours which meet patient need – eg. 7am to 9.30pm weekdays and open at weekends).*
- *There should be a walk-in immediate access service.*

1.2 What are walk-in centres?

Walk-in centres have the following key characteristics:²

First-contact care, i.e. patients are expected to attend with new, or unanticipated, health problems for which care has not already been sought elsewhere.

Immediate access, i.e. patients require no referral or appointment to access care.

Extended opening hours, i.e. outside the usual working day.

No follow-up or continuing care, i.e. care or advice is given for the immediate problem. If further care is needed patients are advised to attend other services

Generalist, i.e. the services available are generalist rather than specialist in nature.

Walk-in, i.e. patients are expected to present with health problems that are not so severe as to render them unable to attend unaided.

2. What is already known about walk-in centres?

Although the policy of NHS walk-in centres is new in the UK, they have existed in the USA and Canada for a number of years. There are also other areas of UK provision with similarities to walk-in centres, such as minor injuries units, genitourinary medicine clinics and family planning services. A limited amount of experience has also been gained through the private Medicentre walk-in services.³

2.1 Walk-in centres in the USA and Canada

In the USA, walk-in centres originated as free-standing emergency centres in the 1970s. They evolved into ‘urgent care centres’ or ‘ambulatory care centres’, many of which opened during the 1970s and 1980s. They are mainly located in shopping malls. Patients pay a fee for each visit.

In Canada, walk-in centres also opened in the 1970s. The Canadian health service is more similar than the USA health service to the NHS, as it is also funded through general taxation. As in the UK, GPs also have a gatekeeper role to secondary care and patients do not have to pay to use Canadian walk-in centres. However, in Canada, as in the USA, the walk-in services are largely doctor-led; this allows a wider range of prescribing than the nurse-led services being established in the UK.

A review of walk-in centres in Canada described them as falling into two main types. The first type had extended opening hours and little connection to local doctors. The second model was an ‘after hours’ model, similar to general practice co-operatives in the UK, with links to local family practices. Evidence existed of a lack of continuity of care between walk-in centres and general practices in Canada. Walk-in centres in Canada were used mainly by adults aged under 35 years and children with minor medical conditions such as respiratory infections. Older people and those with chronic medical conditions were relatively less likely to attend.⁴

2.2 Demand for walk-in services

A literature review of walk-in centres and related services, such as minor injuries units, showed that most published studies were of a simple descriptive nature.² The review found that most walk-in services were dealing with between 20 and 40 patients per day. Over half of the demand occurred 'out of hours', with the busiest times being before the working day and in the early evening. Overall, demand was equally balanced between male and female patients and was dominated by younger age groups. According to the review, a number of US studies have suggested that the socioeconomic status of people using walk-in centres tended to be above that of people living in the surrounding area. The review also found that the majority of attendees were registered with a GP. However, one study in a deprived urban community suggested that many of the patients attending, who were not registered, may resist efforts made by walk-in centres to incorporate them into a traditional system of primary care.

2.3 What do people come to walk-in centres for?

The same literature review found that common reasons for presenting at walk-in centres were:

- upper and lower respiratory infections
- skin disorders
- musculoskeletal pain.

In terms of injuries, lacerations, strains, sprains and musculoskeletal pain were the commonest reasons given for attendance.

The review also found that only a minority of patients had tried to contact their usual doctor before attending walk-in services. Patients valued the convenient hours and location and the fact that there was no need for an appointment. If the walk-in centre had not been available, most patients said they would have attended their own GP or the local A&E department. Almost all users were satisfied with the care they received at the walk-in centres.

3. Aims and methods of this project

As with many new services, NHS walk-in centres are evolving rapidly. This project provides a snapshot of how NHS walk-in centres are developing in London. The data were collected between February and April 2001.

3.1 Aims

1. Describe the local context of London walk-in centres, including their situation, proximity to other services such as A&E departments, ways in which they interact with other services, and the nature of the caseload.
2. Describe the key issues relating to staffing of walk-in centres, including staff perceptions of the size of their workload, challenges to the nursing role, mechanisms of support, education and training, and issues for clinical governance.
3. Explore the nature of demands made upon walk-in centres in terms of patients with complicated problems and the challenges to continuity of care and continuity of information that this poses.

3.2 Methods

While our aim was to provide a snapshot of the development of walk-in centres in London, we were aware that the DoH had funded a national evaluation and we were keen to avoid duplicating work. The focus of this study was therefore guided to some extent by preliminary discussions with senior managers at two London walk-in centres, who identified the major issues as being staffing issues, such as recruitment, training and developing the nursing role, and interaction with other local services.

Interviews with walk-in centre staff

Face-to-face interviews were conducted with a range of walk-in centre staff, including lead nurses and nurses of different grades, project managers and walk-in centre GPs. All interviews were recorded to help with analysis.

Topics in these interviews included:

- Perceptions of demand and complexity of caseload.
- Issues relating to staff recruitment, e.g. any difficulties attracting suitably experienced nursing staff.
- New challenges brought to the nursing role and areas where there is role ambiguity.
- How closely matched are the expectations placed upon nurses with their own perception of role and competence.
- How any training needs identified are being met.
- The mechanisms that exist for support to staff taking on new roles.
- Identifiable causes of stress.
- The roles that members of primary care teams, other than nursing staff, play in the walk-in centre and whether there is a need for expanding the team.
- How staff interact with other professionals working within PCGs/PCTs or other local services.
- Issues relating to continuity of care and information.
- How clinical governance is being implemented.

Interviews with other local stakeholders

Interviews were carried out with primary care stakeholders associated with three of the London walk-in centres, including GPs working in practices close to them, PCG/PCT chairs and a chief executive and a practice nurse. Senior nurses and a consultant from A&E departments near to the walk-in centres were also interviewed.

Interviews with local stakeholders covered:

- The local context in which walk-in centres are working.
- Views on appropriate demand for walk-in centres.
- Opportunity costs of using resources on walk-in centres.
- How the role of nursing staff within the walk-in centre is perceived.
- The role of members of primary care teams, other than nursing staff, in the walk-in centre and perceived gaps in the team.
- How staff interact with other professionals working locally.

- Any joint initiatives around training, education and clinical governance.
- Issues relating to continuity of care and information.

Routine monitoring data

Our initial intention was to combine interviews with walk-in centre staff and selected local stakeholders with an analysis of relevant documents and routine monitoring data. The London Regional Office of the NHS Executive was asked to provide access to routinely collected data in order to help describe the caseload and nature of demand. After repeated requests for access to these data, we were told by the DoH that they could not be supplied to us due to uncertainties over data quality.

3.3 Analysis

The interview data were categorised into broad topics and analysed to identify emergent themes about services provided, what people actually attend for, organisational issues, staffing of walk-in centres, induction periods for staff, the nursing role in walk-in centres, quality of services provided and working with other local services. Summaries were fed back to the interviewees in order to validate responses.

4. NHS walk-in centres in London

Across London, nine NHS walk-in centre pilot sites opened during 2000. Six of the nine are based on hospital sites. The other three are Soho, which is just off Oxford Street; Croydon, which is on the High Street; and Parsons Green, which is in Fulham.

Soho NHS Walk-in Centre

Soho NHS Walk-in Centre at 1 Frith Street opened in January 2000. It is open Monday to Friday from 7.30 a.m. to 9 p.m. and at weekends from 10 a.m. to 8 p.m. The walk-in centre is located within the Soho Centre for Health and Care, which provides a large number of primary health and social care services to the local community. The centre had already existed as a minor treatment centre prior to becoming a walk-in centre.

Tooting NHS Walk-in Centre

Tooting NHS Walk-in Centre is in the grounds of St George's Hospital and opened in April 2000. It is open Monday to Sunday from 7 a.m. to 11 p.m. The building is shared with the mental health liaison service.

Edgware NHS Walk-in Centre

Edgware NHS Walk-in Centre is on the site of the Edgware Community Hospital and it opened in September 2000. The building is linked to an Urgent Treatment Centre. It is open Monday to Friday from 7 a.m. to 10 p.m. and from 9 a.m. to 10 p.m. at weekends.

North Middlesex NHS Walk-in Centre

North Middlesex NHS Walk-in Centre is on the site of the North Middlesex Hospital NHS Trust and opened in July 2000. It is open Monday to Friday from 7 a.m. to 10 p.m. and at weekends from 9 a.m. to 10 p.m.

Whitechapel NHS Walk-in Centre

Whitechapel NHS Walk-in Centre is on the site of the Royal London Hospital near to the A&E department and opened in December 2000. It is open Monday to Friday from 7 a.m. to 10 p.m. and from 9 a.m. to 10 p.m. at weekends and on Bank Holidays.

Newham NHS Walk-in Centre

Newham NHS Walk-in Centre is on the site of Newham General Hospital, near to the A&E department and opened in November 2000. It is open Monday to Friday from 7 a.m. to 10 p.m. and from 9 a.m. to 10 p.m. at weekends and on Bank Holidays.

Croydon NHS Walk-in Centre

Croydon NHS Walk-in Centre is located at 45 High Street, Croydon, and opened in December 2000. It is open Monday to Friday 7 a.m. to 10 p.m. and at weekends from 9 a.m. to 10 p.m.

Charing Cross NHS Walk-in Centre

Charing Cross NHS Walk-in Centre is on the Charing Cross Hospital site next to the A&E department and opened in March 2000. It was previously a minor treatment centre. It is open Monday to Friday 8 a.m. to 10 p.m. and at weekends from 9 a.m. to 10 p.m. They have walk-in dental services.

Parsons Green NHS Walk-in Centre

Parsons Green NHS Walk-in Centre is at 5–7 Parsons Green and opened in March 2000. It was previously a minor treatment centre. It is open Monday to Friday 8 a.m. to 10 p.m. and at weekends from 9 a.m. to 10 p.m.

5. Findings of the research

5.1 *What services do walk-in centres provide?*

The advertising of walk-in centres says that advice and treatment should be available for:⁵

- coughs, colds and flu-like symptoms
- information on staying healthy and local services
- minor cuts and wounds – care and dressings
- skin complaints – rashes, sunburn, headlice and nappy rash
- muscle and joint injuries – strains and sprains
- stomach ache, indigestion, constipation, vomiting and diarrhoea
- women’s health problems, e.g. thrush, menstrual advice
- hayfever, bites and stings.

Walk-in centres have also been asked to introduce additional core services, including cholesterol testing, phlebotomy (blood taking), blood pressure checks and emergency contraception.

Other services offered vary by walk-in centre. Some examples of other services offered are:

- Tooting and Parsons Green NHS Walk-in Centres offer some mental health services
- Charing Cross NHS Walk-in Centre has dentistry services
- Parsons Green NHS Walk-in Centre has an osteopath on site and offers podiatry and phlebotomy services
- Charing Cross and Parsons Green NHS Walk-in Centres are introducing domestic violence screening for all women and chlamydia screening for young women
- Edgware NHS Walk-in Centre offers a phlebotomy service
- Soho NHS Walk-in Centre has a full-time health promotion specialist
- North Middlesex NHS Walk-in Centre has a citizens’ advice service.

In addition to the types of services offered varying by walk-in centre, several people interviewed commented that the services available depended upon the individual competence and training of the staff on duty at any particular time.

Key points

- All walk-in centres provide a range of assessments and treatments for minor illness and minor injuries and advice and information about other services.
- Additional services offered vary by walk-in centre.
- The range of services on offer at any given time at a walk-in centre depends upon the individual competence and training of the staff on duty at the time.

5.2 What do people actually come to London walk-in centres for?

A request was made to the DoH for routine monitoring data regarding which groups of people attend walk-in centres and why they attended, but these data were not provided. It was therefore impossible to describe the actual caseload of each walk-in centre. From our interviews with staff, it seemed that the typical problems brought by people attending London walk-in centres are coughs and colds, diarrhoea and vomiting, abdominal pain, urinary tract infections, earache and sore throats, hayfever, rashes, minor injuries, backache, requests for general health advice, and attendance for emergency contraception. Several centres have noticed that requests for emergency contraception have fallen since it became available over the counter from pharmacies.

One lead nurse explained that there are a couple of cases a day where people come about something that the walk-in centre cannot manage. Examples include people wanting repeat prescriptions of drugs, e.g. asthma medicines, and people with chronic health problems wanting to be referred to hospital about their condition. One manager commented that the caseload was much more complex than they had originally expected.

People presenting with sudden, severe problems that require assessment and investigations in the A&E department also create a challenge to walk-in centres. This is a particular problem at Edgware NHS Walk-in Centre, which is on a hospital site where the A&E department has closed. Although the walk-in centre is linked to an Urgent Treatment Centre, people still use the combined service as though they are an A&E department, which results in several patients being transferred out in a blue-light ambulance each week.

Some patients visit a walk-in centre because they cannot get an appointment with their GP or do not have a GP. The proportion of people attending one centre who say they are not registered with a GP was estimated at 45 per cent. At Soho NHS Walk-in Centre, which differs from other London walk-in centres due to its central location, the majority of people using the centre are working in the area.

Several interviewees stated that the national publicity about walk-in centres encourages a very wide range of people to attend. However, they stressed that the concept of inappropriate attenders was not relevant to walk-in centre practice. As a project manager explained:

We don't want to give anybody the message that they shouldn't have come here. We may not be able to provide the right treatment but we want to give some sort of help or advice to all patients. We embed the idea during the induction [for new nurses] that patients shouldn't feel they are wasting people's time. There is no sense of the inappropriate attender. If we can't help, we can direct them to a [more suitable] place.

Key points

- Routine monitoring data from DoH were not provided.
- Most people attend the walk-in centres for minor illnesses, but the case mix varied and some people present with complex problems.
- Walk-in centres have the philosophy that they should be able either to help people or redirect them and did not perceive anyone as an 'inappropriate attender'.

5.3 Organisational issues**5.3.1 How many people are seen and who are they?**

These figures are estimates extracted from the interview data and as such can only give an estimate of the numbers of people using the service. They have been extrapolated to estimates per month:

- Soho NHS Walk-in Centre: approximately 1670 per month.
- Charing Cross and Parsons Green Walk-in Centres: approximately 3300 per month across both sites.
- North Middlesex Walk-in Centre: approximately 3510 per month.
- Edgware Walk-in Centre: approximately 1000 per month (finished episodes).
- Tooting Walk-in Centre: approximately 1950 per month.

One centre reported that most people attending were aged between 25 and 45 years old and that very few elderly people use the service.

5.3.2 Triage system to prioritise and redirect people

Most of the walk-in centres are trying to implement a system for prioritising and redirecting people (triage) where appropriate. This is to ensure that people do not wait for long periods of time to ask for items such as repeat prescriptions, which cannot be provided, and to ensure that very ill people are not kept waiting. How this is being done varies. Some walk-in centres have one nurse constantly doing triage and keeping an eye on the waiting area. This nurse has to explain to people that he/she will just be

asking a few questions to ensure that they are in the right place. In some cases, this nurse will sort out the problem if they can do so quickly. Otherwise, the patient will then be asked to wait to see either a nurse, or in some cases a GP, for a full consultation. One nurse commented:

At present the junior nurse takes a brief history and then most people are passed on to the nurse practitioner. Sometimes, it [the triage] takes too long; it's almost like being seen properly and the problem could be sorted out at the same time.

The guidance from DoH is that everyone should be seen for triage assessment within 15 minutes of arrival at the walk-in centre. Some centres are finding it difficult to release one person full time to carry out triage. Some nurses also find that the concept goes against their value of holistic care if the patient has to see different people, possibly giving the same information more than once. At Edgware NHS Walk-in Centre, where the service is closely linked to the Urgent Treatment Centre, the two services share their reception and triage system. This poses particular problems for staff who have been recruited to the walk-in centre from community backgrounds because the Urgent Treatment Centre sometimes deals with people with quite sudden and serious illness (e.g. cardiac arrest). Some of the walk-in centres are trying to develop a shared triage system with their local A&E department to avoid patients who need to be referred from one to the other having to undergo the same process twice.

Key points

- Most of the walk-in centres are trying to implement a system for prioritising and redirecting people where appropriate (triage).
- The guidance from DoH is that everyone should be seen for triage assessment within 15 minutes of arrival at the walk-in centre.
- Some nurses find that the concept of triage goes against their value of holistic care if the patient has to see different people.

5.3.3 Consultation and waiting times

One of the main attractions of walk-in centres is that people do not need an appointment, and the convenience of that appeals. However, this inevitably leads to peaks and troughs in demand. Busiest times reported were Mondays and early evenings. Quietest times reported were very early mornings. In the absence of data on waiting times, it is difficult to comment on the average length of wait, but this must vary throughout the day. Occasionally, during very busy periods, several walk-in centres have experienced waits of up to two hours to see a nurse practitioner or doctor. One person commented that waiting times are going up at their walk-in centre.

Nurses reported that the amount of time taken to consult with patients varied hugely depending on what they had come about. One person commented:

Some take 40 or 50 minutes, I mean if they need to talk, then you can't do much about it ... I don't think we should have to stop them talking.

One walk-in centre reported that their average consultation time was 12 minutes, while another person said it was 20 minutes at their walk-in centre. A GP working at a walk-in centre said:

I probably have at least five minutes longer per patient here than at my surgery and if we're not busy I spend even longer.

Key points

- No appointment is needed to attend a walk-in centre.
- Busiest times reported were Mondays and early evenings and quietest times reported were very early mornings.
- Consultation length is longer than in 'traditional' general practice.
- Some walk-in centres have experienced waiting times for patients of up to two hours to see a nurse or doctor at very busy times.

5.3.4 Computer systems

It was expected that walk-in centre staff would use decision support software during consultations from when they first opened. Some of the walk-in centres have piloted different makes of decision support software. The system piloted most frequently was the Telephone Advice System (TAS), and in general it was not found to be helpful. Resources have been wasted by several walk-in centres investing in systems that are now being replaced.

It was thought that ideally walk-in centres would use the same software as NHS Direct to improve continuity in the care given. However, the decision support software available is designed for telephone consultation rather than face-to-face use and several nurses commented that the systems available are over-sensitive in this setting. For example, if the patient says they are short of breath, then the software takes the nurse down a specific course of action which may be inappropriate if the nurse can see that the person does not look breathless.

The walk-in centres have now been told to all start using the NHS Clinical Assessment System (CAS) by August 2001. To use this system, each nurse must undergo five days of training. Some walk-in centres have experienced considerable difficulty in releasing people for training while still maintaining a service for patients.

Key points

- Suitable decision support software for face-to-face use has not been available so far in the walk-in centres.
- A new system called NHS CAS will be introduced from August 2001.
- It may be difficult for walk-in centres to release staff for sufficient time to be trained on the new computer system.

5.3.5 Patient group directions and supplying medication

Nursing staff at the walk-in centres use patient group directions to supply medication to patients. Patient group directions are protocols, which when signed by a doctor and agreed by a pharmacist, act as a direction to a nurse to supply or administer prescription medicines based on their own assessment of patient need. Some nurses

felt that their practice was being restricted by the time taken to draw up patient group directions and protocols.

Each walk-in centre has developed its own patient group directions. In centres where a minor treatment centre already existed, some patient group directions were already available and this saved work at the beginning. In the other centres the agreement of these with staff at local trusts and health authorities has created a large workload.

Patients are supplied with medication from stock maintained at the walk-in centres and pay a prescription charge in the same way they would in a pharmacy.

Key points

- Nursing staff at the walk-in centres use patient group directions in order to supply medication to patients.
- Each walk-in centre has developed their own patient group directions and this has created a large workload.
- Patients are supplied with medication from stock maintained at the walk-in centres and pay a prescription charge in the same way they would in a pharmacy.

5.3.6 Central guidance versus local control

As the NHS walk-in centres opened so far are all pilot sites, the aim is to use their experience to inform future developments. The walk-in centres have therefore been given some freedom to develop differently. An advantage of this has been the ability to be responsive to local needs. However, some aspects of the organisation of the walk-in centres have been closely controlled by central guidance from DoH. To some extent, tension has been created between central guidance and local control. One person commented:

The centre needs to ease up and let people do their job.

An example of this tension is that walk-in centres are under pressure to expand the range of services provided and to introduce innovation in the types of services. Walk-

in centres have been asked to introduce additional core services, including cholesterol testing, phlebotomy (blood taking), blood pressure checks and emergency contraception. Some walk-in centres operate at the same location as acute hospital trusts, where services such as phlebotomy are already provided, and see the introduction of these as duplicating existing services. Other local stakeholders may object to the introduction of tests, such as cholesterol testing, without agreement over how patients with abnormal results will be followed-up and managed. A GP commented:

They shouldn't be doing any chronic disease management ... they shouldn't be doing cholesterol screening. There are lots of models of checking blood pressure outside supermarkets and there is no evidence base for it. It needs to be evidence-based policy.

Walk-in centres have been set targets centrally to triage people within 15 minutes and see them within 30 minutes. Central guidance has also been issued to them over opening times and the fact that they must not close their doors during those hours, even if many people are waiting. One walk-in centre, when forced to open on Christmas day, only saw one person. At times, walk-in centre staff may feel that it is appropriate to close for team meetings or training, but they do not have control over this.

Areas that were highlighted as appropriate for greater central guidance were on staffing issues, such as background, induction and grading of nurses and GP support. A lead nurse at one of the centres commented:

The biggest issue for me is one around grading and training ... if you look across the country in terms of grades and skills [they are very different] the Government wants people to get the same level of treatment if they walk into Edgware or Soho, but you can't do that without getting the grades and skills right.

However, one centre manager commented that greater central guidance would mean that learning from the diversity of the pilots would not occur.

Several lead nurses suggested that patient group directions should have been developed centrally in order to reduce the workload created. One nurse commented:

The DoH could have been more supportive ... for example, patient group directions could have been developed centrally.

Local flexibility and variation in services between walk-in centres also creates a tension in terms of advertising the services. The advertising materials may lead patients to believe that they can come to a walk-in centre with any problem and also that each walk-in centre will provide them with the same services. A GP commented:

The Government has said you walk-in and get what you want ... the propaganda exceeds the reality.

Key points

- There is pressure from the centre to increase the range of services offered, including services such as phlebotomy, cholesterol testing and blood pressure measurements, but there is some local resistance to this.
- Many staff felt that more central guidance on staffing issues, such as background, induction and grading of nurses and a co-ordinated approach to developing patient group directions would have been helpful.
- Difficulties arise between central advertising of walk-in centres, which may give patients the impression that each walk-in centre will provide them with the same services, and local variability in provision.

5.4 Staffing of walk-in centres

In the absence of central guidance on the number, grade, previous experience and initial training of walk-in centre nurses, each one has evolved differently.

5.4.1 Staffing levels, grade mix and GP support

The staffing levels, grade mix and level of support from GPs are shown in Table 5.1.

Table 5.1 Staffing levels, grade mix and level of support from GPs

Walk-in centre	No. of nurses	Grade mix	GP support
Soho	9 wte	1 H grade 8 G grades	5 sessions/week
Newham	9.7 wte	0.7 I grade 9 G grades	1.5 wte GPs
Tooting	9.5 wte	2.6 H/nurse consultant grades 1.7 G grades 3 F grades 2.2 E grades	GP present from 7.30 p.m. to 10 p.m.
North Middlesex	14 wte	0.5 I grade 1 H grade 9 G grades 3.5 E grades	2 sessions/day, each for 3 hours
Whitechapel	12 wte	1 nurse consultant 2 H/I grades 9F/G grades	1 GP on site all the time (3 wte)
Charing Cross	6.5 wte	1 H grade 5 G grades 0.5 F grades	None
Parsons Green	6.5 wte	1 H grade 5 G grades 0.5 F grades	Local GP co-op covers evening sessions from site; will see some patients
Croydon	9.5 wte	0.5 nurse consultant 0.7 H grade 4 G grades 4.3 E grades	3 hours/day (GP advice for nurses available all the time by telephone)
Edgware	9 wte	1 H grade 4 G grades 4 F grades	4 sessions/week (for three months initially)

On the subject of skill mix, one lead nurse commented:

We were initially told we have to have skill mix but I couldn't see how they [junior nurses] would function.

Since nurses were largely seeing people with undifferentiated medical problems, the nurse felt that there would be a very limited role for staff of more junior grades. However, other lead nurses commented that positions for less experienced nurses could be seen as training positions, with nurses able to work their way up to being a fully trained walk-in centre nurse practitioner, and that junior nurses also had a role in providing services, such as dressings and phlebotomy.

The walk-in centres differ in terms of the extent to which they employ GPs to do sessions. At one centre, local people had become aware of when the GP sessions were and turned up specifically to see the doctor. The GP sometimes had up to 20 patients already waiting to see them when they arrived. Walk-in centre staff were concerned that people using the walk-in centres often expected to see a doctor rather than a nurse and one nurse commented:

Public expectation is that, like every other service, you go and see a doctor.

5.4.2 Recruitment and retention of staff

Recruiting suitable staff has generally proved to be difficult in London. Some of the posts listed above are vacant and some shifts are filled by agency or bank staff. One lead nurse commented that:

Recruiting has proved to be difficult; we haven't been able to recruit up to the full. [In] London in general [it] is difficult to recruit and the fact that walk-in centres are new ... in the first year ... it's taking time to warm up to them. Recruitment is a big issue, there are lots of us looking in the same pot ... A&E, NHS Direct, us [walk-in centres], all those who want to be at the forefront.

Project managers reported that recruitment of practice and community nurses was particularly difficult. The long hours and shift patterns operated by walk-in centres are unattractive to most practice nurses compared with their current working hours. Shift systems, evening and weekend work and a high patient throughput were all more familiar to A&E nurses. Walk-in centre work was also regarded by some nurses as carrying greater responsibility than practice nursing, without necessarily being rewarded by a higher grading or salary. Comments included:

The sort of nurses we're looking for would be getting an H grade in the community or [general] practice on the whole and the hours are quite favourable so often it's not that easy to attract people.

These places should be run by nurse practitioners, but we have had to recruit at a level below that and train people up and that has clinical risk management issues.

Key points

- In the absence of central guidance on the number, grade and background of nursing staff and support from GPs, each walk-in centre has evolved differently.
- Recruiting suitably qualified staff, particularly from practice and community nursing backgrounds, has generally proved to be difficult in London.

5.5 Induction period for staff

The walk-in centres differ in the length and type of induction that new staff receive. At each centre, the induction period is tailored to the needs of the individual. Some centres were able to have a lengthy induction period before opening, for example, Edgware had six weeks prior to opening during which time the staff underwent induction, training and had time to bond as a team, while Croydon had 20 weeks due to delays in building work. Other centres had to carry out the induction of new staff after they were already open, while still maintaining a service. The induction period, and its content, of each walk-in centre is shown in Table 5.2.

Table 5.2 Induction period and content at London NHS walk-in centres

Walk-in centre	Induction period
Soho	Two-week induction prior to opening included examination skills, minor injuries unit, sexual health, homeless centres
Newham	Three-week induction, with first week spent on induction to the Trust, pharmacology and computer training, and weeks two and three were spent as a supernumerary nurse, sitting in with other nurses
Tooting	No set length of induction, varies with individual needs
North Middlesex	Two-week induction into local procedures, how the walk-in centre and local A&E department are run, and basic life support. Further induction based on individual needs
Whitechapel	Two-week induction, including local procedures, RCN course on physical assessment, and topical clinical issues
Charing Cross	Four-week induction (one week if bank staff). Content depends upon individual needs, with emphasis on physical assessment and consultation skills
Parsons Green	Four-week induction (one week if bank staff). Content depends upon individual needs, with emphasis on physical assessment and consultation skills
Croydon	Around 20 weeks' induction period, including clinical assessment skills and teaching on paediatrics, mental health, minor injuries, minor illness, pharmacy and prescribing and family planning. There were also opportunities to shadow school nurses, district nurses and nurse practitioners at other walk-in centres, and to visit services such as NHS Direct and Citizens Advice Bureau
Edgware	Six weeks' full-time induction prior to opening, including RCN course on physical assessment, resuscitation, and specific topics, such as ear, nose and throat and skin complaints

5.6 The nursing role in walk-in centres

Walk-in centres are a new setting for providing nurse-led primary care. They provide opportunities for both extending the nursing role and challenges in terms of clinical skills. Nursing staff reported being attracted to working in walk-in centres as they were at the forefront of nursing. One person commented:

I'm happy to be at the cutting edge of nursing reform.

5.6.1 Backgrounds of nurses

Nurses employed at walk-in centres have very variable backgrounds. Many have worked in A&E departments or minor injuries units. Some have worked as practice nurses. Other previous occupations have included occupational health, drug and alcohol counselling, health visiting, palliative care, district nursing, midwifery and paediatrics. One lead nurse suggested that, when recruiting staff, they looked for aspects of personality, maturity and confidence rather than at the setting in which applicants had been previously working.

5.6.2 Extending the nursing role

The nurses described two key challenges in their new roles. Firstly, the requirement to combine clinical assessment – a core part of the nursing role – with diagnosis and creation of a treatment and management plan. Secondly, was the diversity of patient case mix in walk-in centres.

Diagnosis and treatment

While many of the walk-in centre nurses had experience of assessing and describing a patient's clinical problems, and of providing treatments such as stitching and plastering, few were used to making their own diagnosis and developing a treatment or management plan. Their confidence in doing this reflected the degree to which they had previously been practising autonomously. In the words of one nurse:

The main difference is sending people home. It's a new challenge. In A&E it was always the doctor's responsibility – even though they [the

more junior doctors] may have come and ask me ‘what’s this’ or ‘what’s that’ and I could reel it off ... Now it’s part of our responsibility. At the start we were very aware of what we didn’t know and A&E got loads of referral from us.

In situations of uncertainty, one option was to seek a second opinion from a nursing colleague. The nurses described good teamwork, with other nurses always willing to review a patient if a colleague was unclear about a diagnosis or treatment plan.

A second option was to refer patients to a GP linked to the walk-in centre. All centres now have at least some support from GPs – though not necessarily available at all times. At times when a GP was not available, the nurses would either ask patients to come back or refer them to the patient’s own GP, the out-of-hours GP service, A&E departments in their hospital, or directly to the relevant specialist on call. Data on the number of referrals made in each walk-in centre were not available, but each nurse typically referred one or two such cases per week.

One manager explained that a GP was not recruited until a few months after the walk-in centre opened. She felt strongly that this had helped the centre’s nurses to develop a greater sense of autonomy:

If we had started a service ... with GPs around from the beginning, then right from the start you sink into a relationship where you think I can’t finish this, I must give it to the GP to finish off. That gives the nurse no real autonomy. Starting off without a GP gave us the freedom to discover that we could complete cases ourselves.

In fact this centre was co-located with a GP out-of-hours co-operative and the evening nursing staff had been able to ask, informally, for advice from co-operative doctors. During the day, the highly experienced lead nurse could provide support to the other nurses. The extent to which arrival of a resident GP will affect nursing autonomy remains to be seen, but the manager remained concerned:

I will worry that now we are [about to get] lots of GP back-up, we'll slip into the old-fashioned GP–nurse relationships.

Coping with a varied case mix

While most walk-in centre patients present with common clinical problems, a small number have more severe problems, multiple symptoms or request a second opinion or referral for a long-standing condition (see Section 5.2).

Coping with this varied case mix required a combination of clinical skills and flexible arrangements with other services. The nurses were trained during their induction period to take a full medical history and examine each of the body systems. Vague symptoms, such as dizziness and headaches, were described as the hardest to assess, since they could reflect a wide range of clinical problems, while abdominal pain was also difficult for some nurses. Assessing and diagnosing such patients presents a real challenge to walk-in centre nurses and 'second opinions' from nurse colleagues or a GP, if available, were an important resource in such situations. Referral to A&E departments or on-call hospital doctors was used as a safety net in more severe cases. Patients with clinical problems beyond the scope of the walk-in centre could be identified in advance in walk-in centres using a triage system and referred elsewhere. People requiring investigations were typically referred either to an A&E department or to their GP if registered. In these situations, the nurses emphasised the role they could play in reassuring patients and in providing opportunistic information or health promotion advice.

Challenges for walk-in centre lead nurses

Lead nurses have a wider range of responsibilities than the rest, including protocol development, leadership, training and supervision of other staff. The greatest challenge noted by one lead nurse was her own role in developing the skills and competencies of walk-in centre nurses to their full potential:

None of the nurses have the full range of experience you need in a walk-in centre. One piece of training which I have said is mandatory is doing the minor injury module at [X] University. It's a self-

directed study course with a doctor mentor. The rest depends on an individual assessment of each nurse. They have a very structured and supported start at the walk-in centre, including some sessions when I observe them. After a couple of months I discuss with each nurse what her needs are and we work out how to fill in the gaps. This may include pharmacy training about safe prescribing and how to take a drug history, A&E training, the emergency nurse practitioner course.

Key points

- Walk-in centres provide opportunities for extending the nursing role and nursing staff reported being attracted to working there as they were at the forefront of nursing.
- Major challenges were diagnosing and treating patients autonomously and coping with the varied case mix.
- Lead nurses have a wider range of responsibilities than the rest, including protocol development, leadership, training and supervision of other staff.

5.6.3 Interface between the nursing and GP role

Given the varied case mix seen by walk-in centre nurses, many struggled to describe how their role fitted in between ‘traditional’ nursing and general practice. Several stressed that they were not ‘mini’ GPs, emphasising that their nursing training equipped them to do something beyond GP-style consultation. When pressed on what this distinction involved, nurses emphasised the importance of communicating with patients, giving them space to tell their stories and not rushing them:

We’re able to listen to people here, take time to listen and let them tell their stories. They want somebody to hear their story ... Loads of people here are really worried about their health. We can give them time which GPs and A&E staff can’t give them.

Patients have high expectations of what we can do ... We mustn’t rush them. We mustn’t feel so pressured that we send people out too soon.

If we cut out all the frills we'll be just like GPs.

But other comments contradicted these views. One centre manager noted the similarity between walk-in centre attenders and the people seen in a typical GP waiting room, with plenty of coughs and colds, headaches and tummy aches. A nurse interviewee explained:

We don't want to be mini-doctors but we do need to make sure we can deal with all the chronic cases. It would be very reassuring to know how GPs do it ... Just look at my bookshelf. It's got GP textbooks not nursing books. And I want to see the [British Medical Journal] ... I'm past reading the Nursing Times and Nursing Standard.

Key points

- Walk-in centre nurses struggled to describe how their role fitted in between 'traditional' nursing and general practice.
- Nursing staff emphasised that their nursing training equipped them to do something beyond GP-style consultation, with emphasis placed on communicating with patients.
- Similarities were noted between the kind of problems people bring to walk-in centres and the types of problems presented to GPs.

5.6.4 Fit with previous experience and role stresses

Many of the nurses employed have worked in A&E departments or minor injury units, both of which equip them well for walk-in centre work. Those with practice nurse experience emphasised its importance in relation to self care and health promotion advice. Nevertheless, each nurse had a different breadth of experience on which to draw in their current role and few had extensive clinical experience of diagnosing and managing patients autonomously.

Key causes of stress included:

- The constant pressure of patients waiting to be seen and thus the tension between taking the time necessary for each patient and avoiding long waits to be seen.

- Seeing patients who expect to be treated at the walk-in centre but whose condition requires additional facilities and who must be referred to another setting.
- Uncertainty about the diagnosis or management plan for a small number of patients, particularly at times when only one nurse is working and colleagues are not around to give a second opinion.
- Feeling that they need to be able to give an answer to every problem.
- For lead nurses, a major stressor was the bureaucracy created by DoH involvement in developing the walk-in centre and by the requirement to develop local protocols and prescribing directives.
- Limited feedback on patients, leading to difficulty knowing whether initial diagnosis and management were appropriate.

The challenges of working long shifts and seeing a fairly undifferentiated case mix also created some stress for walk-in centre staff. As one manager explained:

One of the biggest worries I have after speaking to other managers is that the nurses have at last been given the autonomy they've been shouting for and they can't cope with it and feel very unsupported.

Key points

- Each nurse had a different breadth of experience on which to draw in their current role and few had extensive clinical experience of diagnosing and managing patients autonomously.
- Causes of stress were waiting times, uncertainty over diagnosis, people who needed to be referred and limited feedback on what happened to patients after they were seen.
- For lead nurses, a major stressor was the bureaucracy created by DoH involvement in developing the walk-in centre and by the requirement to develop local protocols and prescribing directives.

5.6.5 Training, education and support

Each walk-in centre has developed a wide-ranging induction programme (see Section 5.5) and an on-going education programme for its staff. Furthermore, each has a

generous training budget to pay for courses on minor injuries, minor illnesses and nurse practitioner skills, which are the ‘bread and butter’ of walk-in centre work. A key role for the lead nurse lies in identifying and meeting the training and development needs of centre nurses, each of whom has a different clinical background and breadth of experience. The need to balance study leave with the staffing levels needed for a prompt, high-quality service has led to some London walk-in centres having to increase the number of core nursing staff.

One lead nurse raised questions about the most appropriate type of training and experience for walk-in centre nursing, emphasising her belief that clinical experience, learned in an apprentice-type setting, was every bit as important as formal nursing education, much of which was more theoretical than practical. She used a combination of supervised sessions and individual reviews to assess the clinical competence and training needs of each new nurse who joined the centre. This approach was similar to the way new GP registrars are assessed by their trainers in order to identify training and development needs. However some centres reported finding it difficult to have regular team meetings and training due to service commitments.

In addition to formal training and education, walk-in centre nurses obtained important, ongoing support from their colleagues and peers in other centres. There was a strong sense of teamwork in the walk-in centres, with a universal commitment to discuss difficult cases, ask for advice when at the limits of previous clinical experience and to accept personal limitations and refer patients on. Evolving relationships with A&E departments and hospital on-call teams were starting to result in protocols for the seamless transfer of patients to these services when necessary.

Key points

- Each walk-in centre has developed a wide-ranging induction programme and an on-going education programme for its staff.
- Walk-in centres are finding it difficult to balance study leave for staff with the staffing levels required to provide a prompt, high-quality service.
- There was a strong sense of teamwork in the walk-in centres, with a universal commitment to discuss difficult cases, ask for advice when at the limits of previous clinical experience, accept personal limitations and refer patients on.

5.7 Ensuring the quality of services provided

On-going training and education of staff and treatment in accordance with patient group directions are important determinants of the quality of walk-in centre services. All of the walk-in centre staff recognised the importance of auditing their activity. Walk-in centres are all involved in collecting monitoring data for DoH, while some have also been carrying out their own local audits. These included auditing the quality of documentation in patient notes and management of sore throats, while Edgware was auditing their referrals to the Urgent Treatment Centre. One lead nurse commented that it was hard to find time for local audit and that nurses, other than the lead nurses, found it difficult to be involved due to service commitments.

Comments from staff about the quality of services provided at walk-in centres included:

People are very happy with it so far.

Patients are completely satisfied on the whole.

The subjective views of staff will be complemented by data on patient views when the national evaluation of walk-in centres reports.

Key points

- On-going training and education and treatment being provided under patient group directions are important in the delivery of a high-quality service.
- Walk-in centre staff recognised the importance of auditing their activity, all were involved in collecting monitoring returns for DoH, and some had been working on their own local audits.
- Staff at walk-in centres felt that patients were generally happy with the service provided.

5.8 Working with other local services

All of the walk-in centre staff recognised the importance of developing links between themselves, A&E departments, primary care providers and other local services.

5.8.1 Links with hospital services

Walk-in centres are developing links with the A&E department, trying to develop two-way referral guidelines and at some centres working on a shared system for triage. One person commented:

With A&E we've got an agreement that they will accept our triage [if people need to be referred across] and that the waiting time will be from when the person first started waiting at the walk-in centre ... but there are some problems with it still.

There were also important issues to be resolved relating to referral direct to specialists without going via the A&E department. Examples given by nurses of things they had referred directly to specialists included tendon injuries and alopecia. One nurse commented:

It's tricky ... are you going to be accepted ... it's a doctor nurse thing but if you speak the right language then it's not a problem.

It was recognised that referring patients for chronic conditions or those requiring follow-up, e.g. for back pain or breast lumps, was not appropriate and should be done via a GP.

Key points

- All walk-in centres are developing links with the A&E department, trying to develop two-way referral guidelines and at some centres working on a shared system for triage.
- There were important issues to be resolved relating to referral direct to specialists without going via the A&E department.
- It was recognised that referring patients for chronic conditions or those requiring follow-up, e.g. for back pain or breast lumps, was inappropriate and should be done via a GP.

5.8.2 Links with general practice

All the walk-in centres saw facilitating access back into ‘traditional’ primary care as a priority. Some had systems in place on site for registering patients who were not registered with a GP. A PCG chair commented that in terms of facilitating registration with local GPs their centre had not been as successful as they had thought it would be. One lead nurse commented that she would have liked walk-in centre nurses to be able to go and sit in with local GPs as part of their training, but that they wanted to be paid and the cost was too great.

If the patient has a local GP, then a copy of the nurse’s notes is faxed or posted to the GP if the patient gives permission. In some walk-in centres, the fax is generated automatically by the computer system. If the patient is not local but has a GP, then in general they are given a letter to take to their GP. Nursing staff did not find it a particular problem that they had no previous records on the patient; they simply said that it takes longer to see people because they had to gather more information. The main problem for them in terms of continuity was that they did not generally get any feedback on what they had done and whether the person had got better and therefore they missed out on an important learning opportunity.

Several of the sites have the local GP ‘out-of-hours’ co-operative based in their premises. Relationships have been fostered through this mechanism and in some cases the GPs see walk-in centre patients if the nurse practitioners ask them to. Some of the walk-in centres have, since the beginning of April, become part of PCGs or PCTs.

Key points

- All of the walk-in centres saw facilitating access back into ‘traditional’ primary care as a priority.
- All the walk-in centres have systems in place to communicate information back to patients’ GPs if the patient agrees.
- Relationships with local GPs have been fostered through GP ‘out-of-hours’ co-operatives working from the walk-in centre premises. Some walk-in centres have been incorporated into PCGs or PCTs.

5.8.3 Impact on other services

We did not have data on the trends in numbers of people being seen at A&E departments or by primary health care teams near to walk-in centres. A GP in a practice near to a walk-in centre said that they had not noticed any change in their workload since the centre had opened and an A&E nurse commented that:

Their numbers have shot up but ours haven’t gone down comparably.

People working in other settings felt that resources had been thrown at walk-in centres, rather than, for example, the A&E department or ‘traditional’ primary care, and that it was not necessarily the best use of resources. However, one PCG chair did point out that it might have been difficult to increase access for patients in ‘traditional’ primary care settings.

6. Key issues raised by walk-in centres

The London NHS walk-in centres, which opened during 2000, are making good progress in developing their services. Each walk-in centre has evolved differently. This reflects their differing local priorities, location, relationship to other organisations and also the absence of central guidance on key issues, such as staffing.

Why do people use NHS walk-in centres in London and what services are available?

We did not have access to the DoH's routine monitoring data to describe the types of problems that patients bring to walk-in centres. From the staff interviews, it appears that most people are attending with minor illness, such as viral and urinary tract infections, or to obtain emergency contraception. Staff have been surprised by the complexity of the case mix. A minority of people attend for repeat drug prescriptions or for chronic health problems, hoping to be referred to hospital for their condition. Triage systems are being introduced at most walk-in centres that should allow people who cannot be managed there to be redirected swiftly to more appropriate services.

Local variation in the services provided between walk-in centres creates a difficulty in terms of advertising the service. Centrally produced advertising materials may lead patients to believe that each walk-in centre will provide them with the same services. The reality is that the role of walk-in centres does – and should – vary, depending on the locality, population served and on other local services provision. A survey in Wakefield revealed that local people had considerable support for a walk-in centre but that they expected a choice of whether to see a nurse or a doctor and treatment for a wide range of problems, including mental illness, while 58 per cent of respondents said they would use the centre for an chronic illness, such as asthma.⁶ A key challenge for walk-in centres is to be clear about their role, communicate their role to the public and thereby improve the match between public expectations and service provision reality.

When the national evaluation of walk-in centres reports, we will have data on the average length of consultations that people receive at walk-in centres. Our impression

was that the consultations provided by walk-in centres were longer in length than those available in ‘traditional’ general practice. Patients report greater satisfaction with longer consultations and duration correlates with patient enablement.^{7,8} But the cost-effectiveness of longer consultations and opportunity cost to the NHS should be considered. Informed debate is needed over whether extending access to this type of service is a priority for the NHS.

Central guidance versus local control

In addition to providing services for minor illness, and in some cases minor injuries, walk-in centres have been issued central guidance to introduce additional core services. These include cholesterol testing, phlebotomy and blood pressure checks. A key feature identified for walk-in services is that care or advice should be given for the immediate problem with no follow-up or continuing care; if further care is needed patients should be advised to attend other services. Some people interviewed for this study were concerned that if services such as cholesterol testing are introduced into walk-in centres, then difficulties may arise regarding who will follow-up and arrange on-going management for patients with abnormal results. Tension between central guidance over what services should be provided and appropriateness within a local context need to be resolved.

Problems with information technology have also hampered the early progress of walk-in centres. Suitable decision support software, for face-to-face use, has not been available to date. Several centres wasted resources on information technology systems that were then outdated by DoH instructions to all centres to change to a new system, NHS CAS. Releasing staff for the time required to undergo training, while also maintaining a full service, is a problem for some walk-in centres. The problems with information technology need to be resolved before walk-in centres are rolled out further.

Staffing of walk-in centres

The staffing arrangements are different for each of the London NHS walk-in centres. Some centres have recruited a skill mix that includes E and F grade nurses, while other centres have all G grade nursing staff apart from the lead nurse. It is not clear

whether or not the differences in services offered between walk-in centres are in line with the differing skill mix, or how the roles and responsibilities of nurses on different grades are demarcated. It appears that most nurses, apart from lead nurses, are expected to undertake a similar role with similar responsibilities, i.e. deal with undifferentiated medical problems. The advantages and disadvantages of nurse practitioner grade only versus skill mix have been previously highlighted in a minor injuries unit setting.⁹ Issues of optimal mix of nursing grades and the roles of different grades of nurse in walk-in centres need to be resolved.

Recruitment of suitably qualified staff to walk-in centres has generally proved difficult in London. Recruitment and retention of nursing staff is difficult in many parts of the NHS,^{10,11} and walk-in centres exert additional pressure on that scarce resource—highly qualified nurses. The impact of recruiting nurses to posts in walk-in centres on other NHS services needs to be considered if the initiative is to be expanded.

Walk-in centres and extending the nursing role

Walk-in centres extend the limits of traditional nursing to include diagnosis, treatment and the authority to discharge patients from further clinical follow-up. This level of responsibility underpinned why many of the nurses interviewed were enjoying their job, but it was also a cause of stress, particularly while they were developing confidence in their clinical skills and judgement.

The availability of ‘second opinions’ from other nurses or doctors associated with the walk-in centres provides an important safety net in cases of clinical uncertainty. However, one manager questioned whether it jeopardised the development of autonomy in the centre’s nurses to have doctors too easily available.

Challenges to the nursing role occur in a variety of ways. The need to keep waiting times to a minimum created some role stress and, at times, conflicted with core nursing roles of providing holistic care and allowing patients the time they need to talk about their problems.

The diversity of the patient case mix tested the nurses' diagnostic skills to the full. But while one manager described walk-in centre reception areas as 'just like a GP waiting room', many nurses were adamant that they were not just 'mini-GPs'. It remains to be seen whether pressure to keep waiting times to a minimum force the nurse–patient encounter in walk-in centres to become shorter and more like current interactions between GPs and patients.

We did not aim to evaluate the clinical outcomes of care, but with nurses working at the limits of their prior experience, this is clearly an important question. Research on extending nursing roles in general practice generally show patient satisfaction to be higher after consultation with nurses than with GPs and does not describe adverse clinical events associated with nurse consultations. They demonstrate that most nurse consultations are longer than those with a GP. Results vary in terms of differences in referrals, prescribing and follow-up between nurses and GPs, but the studies generally lack power to detect significant differences in clinical outcomes.^{12–16} Direct comparison of walk-in centre services with these studies is difficult due to differences in nursing skill mix and case mix.

Findings from nine nurse-led personal medical services (PMS) pilots are also relevant. Lewis argues that nurse-led services have been popular with the client groups involved.¹⁷ He also reports concern among participating nurses about the wide range of competencies they are expected to demonstrate and the lack of standards, qualifications and training criteria to shape and support the work of the nurse practitioner.

This work raises a key challenge for the future development of nurse-led primary care services in general and walk-in centres in particular. What training and experience is required to equip these nurses – recruited from a range of clinical backgrounds – to do their job? All have a slightly different range of knowledge and skills, and so far, no standardised person specification has emerged for walk-in centre work. The lead nurses interviewed differed in their attitudes to the importance of formal qualifications compared to practical experience. Nurse practitioner courses were felt by some to be too theoretical, and thus less good for developing skills in examination and diagnosis.

Similar issues were raised by Roberts-Davis in her study of innovative nursing roles in Canada.¹⁸

Lack of a clear terminology for specialised nursing roles makes it difficult to pin down the core competencies that walk-in centre nurses might be expected to have. The responsibilities of walk-in centre lead nurses for clinical work, leadership within their organisation, training and service development are clearly compatible with definitions of the advanced nursing role. But the nature of the role of other walk-in centre nurses, and the ideal background and training required to fulfil it is less clear.

The policy document *Making a Difference* proposes a new career progression for nurses with four distinct grades linked to responsibilities and competencies needed for each grade.¹⁹ There is however no specific detail on what these are. Explicit discussion of this detail is necessary to guide the future development of walk-in centres.

Training and development for walk-in centre staff

Walk-in centres differ in the length and type of introductory training given to new staff. Some centres provided a lengthy induction period before opening whereas other centres had to carry out the induction of new staff once already open and maintaining a service. Introduction of standardised induction procedures across the walk-in centres would be helpful for new staff.

Like GPs, walk-in centre nurses are faced with a wide array of clinical problems; systems to help them cope with this diversity will be important. It may be that lessons can be drawn from the training of GPs. It is only in recent years that this has become formalised into a structured assessment process, guiding development towards becoming an independent practitioner. GP registrars start with a cluster of clinical experience and the gaps are filled systematically during the training year – through a combination of taught courses, apprenticeship learning with a trainer, individual practice and self-directed learning.

Lead nurses in several London walk-in centres are, to some extent, recreating such a system – albeit more informal – in their own centres. But as the number of centres grow, along with the number of nurses working in them, this mentor-type role will need to be shared with others. One lead nurse’s vision of new walk-in centre nurses linked to more experienced colleagues, who act as mentors and training advisors, offers a possible model. This could be linked to external training courses for developing the clinical and diagnostic thought processes that are not currently a core part of the nursing curriculum. The generous training budgets available to first-wave walk-in centres make this a possibility. It remains to be seen whether the same level of personal development will be available if walk-in centres are rolled out further.

Quality of walk-in centre services

We did not aim to evaluate the quality of service provided by walk-in centres. However, quality assurance and clinical governance is a key concern for walk-in centres and the interviews allow us to make some observations. Patient group directions being used²⁰ should help to assure the quality of prescribing. The lack of feedback on patients referred to other services represents a lost opportunity for learning and improving quality. All the walk-in centre staff recognised the importance of auditing their activity. Comments that it was difficult to find time for local audit, and for nurses other than the lead nurses to be involved due to service commitments, create a dilemma. Involvement of individual staff will be important both for quality assurance and personal and professional development, but may disrupt patient care. Quality assurance systems should be developed and all walk-in centre staff must be involved in auditing their activity.

Working with other services

All of the walk-in centre staff recognised the importance of developing links between themselves and other local services. They are working hard with local A&E departments, trying to develop two-way referral guidelines. There are important issues to be resolved relating to referrals directly from walk-in centres to specialists, such as the type of problem that can be referred and who can refer them. Some walk-in centres are evaluating their referrals to other services, though defining appropriate referral patterns will be difficult.

The General Practitioners Committee (GPC) has said that, with the current shortage of GPs, walk-in centres could help to address the growth in workload and respond to demands for wider access, but is concerned that the centres could generate additional demand.²¹ The national evaluation of walk-in centres is collecting some data on the impact of walk-in centres on other local services, although as with NHS Direct,²² it is methodologically difficult to produce strong evidence of an effect. The GPC also commented that the key features of general practice must not be lost – the comprehensive medical record, the link between patients and practices and the GPs' gatekeeper role.

In both Canada and the USA, extending the nursing role, particularly the development of primary care services run solely by nurses, has met with a degree of resistance from the medical profession.^{23,24} There has been resistance to NHS walk-in centres from some GPs,²⁵ but also reports of GPs coming round to the idea.²⁶ Walk-in centre staff involved in this project recognised the importance of working closely with local GPs. All of the walk-in centres saw facilitating access back into 'traditional' primary care as a priority. Several of the sites have the local GP 'out-of-hours' co-operative working from their premises. Relationships have been fostered through this mechanism.

There was, however, an element of scepticism from local stakeholders over the generous resources allocated to walk-in centres compared to the A&E department or 'traditional' primary care. Not everyone was convinced that walk-in centres represent the best use of NHS resources and concerns were voiced over what will happen when the three years of funding as pilots comes to an end. One walk-in centre manager said:

Year after year the NHS gets cutbacks ... at some point it will start to affect us ... that will create a backlash when luxury services like us are in the same pool.

The integration of walk-in centres into local PCGs or PCTs should at least ensure that their development is in line with other local primary care service priorities.

The future of walk-in centres?

The walk-in centres set up so far are all pilot projects; as such, their experience should inform future developments. If walk-in centres are to be rolled out, then the following key issues need to be considered:

- Walk-in centres need to be clear about the role they perform within their locality and to communicate this to the public, so ensuring a good match between public expectations and service provision reality. National guidance should not prevent service development being based on a thorough examination of local needs.
- Walk-in centres can offer longer consultations, at times and in locations that are convenient for patients. Explicit discussion is required on the balance between patient convenience and satisfaction, patient throughput and the opportunity cost to the NHS.
- The optimal mix of nursing grades and the roles of different grades of nurse must be clarified and the impact on other NHS services of recruiting nurses to posts in walk-in centres should be considered.
- Working in a walk-in centre is stressful and nurses are working at the limits of their clinical experience. The background, experience and core competencies required to equip walk-in centre nurses to do their job needs to be agreed and necessary systems for supervision and training must be put in place.
- Quality assurance systems should be developed and all walk-in centre staff must be involved in auditing their activity.
- Close links between walk-in centres and other local primary care providers should be fostered, in particular regarding staff training and development, registering of unregistered patients, and a potential role in 'out-of-hours' provision.

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