

# Part 1

## Setting the Scene of Practice and Walk-in-Centre Nursing

In the chapters that follow in Part 1 of this book, the historical development of practice nursing and walk-in-centre nursing are explicated. The context of practice is delineated in relation to advanced practice, as it is recognised that practice nurses and walk-in-centre nurses are now working at an advanced practice level. Part 1 sets the scene for the professional issues chapters that follow in Part 2 of this book.



# The historical development of practice nursing and walk-in-centre nursing

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## Introduction

The aim of this chapter is to explore the historical background in the growth of practice nursing (PN) and walk-in-centre (WiC) nursing in the UK. The reasons for growth in these two distinct nursing groups are examined and related to governmental health policy. A critical discussion ensues on the impact that both practice nurses (PNs) and WiC nurses have had on their respective communities.

### Learning Outcomes

- To understand the reasons for the growth in practice nursing
- To comprehend the reasons for the introduction of walk-in centres by the National Health Service (NHS)
- To be able to articulate the differences and similarities between practice nursing and walk-in-centre nursing:
  - a. the complexities and questions concerning the efficiency of walk-in centres
  - b. the possible future evolution of the National Health Service walk-in-centre concept.

## Background

In order to place our discussion in the appropriate context, we should begin by looking at the definition of the term primary health care. Unfortunately, there is no universally agreed definition (Peckham and Exworthy, 2003).

For example, in the Alma Ata declaration, the World Health Organization (WHO) defined primary health care as ‘essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally available to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination’ (WHO, 1978:VI:3–4).

Starfield (1998:8–9) indicated that primary care is ‘that level of a service system that provides entry into the system for all new needs and problems, provides person-focused (not disease-orientated) care over time, provides for all but very uncommon or unusual conditions, and co-ordinates or integrates care provided elsewhere or by others’, while Lakhani and Charlton (2005) argue that the definition of primary care will be dependent upon the identity of the care provider and the location of care provision as well as the type of service provided. Jones and Menzies (1999:3) support this view, that patients present themselves to general practice as the ‘first level of professional care, accessed when self-care is seemed inadequate’.

PNs and WiC nurses have cultivated and developed an important role in the provision of both treatment and health promotion services to patients in the context of primary health care. This emphasis is evident in the principles that underpin primary care. Drennan and Goodman (2007) have identified five principles that underpin primary care which are:

1. accessibility to health services;
2. use of appropriate technology;
3. individual and community participation;
4. increased health promotion;
5. disease prevention.

This concept of primary care, with the associated five principles, is the context within which we will examine, in turn, the development of both PN and WiC nursing in the UK.

## **Practice nursing**

The increasing role of the PN within primary care has seen a significant rise in numbers. In 1983, the numbers of whole time equivalent PNs in England and Wales were 1,729 (Williams, 2000). This figure rose to 7,520 in 1990 (Ross and Mackenzie, 1996) and to 23,797 in 2006 (Robinson, 2007). This meteoric rise in the numbers of PNs made them the largest branch of community nurses in 2001 (Macdougald et al., 2001). What has precipitated this huge growth in PN numbers? In order to understand why this growth has occurred, it is necessary to understand how governmental health policies have influenced this growth. Ham (1992) has argued that there is little agreement regarding the definition of policy. However, other writers have been more specific in defining health policy as having

guidelines for organisational action in terms of the implementation of its goals and action plans (Watson and Wilkinson, 2001).

Peckham and Exworthy (2003) argue that governmental policy interest in primary care only began to develop in the 1960s with a keener interest in the role of primary care and its organisation. They identified a number of key factors that have contributed to the growth in this area namely:

- an increase in the availability of medical techniques and technologies;
- the increasing need to provide community-based care for patients with long-term conditions;
- the need to increase access to health care following the introduction of the National Health Service in 1948;
- the shift of care from secondary to primary care (Peckham and Exworthy, 2003).

The general practitioner (GP) *Charter* in 1966 changed the way in which GPs were paid. Furthermore, the *Charter* gave GP incentives for procuring better premises and the reimbursement of ancillary staff, which culminated in the employment of PNs (Macdougald et al., 2001; Hampson, 2002). Although the 1966 charter led to a rise in the numbers of PNs, it was the GP contract of 1990 that significantly increased these numbers. In 1990 alone there was a 60% increase in PN numbers (Luft and Smith, 1994). The main changes in the 1990 contract were:

- an increased emphasis on capitation services, with the payment to GPs being directly related to the number of registered patients;
- the setting of target payments for certain procedures such as the administration of immunisations, cervical cytology and child health surveillance;
- additional incentives to run health promotion services (e.g. a designated hypertension clinic), undertaking minor surgery and working in deprived areas;
- the requirement to provide health checks for certain groups of patients, such as all new patient registration at a general practice, those patients having not attended a practice for 3 years and all those patients over 75 years of age (Ross and Mackenzie, 1996).

Taken together, the changes resulted in GPs being strongly motivated to employ PNs to provide primary health care services not directly requiring a doctor. This increased the throughput of general practices in terms of the number of registered patients they could support, and therefore GP's earning power. The development of a distinct role for PNs, with a generally well-defined remit within primary health care delivery, laid a foundation upon which the concept of the WiC as a nurse-led health care delivery vehicle could be built.

## WiC nursing

The Department of Health (DoH, 1997) has stated that the NHS needs to modernise in order to meet patients' expectations for an up-to-date, quicker, more

responsive health service. In April 1999, nurse-led WiCs were piloted as part of a bid to modernise health services with improved access to primary care services (DoH, 1999). NHS WiCs are intended to complement other initiatives such as NHS Direct and Healthy Living Centres (DoH, 2001).

Since they were introduced in 2000, NHS WiCs have treated over five million people. There are currently around 90 NHS WiCs in England providing quick and easy access to a range of NHS facilities ([www.nhs.uk](http://www.nhs.uk)), with further sites being developed.

As a further development to the WiC scheme, the NHS has contracted with the private health care sector for the provision of a number of commuter WiCs. These are located close to railway stations and focus predominantly on providing services to 'out-of-area' patients, for whom seeing a GP can be difficult to manage within regular office hours.

There are three common themes in the development of WiCs (Salisbury et al., 2002). First is the improvement of accessibility, second is to make the NHS more responsive to modern lifestyles and third is maximising the role of nurses as more cost-effective health care providers in the majority of cases.

The concept of WiCs can be traced to other developments in the UK and abroad. For example, the minor injuries units, entirely staffed by nurses, replacing small casualty departments as services are rationalised within larger centralised accident and emergency (A&E) departments, offer a safe, effective and popular service (Dolan and Dale, 1997; Heaney and Paxton, 1997). Another example is the telephone helpline, NHS Direct, that has been implemented nationally. The positive evaluation of NHS Direct has led to the suggestion that nurses working with decision support may be able to provide similar advice face-to-face. The research work of Kinnersley et al. (2000) and Venning et al. (2000) has supported the notion that nurses with additional training can manage most patients presenting with acute minor illness. These results, which build upon the foundation laid by PNs, led more or less directly to the concept of the NHS nurse-led WiC.

Note that the notion of the WiC as a nurse-led health care delivery vehicle within the NHS is very different from those that exist in other countries, even though WiCs in other countries predate those of the NHS by many years. For example, the first WiCs in the USA opened in the early 1970s and were termed 'emergency centres', 'ambulatory care centres' or 'urgent care centres'. During the 1980s, walk-in medical clinics were also developed in Canada. These walk-in clinics in other countries are, however, doctor-led and can therefore provide full GP services, whereas NHS WiCs are nurse-led, treating only acute minor ailments. This reflects an important difference in aim between the NHS and the health systems of these other countries. The main aim of these clinics in other countries is to provide care outside normal office hours for important sectors of society, such as affluent working professionals (Borkenhagen, 1988). Whereas, the NHS WiC can be construed as an attempt to deflect the care of patients with minor ailments away from A&E departments, thus increasing the global cost effectiveness of the NHS.

As there has been controversy over the role and impact of walk-in clinics on primary health care in other countries for over two decades, NHS WiCs have been one of the most controversial initiatives within the NHS in recent years.

As one would expect, some aspects of the NHS WiC concept have been relatively successful, while other aspects have been less so. According to Salisbury's Final Report of the National Evaluation of NHS WiCs (Salisbury et al., 2002), WiCs have been generally successful in four basic areas: patient satisfaction, access to care, quality of care and patient appropriateness.

Patient satisfaction was consistently identified by WiCs as a success. This was mainly judged by verbal feedback from patients as well as some letters of appreciation. Few centres had the resources to carry out formal surveys of patients' views, and in light of this, one must take into account the tendency for dissatisfied patients to be less vocal and to simply seek care elsewhere rather than complain. No statistics on repeat patients at NHS WiCs are available at this time.

Access to care was identified as the second successful aspect. The general conclusion is that WiCs, with their extended hours of operation, improve access for those whose situation makes access to their regular GP difficult on a day-to-day basis. For example, the increasing numbers of people who commute long distances to work all potentially fall into this category, with the commuter centres specifically targeted towards this group. The WiCs provide a new avenue to health care services which is highly valued by those who use the service.

Thirdly, we have quality of care. The quality of the organisation, interpersonal care, advice and treatment provided in WiCs has been generally excellent. Of course, there is always room for improvement, for example, the use of Patient Group Directions (PGDs).

And lastly, the fourth success to result from the introduction of WiCs is seen to be appropriateness of clients. With any health care service which has a limited remit, i.e. not all health care services are available, there is a risk that a substantial fraction of patients seeking to make use of the service have needs which fall outside the remit of care. There was a general consensus among WiC health care professionals that the overwhelming majority of presenting cases were appropriate to be seen at a WiC. This tends to indicate that the remit of WiC service is broad enough to be generally useful, as well as indicating that communication to the public of the role and services available from WiCs has been effective.

On the other hand, it is far from clear that the introduction of NHS WiCs has been an overall success, in spite of the four points noted above. Central in this debate has been the impact of the WiC initiative on other health care providers. The results of the study tend to indicate that the only significant impact of WiCs has been to reduce workload growth somewhat on local GP practices, with no statistically significant impact at all found on A&E departments (Salisbury et al., 2002).

If NHS WiCs are particularly efficient at providing health care services, then they could have a net positive impact on the efficiency of the overall health care system. According to Salisbury et al. (2002), the direct cost of an NHS WiC consultation is less than that of a consultation in A&E departments, but remains more expensive than consultations undertaken through the main alternative providers such as GPs, PNs, pharmacists and NHS Direct. Therefore, the fact that WiCs seem to draw most of their clients from less expensive health care providers would support the conclusion that the NHS WiC is having a negative impact on

the efficiency of the overall health care system. If these results are confirmed by further studies, then there will be an important question as to whether the current WiC model is the right one, or whether there is perhaps a more efficient way of achieving the same aims.

Future NHS developments, such as those outlined in the *High Quality Care for All: NHS Next Stage Review* by Lord Darzi (DoH, 2008), may result in the current NHS concept of the WiC evolving significantly. It may be possible, for example, to recast the nurse-led WiC as a component within a more general health care access avenue which combines the improved access of existing WiCs with the general-purpose nature of GP and hospital outpatient services.

## **Extended role in PN and WiC nursing**

The development and evolution of PN and WiC nursing as distinct disciplines has led inevitably to an expansion in nurses' scope of practice and responsibilities. Along with this naturally comes a demand for greater training and skills development. The implementation of legislation which has served to formalise the role of PGDs and independent nurse prescribers, in conjunction with the continued growth in PN, has led to substantial increases in demand for nurses with these skills. This growth in demand has been further fuelled by the NHS WiC initiative. Both PN and WiC nursing are a natural fit for PGD and/or independent prescribing skills.

The development of PGD skills amongst nurses is not, however, encouraged by the lack of a national model, leaving many decisions to the local Primary Care Trust (PCT). Principal amongst which are the basic PGD definitions, and in particular the PGD training requirements, which make PGD skills difficult to transfer from one PCT to another.

Less formal, but no less important for the development of nursing in the practice and WiC settings is improvement in patient first-contact and triage skills. These can be considered important sub-disciplines as well as advanced nursing skills, making them suitable areas for specialised training. However, the lack of such specialised training creates challenges for nurses to improve their skills in these areas. Informal learning from colleagues, seminars and conferences, and the professional literature are some of the ways in which PNs and WiC nurses make themselves more competent practitioners.

## **Conclusion**

Changes in NHS policy led to the development of PN as a more formal distinct nursing sub-discipline. This led more or less directly to two related developments, the first being the implantation of nurse-led minor injury units within some A&E departments, and further to the development of the nurse-led WiCs. The WiC was intended to improve access to NHS, as well as to absorb some of the minor ailment

workload from A&E departments, and improve the overall efficiency of the NHS. While there is some evidence that WiCs have improved access, there is no evidence that NHS efficiency has improved with their introduction.

The impact of the development of practice and WiC nursing on nursing skills has been very positive. This is despite certain difficulties such as a lack of national standardisation for PGDs and a lack of formal training for other advanced nursing skills like triage and first-contact.

The future of the WiC nurse, unlike that of the PN, is not assured. Changes in NHS policy, e.g. as a result of the report by Lord Darzi, may imply that the WiC becomes a more full-featured health service, but it also could be absorbed into a new structure yet to be defined.

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