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To: [REDACTED]
Subject: FW: SG's evidence review on Walk in centres
Date: 12 March 2026 15:33:28
Attachments:

Hi [REDACTED],
Please see in case of interest

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[REDACTED] (NHS Healthcare Improvement Scotland)
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Subject: RE: SG's evidence review on Walk in centres

Many thanks for sharing [REDACTED]
[REDACTED], please see attached for information ahead of our meeting with Rosie
BW
[REDACTED]

From: [REDACTED] (NHS Healthcare Improvement Scotland)
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Subject: SG's evidence review on Walk in centres

H [REDACTED],

Please find attached review I mentioned yesterday that H&SC Scotland undertook for SG on Walk In Centres.

Best wishes

[REDACTED]

[REDACTED]
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Healthcare Improvement Scotland

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Primary care and community walk-in services

Evidence summary

Key messages

For patients, primary care walk-in services offer improved convenience and satisfaction and may increase healthcare access for some population groups.

The evidence regarding the impact of primary care walk-in services on demand for other healthcare services is limited, dated or uncertain. The cost effectiveness evidence on primary care walk-in services is limited by the scarcity of cost analyses and the absence of data on attributable health outcomes.

Key enablers of successful implementation of walk-in services are local needs assessments, strong relationships with existing healthcare providers, accessible locations, effective triage and data recording systems, and targeted marketing.

Robust service evaluations are needed to inform policy decisions and optimise the implementation of general practitioner (GP) walk-in services within NHSScotland.

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Overview

Background

Primary care (or GP) walk-in services are designed to provide rapid access to care for people with minor illnesses and injuries, with the aim of improving access to healthcare for patients while alleviating pressure on other healthcare services.^{1, 2} This evidence summary synthesises published literature on the effectiveness, cost implications, patient and healthcare provider experiences, service evaluation and implementation considerations associated with walk-in services.

In practice and in the published literature, the term 'walk-in service' is used to describe several different models of care. Variations in walk-in services include whether they are GP-led or nurse-led, co-located or community-based, their opening hours and the specific healthcare services offered. This variation makes comparisons difficult which means it is challenging to understand which elements of a walk-in service are driving the outcomes. Since walk-in services can be led by GPs, nurses or other health and social care providers, they are referred to in this document as primary care walk-in services based on the type of healthcare offered rather than the type of provider.

Methods

A systematic search was undertaken between 7–14 April 2026 to identify relevant studies from bibliographic databases and grey literature sources. Eligible studies included systematic reviews, observational studies, service evaluations and qualitative studies addressing effectiveness, costs, experiences, evaluation and implementation of primary care walk-in services. Studies were selected using predefined PICOS (population, intervention, comparator, outcomes and setting) criteria but no formal critical appraisal was conducted.

Results

Evidence on the effectiveness of walk-in services is mixed and comes from observational studies that have a higher risk of bias than randomised controlled trials (RCTs).³⁻¹² Walk-in services may contribute to modest reductions in emergency department (ED) attendance, particularly when co-located with ED departments, although effects are generally small and often measured only within the first 12 months of the walk-in service opening.³⁻¹² No consistent impact on general practice workload was found in the two studies measuring this outcome.^{5, 6} Evaluations of walk-in services in England found that patients prioritise rapid access over continuity of care, while healthcare professionals expressed mixed views regarding the impact of walk-in services on healthcare continuity.^{1, 2, 13}

Walk-in services appear to improve access to primary care for some underserved or hard-to-reach populations, those facing barriers to traditional GP services, such as people facing language barriers, homeless people and traveller communities, as well as young men, workers and students.^{1, 2, 14-16} However, overall use of walk-in services in England remained

substantially lower than use of general practice services, suggesting a limited contribution to increasing system-wide access to healthcare.

No cost-effectiveness analyses were found. Cost data from walk-in services in England indicate that walk-in service consultations are typically more expensive than general practice consultations with a GP or nurse but less costly than ED visits.^{2, 11} This evidence on the economic value of walk-in services is uncertain and comes from 2001 and 2007 and therefore may be outdated.

Patient satisfaction with walk-in services was consistently high, particularly regarding convenience, waiting times and staff interactions.¹⁷⁻²⁰ Patient satisfaction was influenced by waiting times and patient age, with longer waits and younger age associated with lower levels of satisfaction.^{17, 20} In one study, healthcare professionals highlighted the benefits of walk-in services in improving accessibility and patient choice, but also raised concerns regarding duplication of services, increased demand for healthcare and value for money.²¹

Ten out of 11 published evaluations of primary care walk-in services used basic qualitative methods, such as interviews.^{1, 13, 16, 22-28} The most comprehensive evaluation of walk-in services was the first national evaluation of nurse-led walk-in services in England 2000–2001, which used a mixture of qualitative and quantitative methods.² Key enablers of successful implementation of walk-in services derived from these evaluations include conducting local needs assessments, building strong relationships with existing healthcare providers, selecting accessible locations, effective triage and data recording systems, and targeted marketing.^{1, 13, 16, 22, 23, 27, 28}

Conclusion

Overall, the evidence suggests that primary care walk-in services can improve convenience and satisfaction for patients and may increase access for some groups. Their wider impact on ED attendance, GP workload and system-level access remains uncertain because the available evidence is largely observational and dated.

The evidence provides some dated information on the costs associated with walk-in services and how these compare with alternative models of care. No formal cost effectiveness analyses were identified and the available evidence is insufficient to determine whether walk-in services represent a cost-effective use of NHS resources.

The available evidence suggests that any future implementation of walk-in services should be supported by strong links with existing healthcare services and accompanied by robust evaluation to assess impact, equity and costs.

Summary

Impact of walk-in services on other healthcare services

- Results from 10 observational studies (six more than 10 years old) assessing the impact of primary care walk-in services on activity levels in ED departments indicate that primary care walk-in services may contribute to reducing the number of patients attending ED. The generalisability of the findings is limited because of variation in the locations of the walk-in services, the range of services offered and short-term (maximum 12 months) study follow-up.³⁻¹²
- Two observational studies found that primary care walk-in services that are co-located with an ED department may have a greater effect on reducing ED attendance than non-co-located walk-in services.^{5, 9}
- Two observational studies found no statistically significant change in the number of patients attending general practices when a walk-in service was available nearby.^{5, 6}

Continuity of care

- Patients attending primary care walk-in services appear to place more importance on easy and rapid access than continuity of care.^{1, 2, 13}
- The views of healthcare professionals about the impact of primary care walk-in services on continuity of care vary.^{1, 2} Some professionals felt that walk-in services undermined continuity of care, while others felt it was of less importance because most patients were consulting walk-in services about short-lived or one-off care needs.

Improving equitable access to primary healthcare

- Based on data gathered during five service evaluations and observational studies in England, walk-in services may help to improve access to primary care for some population groups.^{1, 2, 14-16} The number of patients using walk-in services remained substantially fewer than the number of patients attending general practices.
- A walk-in service evaluation in England found examples of walk-in services offering access to primary healthcare for populations who historically do not make as much use of healthcare services, including:
 - homeless patients, traveller communities, substance misusers and ex-offenders who can find it difficult to schedule and keep GP appointments

- asylum seekers, refugees and other groups who face language and cultural barriers to accessing healthcare
- workers and students who cannot afford to take time off to attend GP appointments
- people from minority ethnic groups, particularly people of black or Asian heritage
- people who are not registered with a GP practice.¹

Costs and cost-effectiveness of primary care walk-in services

- No relevant cost-effectiveness analyses were found.
- Two studies estimated the cost per patient visit at walk-in services in England and compared it with the cost of other healthcare services, such as a GP appointment or ED visit.^{2, 11} These studies were conducted in 2001 and 2007 which is likely to make the estimated costs inaccurate because of inflation and changes in healthcare practice.
 - An evaluation of walk-in services in England found the average cost per visit at walk-in services was decreasing over time (January 2000 to June 2001) as more people used the service, but remained higher than for other primary care services, such as GP or practice nurse consultations.² Walk-in services co-located with GP practices were the least costly option and shop-front walk-in services the most costly in terms of additional resources required.
 - An observational study comparing costs at eight ED departments with a co-located walk-in service and eight ED departments without a walk-in service found no statistically significant difference in the change in per patient cost between the two groups during the study period.¹¹

Patient and healthcare professional perspectives and experiences

- Four studies conducted surveys to assess patient satisfaction with walk-in services in England.¹⁷⁻²⁰
 - High levels of satisfaction were reported for walk-in services overall, with variation in satisfaction levels across services and different aspects of the service, such as waiting times and staff attitudes.¹⁷⁻²⁰
 - One study (n=6,229) comparing satisfaction between patients attending one of 38 walk-in services and patients attending one of 34 nearby GP practices found that satisfaction was statistically significantly higher among patients at walk-in services for all aspects of the services that were assessed.²⁰
 - Two studies (n=7,259) found statistically significant effects of waiting times (longer waiting times led to lower satisfaction levels) and patient age (older

people were more likely to express higher levels of satisfaction) on patient satisfaction with walk-in services.^{17, 20}

- A qualitative study exploring patient experiences at a walk-in service in England found that patients appreciated the rapid access to primary healthcare and convenient location of the walk-in service.²⁹ Participants perceived GP services as being a precious resource that should be reserved for those with the greatest need.
- One qualitative study exploring the views of healthcare professionals and managers (n=11) about walk-in services in England identified seven themes:
 1. uncertainty about whether services at walk-in services were delivered mainly by nurses or doctors
 2. lack of public awareness of the services provided at walk-in services
 3. uncertainty about the impact of walk-in services on the workload of other healthcare services, such as GP practices and ED departments
 4. perceived increasing demand for healthcare generated by walk-in services
 5. concerns about the appropriate use of walk-in services (particularly when patients can choose to register with a GP at the walk-in service)
 6. creation of increased patient choice but also confusion
 7. mixed views on the value for money offered by walk-in services.²¹

Barriers and enablers to implementing primary care walk-in services

- Key factors associated with the successful implementation of primary care walk-in services include:^{1, 2, 13, 16, 22, 23, 27, 28}
 - a detailed local needs assessment to determine the value of opening a walk-in service in a particular area
 - building strong relationships with existing local healthcare providers
 - an easily accessible location for the walk-in service in areas with high population density
 - consideration of the needs of premises used for walk-in services, including whether they could be co-located with other healthcare services, such as general practices, health services, minor injuries units or ED departments
 - targeted multimedia promotion of the walk-in service that is tailored to each service
 - developing a process for triaging patients to avoid long waiting times and delays in referral to more appropriate services

- procuring and implementing effective data monitoring systems and clinical decision support software
- providing a programme of training, continuing education and professional development for all walk-in service staff.

Methods used to evaluate walk-in services

- Published evaluations of walk-in services have generally used basic qualitative methods, such as interviews.^{1, 2, 13, 16, 22-28} The outcomes evaluated include:
 - descriptive data on individual walk-in services, such as opening hours and services offered
 - who uses walk-in services and why
 - activity levels (number of patients attending the walk-in service)
 - organisational and staffing issues
 - the cost of service provision
 - identifying what works well and challenges to walk-in service provision
 - impact on other healthcare providers, especially general practice and ED.
- The most robust and comprehensive evaluation of walk-in services was a national evaluation of 39 nurse-led primary care walk-in services in England 2000–2001 that used a mixture of qualitative and quantitative methods.² The walk-in services were evaluated against five criteria: improved access to healthcare, quality, appropriateness, impact on other National Health Service (NHS) providers and efficiency. The final evaluation report was based on routine monitoring data (including activity data at the walk-in service and other NHS services), surveys, case studies, role playing of patients and a cost analysis.

Research questions

- Are primary care walk-in services effective at reducing pressure on other NHS services (ED and general practice)?
- Are primary care walk-in services effective at improving equitable access to healthcare?
- Are primary care walk-in services cost effective?
- What are patient and healthcare professional experiences, preferences and views regarding primary care walk-in services?
- What evaluation methods, including theories of change, have been used to assess primary care walk-in services?
- What are the key barriers and enablers associated with effective and equitable implementation of primary care walk-in services?

Methods and approach

A systematic search of the literature was conducted between 7–14 April 2026 to identify systematic reviews, health technology assessments and grey literature reports. Other searches sought to identify primary studies reporting service evaluations, economic evaluations or patient and healthcare professional perspectives on primary care walk-in services.

The search results were screened using the PICOS criteria presented in *Table A, Appendix 1*. *Appendices 1 and 2* provide more details on searching and screening methods and the search strategy used in the Medline database.

Brief description of primary care walk-in services

There is no agreed standard definition of a walk-in service, within the United Kingdom (UK) or internationally.¹ In the first evaluation of NHS walk-in services in England in 2000–2001, walk-in services characteristically had the following features:

- nurse-led or latterly GP-led
- long opening hours from 7.00am to 10.00pm, 7 days per week
- walk-in access without the need for an appointment
- waiting times that were ideally no longer than 15–30 minutes
- a convenient location, sometimes alongside other healthcare services

- offered advice and treatment for minor conditions
- offered health promotion advice and supported people with self-care
- linked with local general practices
- targeted the needs of the local population
- no assumption of continuity of care.²

A later (2014) evaluation of walk-in services in NHS England defined walk-in services as services that provided routine and urgent primary care for minor ailments and injuries with no requirement for patients to prebook an appointment or to be registered with a GP practice.¹ At the time of this evaluation, the walk-in services in England were generally GP-led.

There is no definitive specification for the 16 pilot primary care walk-in services in Scotland.³⁰ According to a news item on the Scottish Government's website, opening hours for the pilot services are variable, with most services expected to open from 12.00pm until 8.00pm, but others opening only during the working day to complement existing out-of-hours service provision. All services are expected to open 7 days a week and to be based in easily accessible locations within the community. The walk-in services are to be GP-led but staffed by a multidisciplinary team that includes advanced nurse practitioners. Although patients will not need an appointment to attend a walk-in service, during the pilot phase walk-in services will only be available to patients who are registered with a local GP within the catchment area for the walk-in service.

Evidence strength, certainty and generalisability

The number of relevant studies (36) identified by the literature searches was small and most studies used observational or qualitative study designs and methods. Twenty-three of 36 studies included in this evidence summary were published more than 10 years ago. It is likely that there have been many changes in healthcare delivery since these older studies were conducted that may affect their conclusions about walk-in services. Many of the included studies assessed the impact of, or evaluated, walk-in services within the first year of opening which limits the conclusions that can be drawn about the long-term effects of primary care walk-in services.

Eleven studies in this evidence summary relate to walk-in services in Australia, Canada, the United States (US) or Sweden. It is unclear how generalisable the results of these studies are to the Scottish context since the healthcare systems in these countries, particularly the US, are different. For example, there are different funding systems in place, patients may be used to accessing healthcare differently and access expectations are likely to vary between countries. The two Australian studies relate to a walk-in service set up based on the NHS England experience and may be more easily generalisable to the Scottish context.

Primary care walk-in services within the UK also varied in terms of their care model, which clinical professions were involved, location, opening hours, etc. This makes comparison between walk-in services challenging and potentially limits the generalisability of published study results.

The evidence included in the sections on [improving access to primary healthcare](#) and [patient or healthcare professional views](#) about walk-in services has been restricted to UK-based studies because these were felt to be the most relevant and likely to generalise to NHSScotland.

No studies were found that reported on the cost-effectiveness of walk-in services because of difficulties with attributing health outcomes to these services. The two UK-based studies in the [cost-effectiveness section](#) were published in 2001 and 2007, which meant that costs had to be inflated to current-day prices. These inflated cost estimates become less reliable the older the original study is and healthcare may have changed substantially since the studies were conducted. The results of these studies should be treated with caution.

Impact of walk-in services on other health care services

Four literature reviews explored the impact of primary care walk-in services on other healthcare services, particularly activity levels in ED departments.³¹⁻³⁴ Only one review described itself as systematic.³¹ Across the reviews there were six relevant included studies (*Table 1*), all of which related to primary care walk-in services in England.^{3, 5, 6, 9, 11, 12} The review authors all noted the limited number of published studies on the effects of walk-in services on other healthcare services and concluded that further research was needed to determine the true impact of primary care walk-in services.³¹⁻³⁴

The six primary studies (published 2003 to 2016) within the reviews were all observational and used one of two methods to assess the impact of walk-in services: examining changes in activity levels before and after the opening of a walk-in service or comparing activity levels between healthcare services in two towns, one with a walk-in service and one without.³² Overall, four of these primary studies suggest there may be small reductions in the number of patients attending ED when a walk-in service is available (*Table 1*).^{3, 5, 9, 12} Two studies reported no statistically significant change in the number of patients attending GP practices when a walk-in service was available.^{5, 6}

Most studies reviewed the impact of walk-in services within 12 months of the service opening. One study (Tammes et al, 2016) suggested that walk-in services may have a greater impact on ED activity levels once they have been open for longer (more than 1 year).¹² In their review, Dadswell et al (2017) suggest that reduced attendance at ED could be the result of more patients going to walk-in services or minor injury units (MIU) instead.³²

Two studies suggested that walk-in services that are co-located with an ED department may result in greater reductions in ED attendance than non-co-located walk-in services.^{5,9} Pinchbeck et al (2014) estimated that 10–20% of patients were diverted away from ED by co-located walk-in services compared with 5–10% of patients from other walk-in services.⁹ Chalder et al (2003) found that ED attendance was reduced by 349 patients per month per site for co-located walk-in services compared with 173 fewer visits per month per site for non-co-located walk-in services.⁵

The review by Salisbury et al (2003) included studies that evaluated the impact of non-UK walk-in services on activity levels at other healthcare services.³⁴ Most of these studies were based on patient survey responses to questions about their intentions to seek care and may not accurately reflect actual healthcare use. One study (total number of patients not reported) reported 67% of patients attending a walk-in service in Canada visited a primary care physician within the next 7 days. One large study (total number of patients not reported) in the US found no effect of walk-in services on activity levels in nearby ED departments. Another study (total number of patients not reported) reported that 24% of patients would attend ED, 28% would contact their GP and 28% would use another walk-in service if they were unable to access the nearest walk-in service. All these studies are now more than 25 years old.

The authors of all the reviews noted several confounding factors that may have affected the ability of the included studies to detect an effect of walk-in services on other healthcare services.³¹⁻³⁴ These factors included:

- studies being conducted within 1 year of a walk-in service opening, which may have limited the size of effect that could reasonably be expected
- the effects of walk-in services on other services may change over time as they become more established and patients become more familiar with the range of health services available to them
- variation in the services offered at different walk-in services making comparisons across studies difficult
- naturally increasing use of health services by a growing and increasingly older population could mask the effects of walk-in services
- demographic differences in patient populations and low levels of health literacy affecting patient choice of healthcare services
- other service-level changes that may have affected activity levels in ED departments or GP practices during the study period
- patients may have attended ED or a GP on the advice of the walk-in service or to get a second opinion after their walk-in service consultation.

Four relevant primary studies were published after the most recent literature reviews (2017–2024, *Table 1*).^{4, 7, 8, 10} These studies used similar observational methods to the earlier studies reported within the literature reviews. Two studies reported results from data gathered over a period longer than 1 year. All four studies were conducted in the US or Canada and mainly focused on attendance rates at ED for low acuity conditions (minor illnesses or injuries). As walk-in clinics in the US are often different from walk-in services in the UK the results should be viewed with some caution. For example, Baughman et al (2021) assessed a walk-in clinic that was in a primary care provider's offices and could only be accessed by patients registered with the practice, Martsolf et al (2017) assessed walk-in retail clinics that are generally located within shopping services and Kurian et al (2023) assessed a walk-in clinic staffed by ED physicians.^{4, 7, 8}

Results from these four more recent primary studies were mixed, with some reporting reductions in the use of ED or primary care services and others reporting no statistically significant changes in activity levels. Where there were reductions in ED attendance, the reduction was generally small, around 1.5% over 1 year.^{4, 8} One study found that an initial decrease in ED attendance when a walk-in service opened was not sustained after 6 months.⁷ In another study, the number of people visiting the walk-in service exceeded the number of patients attending ED for low acuity conditions within 6 months.⁴

Salahub et al (2024) compared attendance at an ED or a primary care practice for patients seen by a different family physician within their normal practice and patients seen by a primary care physician at a walk-in clinic in Canada.¹⁰ In this study, being seen by a family physician within the patient's normal primary care practice resulted in a 10% reduction in the number of patients going to ED within 7 days (6% reduction in low acuity ED visits) compared with patients seeing a physician at a walk-in clinic. When the analysis was restricted to ED activity at the weekends, the results were similar to the main analysis but with a larger percentage reduction in ED visits.

Table 1: Summary of primary studies evaluating the impact of walk-in services on attendance at other healthcare services

Study	Study design	Intervention	Setting and sample size	Assessment measure	Key findings
Primary studies included in literature reviews					
Arain et al (2015) ³	Aim: assess the impact of a GP-led walk-in service on ED and MIU attendance Design: interrupted time series based on routine data and a patient survey	GP-led walk-in services 1 year before and 1 year after opening of the walk-in service	One GP-led walk-in service, one adult ED, one paediatric ED, one MIU Sheffield, UK	Number of daytime (8am to 9pm) 'GP-type' attendances at ED or the MIU GP-type attendances were defined as patients referred or discharged without needing investigations or only needing low-cost investigations	The net proportion of patients who responded to the survey who were potentially diverted from using the ED because of the walk-in service was 14% (n=64). Based on routine data, there was a statistically significant 8.3% (95% confidence interval [CI] 1% to 16%, p=0.03) reduction in daytime non-urgent ED attendance among adults. There was a non-statistically significant reduction in children's ED attendance of 14.9% (95% CI -37.8% to 7.9%, p=0.19). There was a non-statistically significant reduction in attendance at the MIU of 4.3% (95% CI -17.8% to 9.2%, p=0.51).
Chalder et al (2003) ⁵	Aim: assess the impact of NHS walk-in services on the workload at local EDs, GP practices and	Nurse-led walk-in services 1 year before and 1 year after	10 walk-in services, 20 ED departments, 40 GP practices, 14 out-of-hours services	Mean number of consultations per month per ED department	There was a statistically significant reduction in ED consultations of 173.3 (95% CI -334 to -12) per month per site after the local walk-in service opened. In control towns, the non-statistically significant reduction in ED

	out-of-hours services Design: time series analysis with matched controls	opening of the walk-in services	England, UK [part of the national evaluation of walk-in services published in 2002]	Monthly consultation rate at GP practices and out-of-hours services	consultations over this 12 month period was 3 (95% CI -145 to 139) per month per site. The reduction in ED consultation rates after the walk-in service opened was greater at three ED departments with co-located walk-in services (-349, 95% CI -696 to -2 per month per site). In the year after the walk-in services opened, there were 175 (95% CI -387 to 36, p=0.11) fewer ED consultations per month in towns with a walk-in service compared with control towns (not statistically significant). In GP practices in towns with a walk-in service, there was a small non-significant increase in GP workload of 3.9 (95% CI -13.9 to 21.7) consultations per 1,000 patients per month compared with 23.7 (95% CI -8.0 to 55.3) per 1,000 per month in control towns. In the year after the walk-in services opened, GP practices in towns with a walk-in service had 19.8 (95% CI -53.3 to 13.8, p=0.25) fewer consultations per 1,000 patients per month compared with practices in control towns (not statistically significant).
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					The difference in consultation rates at out-of-hours services in control towns was 0.38 greater (95% CI -0.26 to 1.02, p=242) per 1,000 patients per month compared with towns with a walk-in service (not statistically significant).
Hsu et al (2003) ⁶	Aim: assess the effects of an NHS walk-in service on local primary and emergency healthcare services Design: before and after study with unmatched controls	Nurse-led walk-in service 6 months before and 12 months after the walk-in service opened	One walk-in service, nine GP practices in the same town, three GP practices in a control town with no walk-in service, two ED departments, two MIU Loughborough and Market Harborough, UK	Number of same-day GP consultations, out-of-hours service attendances, MIU attendances and ED visits	Attendance at ED increased by 10% after the walk-in service opened (95% CI 0% to 21%). When the analysis was restricted to ED attendance where the patient did not arrive by ambulance, the increase fell to 7% (95% CI -15% to 1%). Attendance at the MIU increased by 22% (95% CI 12% to 33%) after the walk-in service opened. There was no statistically significant difference in same-day GP consultations before and after the walk-in service opened. Compared with control town GP practices, practices in the town with a walk-in service had a mean of 0.02 (95% CI -0.75 to 0.71) fewer same-day GP consultations per 1,000 population (not statistically significant). There was no statistically significant difference between walk-in and control town use of out-of-hours services before and after the walk-in service opened (mean difference

					[MD] 0.07 attendances per 1,000 population, 95% CI -0.06 to 0.19).
Pinchbeck (2014) ⁹	Aim: estimate the impact of walk-in services on ED department attendance Design: observational modelling study	GP- or nurse-led walk-in services Estimates over a 7-year period	228 walk-in services England, UK	Estimated number of patients diverted away from ED	Walk-in services co-located with ED departments had a statistically significant 7% reduction in ED attendance rates. There was no statistically significant effect on ED attendance after the opening of non-co-located walk-in services. In analyses that considered ED attendance only during walk-in service opening hours, 10–20% of patients were diverted away from ED when there was an open co-located walk-in service and 5–10% when there was an open non-co-located walk-in service nearby.
Salisbury et al (2007) ¹¹	Aim: assess the impact of walk-in services co-located with ED departments Design: before and after study with matched controls	Walk-in services co-located with ED departments 6 months before and 6 months after opening of a co-located walk-in service	Eight walk-in services co-located with ED departments, eight matched ED departments without a walk-in service England, UK	ED attendance rates	The mean increase in ED attendances was 813 per month (95% CI -30.3 to 1,655, p=0.06) and 270 per month (95% CI -114 to 655, p=0.17) in the intervention and control groups, respectively. There was no evidence of any statistically significant difference in the change in attendance rates between the intervention and control groups between the before and after periods (MD in change 542 per month, 95% CI -347 to 1,431, p=0.23).
Tammes et al (2016) ¹²	Aim: to investigate relationships	MIU or walk-in services	7,462 GP practices and the nearest ED department,	Self-referred ED attendance	There was lower attendance at ED departments when the rate of attendance at walk-in services or MIUs was higher,

	between primary care patient and practice characteristics and ED attendance Design: cross-sectional study	Data from one financial year	MIU or walk-in service England, UK	Combined self-referred ED, MIU or walk-in service attendance ED attendance with and without local MIU or walk-in services	suggesting patients were diverted away from ED when these alternative services were available. Numerical estimates of these rates are not provided.
Primary studies published after the literature reviews					
Baughman et al (2021) ⁴	Aim: to evaluate the association between walk-in clinic availability and ED use Design: retrospective cohort analysis, including before and after analysis	Walk-in clinic (8.00am to 12.00 noon) within a primary care practice 1 year before and 1 year after the walk-in clinic opened	One walk-in clinic within a primary care practice, one local ED department Pennsylvania, US	Low acuity ED visits Walk-in clinic visits	Rates of total low acuity ED visits per 100 patients decreased by 1.5% after the walk-in clinic opened. Within 6 months of opening, the number of patients visiting the walk-in clinic exceeded the number of low acuity visits to the ED department. On average, there were 95 more patients per month seen in the walk-in clinic compared with hours-adjusted low acuity ED visits (184 versus 88).
Kurian (2023) ⁷	Aim: assess whether low acuity ED visits decreased after opening a walk-in service	ED physician staffed walk-in clinic located 0.8 miles from the ED (open 3.30pm to 11.30pm)	One walk-in service, one ED department US	Low acuity ED visits	Low acuity visits represented 22.7% of total ED visits over the 5 year study period. In the month immediately after the walk-in service opened, there was a statistically significant reduction in low acuity ED visits (-129.8 patients, 95% CI -225.3 to -34.4, p=0.01). This difference was not statistically

	Design: retrospective interrupted time series analysis	3 years before and 2 years after the walk-in service opened			significant at 6, 9 or 12 months after the walk-in service opened.
Martsolf et al (2017) ⁸	Aim: assess whether opening walk-in retail clinics resulted in lower use of ED departments for low acuity conditions Design: retrospective cohort study	Walk-in retail clinics 6 years of data	1,149 ED departments with no retail clinic nearby, 769 ED departments with a walk-in retail clinic within a 10 minute drive US	ED attendance for 11 prespecified low acuity conditions	There was no statistically significant difference in the reduction in ED visits for low acuity conditions between departments with and without a nearby retail clinic. Increased retail clinic availability was not associated with a change in low acuity ED visits (relative risk [RR] 0.999, 95% CI 0.997 to 1.001). For every 40% increase in the number of local retail clinics there was a 1.2% reduction in ED visits for low acuity conditions over 1 year.
Salahub et al (2024) ¹⁰	Aim: compare ED attendance after a family physician visit versus a walk-in service physician visit Design: retrospective cohort study	Primary care physician-led walk-in clinics 1 year period	506,033 patients attending a primary care walk-in clinic, 506,033 matched patients visiting a family physician at their normal primary care practice Ontario, Canada	ED visits within 7 days Low acuity ED visits within 7 days Virtual or in-person visits with any family physician within 7 days	Patients who saw a family physician within their normal practice after hours or on weekends were 10% less likely to visit ED compared with patients who saw a walk-in clinic physician (risk difference [RD] 0.4, 95% CI 0.4 to 0.5; RR 0.90, 95% CI 0.89 to 0.92). Patients who visited a family physician at their normal primary care practice were 6% less likely to attend ED with a low acuity condition compared with patients who saw a walk-in clinic physician (RD 0.06, 95% CI 0.02 to 0.1; RR 0.94, 95% CI 0.91 to 0.98).

					Patients who saw a family physician within their normal practice were more likely to have an appointment with another family physician within 7 days compared with patients who saw a walk-in clinic physician (RD 0.02, 95% CI 0 to 0.04; RR 0.92, 95% CI 0.84 to 1.00). When the analysis was restricted to visits that occurred on the weekends only, the results were similar to the main analysis but with larger differences. Compared with patients who had a visit with a walk-in clinic physician, patients visiting a family physician within their own primary care practice were 21% less likely to attend ED within 7 days (RD 1.0%, 95% CI 0.9% to 1.1%; RR 0.79, 95% CI 0.77 to 0.82).
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Continuity of care

Three evaluation reports based on primary care walk-in services in England considered the issue of continuity of care for patients using these services.^{1, 2, 13} The first evaluation of walk-in services in England was published in 2002 and included evidence on continuity of care from a literature review, surveys, interviews and case studies.² Overall, the authors concluded that patients using walk-in services placed more importance on accessibility than continuity of care.

The literature review within the national evaluation found that walk-in services in the US placed little emphasis on continuity of care because competitive relationships between family physicians and other primary care services, such as walk-in services, were the norm in that healthcare system.² In Toronto, 47% of walk-in services (total number of patients not reported) routinely informed family physicians of patients attending the service. Most patients were unconcerned about the lack of continuity of care, with 20% saying it mattered whether they saw a different physician at each visit and 20% being concerned about the walk-in service not being able to access their medical records. In one study (total number of patients not reported), potential users of walk-in services sometimes preferred the anonymity offered by walk-in services. In contrast, several studies (total number of patients not reported) that were conducted in UK general practice found that continuity of care from a GP who was known to the patient was an important concern for many people, suggesting that people have different expectations from GPs and walk-in services.

In the evaluation survey of users of English walk-in services (n=4,555), respondents were asked how important it was to see a doctor or nurse that they knew.² Approximately half the people attending a walk-in service either wanted to always see (26.6%), or preferred to see (24.7%), the same doctor or nurse. Another 47.3% of respondents did not mind which doctor or nurse they saw at the walk-in service. There was a trend for older people to place more importance on seeing a doctor or nurse they knew. Men were less likely than women to want to see a familiar doctor ($p<0.001$) and patients of white heritage were less likely to want to see a familiar doctor than patients with non-white heritage ($p<0.001$).

In the evaluation survey of healthcare professionals, 43% agreed with the statement that 'walk-in services undermine continuity of healthcare'.² The level of agreement was higher among GPs (55%) compared with ED consultants (41%), pharmacists (28%) and practice nurses (25%). Nurses at walk-in services tended to agree with service users that the lack of continuity of care or access to medical records was not a problem, particularly for patients who were consulting the walk-in service about short-term minor illnesses or injuries.

In interviews conducted as part of the English evaluation, most walk-in service users were happy for their GP to be informed that they had attended the walk-in service and

understood the need for their GP to have a complete record of the healthcare they had received.² At the same time, they valued the additional choice offered by the walk-in service. Case studies suggested that walk-in services had little effect on continuity or coordination of care. Not being able to access a patient's medical records was not relevant in most cases and walk-in service staff used their knowledge of local services to refer patients when necessary.

In an evaluation of a subset of walk-in services in the greater London area, patients attending the walk-in service who had a local GP gave permission for a copy of the nurse's notes from their consultation to be faxed or posted to their GP.¹³ If the patient was not local, but did have a GP, they were given a letter to take to their GP. Nurses did not feel that it was a particular problem not having access to a patient's medical records because they could gather the information they needed from the patient during the consultation at the walk-in service. For nurses at walk-in services the main issue relating to continuity of care was not getting any feedback on what happened to the patient after their consultation.

A second evaluation of walk-in services in England was published in 2014.¹ In this evaluation, commissioners and healthcare professionals sometimes raised concerns that walk-in services did not provide continuity of care, particularly because they did not have access to patients' general practice medical records. However, the report acknowledged that most walk-in services could access patient-held summary care records that showed medications, allergies and adverse reactions, and this may be sufficient for most walk-in service consultations. In some areas, walk-in services had agreements with other local healthcare providers to share access to urgent care records. Although progress had been made in sharing access to patients' full medical records since the first English service evaluation, difficulties remained.¹ Even when walk-in services used the same records system as local GPs or urgent care providers, they did not always have the required access permissions from the providers holding the records. Some stakeholders noted that this might not be a major issue because continuity of care did not appear to be an important concern for many patients attending walk-in services who had an urgent one-time care need.

Improving equitable access to healthcare

No studies were found that specifically focused on whether primary care walk-in services improve access to healthcare. Five studies provided data from service evaluations or observational studies that could be interpreted in terms of access to primary healthcare.^{1, 2, 14-16} The studies included in this section were restricted to those conducted in the UK because the results are more likely to generalise to the Scottish context.

A well conducted, but poorly reported, systematic review and the first evaluation of walk-in services in England in 2000–2001 found that walk-in services improved access to primary care for some population groups.^{2, 14} Over the same 1 year period, GP practices saw 14 times

as many patients as the walk-in services suggesting that walk-in services make a relatively small contribution to improving access to primary care.² Walk-in services were not felt to be effective in addressing inequalities in access to healthcare because the people who used walk-in services tended to be white, middle-class, relatively healthy patients, many of whom were already using other NHS services.^{2, 14} The exception was that walk-in services appeared to improve access to primary healthcare for young and middle-aged men, who generally access primary care less than other population groups.¹⁴

A second evaluation of walk-in services in England in 2014, concluded that the closure of walk-in services may adversely affect patients by making it difficult for them to access primary healthcare when there were difficulties with local access to GP practices.¹ Closure of walk-in services was also thought to limit the ability of primary care to reach groups of people who find it difficult to engage with traditional services or who historically tend to have poor rates of uptake and interaction with primary care. For example, walk-in services appeared to meet the needs of people with lower socioeconomic status and young people with lifestyle risk factors, both of which had been identified as a key target group by the NHS in England. Consequently, the authors of this evaluation concluded that closing walk-in services may result in increased health inequalities if suitable alternative services were not put in place first.

In the 2000–2001 English evaluation, the number of patients visiting nurse-led walk-in services in NHS England had gradually increased over the first 12 months of operation, with an average of 2,556 patients seen per service per month (82 per day) by the end of evaluation period.² This represented a 24–65% increase in patient numbers across all walk-in services in the first year of operation. By the time the second English evaluation was published in 2014, the number of consultations at walk-in services ranged from 12,000 to 60,000 per year (1,000 to 5,000 per month).¹ Thirty-three walk-in services (over 70%) were providing between 20,000 and 45,000 consultations per year (1,667 to 3,750 per month), with another 11 services (24%) providing between 25,000 and 30,000 consultations per year (2,083 to 2,500 per month). NHS England estimated that the number of patients using walk-in services or MIUs had increased by 12% per year between 2003 and 2014.¹ The use of walk-in services by 2014 had exceeded expectations and this put a strain on resources, staff and facilities at some services that resulted in temporary closures to allow for changes to be made to increase their capacity. Throughout the two evaluation periods, GP practices continued to see substantially more patients per month than walk-in services.

The number of patients accessing healthcare through walk-in services varied between the different types of walk-in service.¹ Primary care walk-in services based in hospitals without ED facilities saw the highest average number of patients per month (n=3,200). Walk-in services based in shop-front locations dealt with approximately two thirds that many per month (n=2,219).² In 2009, an evaluation of walk-in services located near train stations to target commuters found that commuter walk-in services saw an average of 87 patients per

day (2,436 per month), with a maximum daily total of 128 patients per day (3,584 per month).¹⁶

In the 2000–2001 evaluation, most people visited walk-in services on weekdays during the daytime.² Peak busy times included the evenings after GP practices had closed, weekends and bank holidays. Weekends and bank holidays had a slightly later busy period starting around 10am compared to around 9am on weekdays. In the 2014 evaluation, most services reported that Mondays or Saturdays were their busiest days.¹ The extended and weekend opening hours, combined with walk-in service location, seems to have allowed people who find it difficult to take time off work for GP appointments to access primary care at a time that suits them.^{1, 2}

The 2000–2001 evaluation found that walk-in services improved access to healthcare compared with general practice and ED departments by offering more same-day appointments with shorter waiting times.² The median waiting time at walk-in services during the evaluation period was 10 minutes (interquartile range 3 to 26 minutes). The authors noted that this would likely change as walk-in services became busier resulting in patients waiting longer to be seen. If this happened, patients may revert to using other healthcare services to deal with their urgent care needs.

An observational study (Maheswaran et al, 2007) explored whether access to walk-in services in NHS England resulted in shorter waiting times for appointments at nearby GP practices.¹⁵ During the 2-year study period (2003–2004) waiting times across all the study GP practices decreased, with the proportion of practices achieving the 48-hour waiting time target increasing from 67% to 87% (adjusted odd ratio [OR] 1.07, 95% CI 1.06 to 1.08 per month). The study found no evidence that walk-in services were associated with this decrease in waiting times at the GP practices (adjusted OR 1.00, 95% CI 0.99 to 1.01 per kilometre increase in distance from a walk-in service). The authors offered possible explanations for this lack of effect of walk-in services on GP waiting times:

- there may be an effect but the study was unable to detect it
- people attending walk-in services may not live nearby and the effect on GP waiting times would therefore be diluted and difficult to detect
- walk-in services may have created additional demand for healthcare and seen patients who would otherwise not have sought help.

The two evaluations of walk-in services in England reached different conclusions about which groups of patients were using walk-in services, suggesting a shift in service user demographics over time.^{1, 2} In the 2000–2001 evaluation, a higher proportion of walk-in service users were men of working age compared with patients attending GP practices.² People attending walk-in services were also more likely to be owner occupiers and to be

educated beyond the age of 18, but less likely to be from an ethnic minority background or elderly, compared with patients attending a general practice. The evaluation concluded that walk-in services improved access to primary care for patients who were mobile and working or shopping in the surrounding area. The second English evaluation in 2014 found that younger people, aged 16 to 45, were the main users of walk-in services.¹ There were slightly more women than men using walk-in services and people from lower socioeconomic groups tended to use the walk-in services more often than people from higher socioeconomic groups. The authors noted that this represented a substantial change in the demographics of walk-in service users since the first evaluation.

The demographic characteristics of people using walk-in services also varied depending on the service's location.¹ Walk-in services based in a city saw more working age patients, while services in residential areas served a higher proportion of young families and services located near a university saw large numbers of students who were not registered with nearby GP practices. In 2000–2001, four fifths of walk-in service users lived locally.² By 2014, 6% of people attending a walk-in service reported working or studying in the area but did not live nearby (this rose to 19–31% for some services).¹ This suggests that walk-in services may improve access for people who are living, working or studying in the surrounding area.

The English evaluation in 2014 found examples of walk-in services being used by population groups who have historically had limited access to primary care.¹ These populations included:

- homeless patients, traveller communities, substance misusers and ex-offenders who can find it difficult to schedule and keep GP appointments
- asylum seekers, refugees and other groups who face language and cultural barriers to accessing healthcare
- workers and students who cannot afford to take time off to attend GP appointments
- people from minority ethnic groups, particularly people with black or Asian heritage
- people who are not registered with any GP practice.

The English evaluation in 2014 and an evaluation of commuter walk-in services in 2009 found that an estimated 3–13% of patients using walk-in services were not registered with a GP practice.^{1, 16}

Both evaluations of walk-in services in England described user-perceived problems with accessing primary care through GP practices.^{1, 2} Walk-in service users and nurses expressed the view that people had to feel (and convince practice receptionists) that their problem 'deserved' a consultation in order to get an appointment with a GP.² In contrast, at walk-in services they did not have to overcome any actual or perceived barriers to access.

In the 2014 evaluation, 71–92% of patients reported they could get an appointment with a GP when they wanted, 49–89% felt they were able to easily contact their GP surgery by telephone and satisfaction with GP opening hours ranged from 71–85%.¹ Around a quarter of people attending a walk-in service (22%) said they had tried to contact their GP first but found there was no appointment available (14%), there was no appointment at a convenient time (4%), there was too long a wait for an appointment (3%) or they could not get through to the practice (1%). Another 24% of patients at walk-in services said they did not try contacting their GP practice because they did not think they would get a convenient appointment. A commissioning body consulted as part of the evaluation found ‘broad correlation between satisfaction with GP access and use of the [two local] walk-in services, with some of the most represented practices having received low MORI patient satisfaction survey scores’.

Costs and cost-effectiveness of primary care walk-in services

Six studies reported costs associated with primary care walk-in services in England, Australia, Canada or the US.^{2, 4, 11, 25, 35, 36} No studies were identified that undertook a formal cost-effectiveness analysis. This reflects a broader challenge in evaluation walk-in services. While costs can be measured, it is difficult to attribute changes in patient outcomes and system impacts directly to the presence of a walk-in service and therefore it is not possible to estimate cost effectiveness.

The available studies differed substantially in terms of walk-in service models, healthcare systems, patient populations and methods of costing. There is a lack of recent evidence from the UK, consequently the findings should be interpreted as providing indicative information on costs and resource use rather than evidence of cost effectiveness, and their applicability to the current NHSScotland context is uncertain.

The costs in each study from the UK have been inflated to 2022–2023 costs. Given the dates of the original estimates (2001 and 2007) these inflated costs are only an approximation because the accuracy and reliability of estimates decreases the older the original data get.

An observational study from 2007 compared costs from eight ED departments with co-located walk-in services and eight ED departments without walk-in services in NHS England.¹¹ Costs were calculated for patients seen for 6 months before and 6 months after opening of the co-located walk-in services. Year-on-year total costs increased by 22% in ED departments with co-located walk-in services and by 10% in ED departments without a walk-in service. This difference in total cost increase was largely driven by a greater increase in clinical staff costs for the ED departments with co-located walk-in services. Costs increased at ED departments with a co-located walk-in service by £6.22 (2022–2023 cost £8.97) per patient per year compared with £8.28 (inflated cost £12.93) per patient per year at ED

departments without a co-located walk-in service. There was no statistically significant difference in the change in per patient cost between the two groups (-£3.06, 95% CI -£16.50 to £10.39, inflated estimates -£4.41, 95% CI -£23.79 to £14.98). The lack of statistical significance remained after adding hospital admission costs as part of a sensitivity analysis. The authors concluded that co-locating walk-in services with ED departments did not substantially affect total ED delivery costs.

In 2000–2001, the first evaluation of English walk-in services included a cost analysis.² The authors compared per visit costs across walk-in services with costs associated with alternative forms of routine healthcare, such as GP appointments or ED attendance. The analyses were based on activity and financial data provided by the walk-in services, supported by data about patients' intentions and referrals obtained from other aspects of the evaluation. The mean cost of a walk-in service consultation over the 1-year evaluation period was £30.58 (inflated cost £54.77), based on walk-in services seeing a total of 838,000 patients at a total cost of £25.6 million. The mean cost per visit gradually fell as the number of patients using walk-in services increased, to a mean of £23.54 (inflated cost £42.16) in services that had been open for more than 1 year.

In the analyses that compared the cost of walk-in service attendance with other forms of healthcare, walk-in services co-located with GP practices or ED departments and open for more than 1 year, could be less costly than patients stated alternatives means of accessing healthcare. This finding was driven by patients having reported they would have gone to ED if there was no walk-in service available. The cost per visit to a walk-in service was higher than the cost of a GP consultation (£15, inflated cost £26.86) and much higher than the cost of a practice nurse consultation (£7, inflated cost £12.54). When the cost of consultations incurred by referrals from walk-in services to other healthcare providers were included in the analysis, walk-in services were more expensive than all the alternatives. The results of these cost comparisons should be treated with caution because the data on patient intentions and referrals were derived from only six walk-in services.

The evaluation authors presented three conclusions from their cost analyses:

- the cost per visit to a walk-in service fell over time, with a mean cost per visit after 1 year that was approximately 50% higher than for a GP consultation
- walk-in service consultations, at the time of the evaluation, were more costly than consultations with a GP, practice nurse, pharmacist or NHS Direct, but less costly than an ED consultation
- some types of walk-in service are less costly than others, with services co-located with GP practices being the least expensive and shop-front walk-in services the most expensive.

An evaluation of an Australian walk-in service co-located with an ED department also found that the cost of a walk-in service consultation was higher than the cost of a GP consultation and lower than an ED consultation.²⁵ In an analysis that accounted for the costs of GP and ED services saved or generated by patients being diverted to the walk-in service, the average cost of walk-in service consultations remained between the costs for GP and ED consultations.

Two studies from Canada compared costs between one ED department and one walk-in service for ambulatory patients presenting with acute respiratory conditions.^{35, 36} In the study that included only adults, there were 170 patients with respiratory diagnoses who attended the ED department and 326 who went to the walk-in clinic.³⁶ The mean cost of the index visit was higher at the ED department compared with the walk-in service. In the study that included only children (aged 17 or under) there were 532 children attending the ED department with respiratory complaints and 201 at the walk-in service.³⁵ The mean cost of the index visit was higher at the ED department compared with the walk-in service.

A study conducted in the US calculated cost savings for the management of low acuity conditions at an ED department compared with a walk-in clinic based in a family practitioners office.⁴ The average cost for a low acuity visit at the ED department was estimated as \$437 (£325) United States Dollars (USD) and the corresponding cost at the walk-in clinic was estimated as USD \$91 (£68). A projected cost saving of USD \$825,902 (£614,636) was generated by seeing 2,387 patients with low acuity conditions in a walk-in clinic instead of the ED department in 1 year.

Patient and healthcare professional perspectives and experiences

Studies selected for inclusion in this section were restricted to those conducted in the UK because they are the most relevant and generalisable to Scotland.

Patient experience and satisfaction

Five observational studies were found that explored patient experiences and satisfaction with primary care walk-in services in England.^{17-20, 29} Four studies were based on patient surveys¹⁷⁻²⁰ and the fifth used semi-structured interviews.²⁹ One of the survey-based studies compared results from patients attending walk-in services with patients attending nearby GP practices for a same-day appointment.²⁰ Three of the survey studies used the same validated questionnaire.^{17, 19, 20} The main focus of the survey studies was patient satisfaction with walk-in services and factors that affected levels of satisfaction. *Table 2* presents the basic characteristics of the five studies.

In the survey-based studies, consecutive patients were given a questionnaire on arrival at a walk-in service. One part of the questionnaire was to be completed before their consultation and the second part after the consultation. The questions on satisfaction were graded from very unsatisfied to very satisfied on a 5-point Likert scale. The qualitative study conducted in-person interviews at participants homes to explore their reasons for choosing and using walk-in services.²⁹ The interview transcripts were analysed thematically.

Table 2: Basic characteristics of five studies reporting on patient experiences and satisfaction with primary care walk-in services

Study	Method used	Number and type of walk-in services	n people	Response rate	Participant characteristics
Arain et al (2013) ¹⁷	survey	Two GP-led services	1,030	57%	Mean age 31.5 years (range 0 to 89); 41% male
Coster et al (2009) ¹⁹	survey	Six commuter services	1,828	58%	Not reported
Chalder et al (2007) ¹⁸	survey	Eight services co-located with ED (compared with eight ED without a walk-in service)	704	36%	Not reported
Jackson et al (2005) ²⁹	semi-structured interviews	One service co-located with a MIU	23	-	Age 28–70 years; 10 men; three non-white; eight seeking help for a child
Salisbury et al (2002) ²⁰	survey	38 nurse-led services (compared with 34 nearby GP practices)	6,229	82%	At walk-in services: median age 29 years; 46.6% male; 87.7% white

Across the survey-based studies, most participants reported high levels of satisfaction with their visit to a walk-in service.¹⁷⁻²⁰ In the study by Arain et al (2013), patient satisfaction varied between the two walk-in services studied, with 64% of patients at one site and 49% of patients at the second site reporting they were highly satisfied with the walk-in service overall.¹⁷ In the study based on users of six commuter walk-in services, 69% (95% CI 58% to 79%) of participants reported being very satisfied with the service.¹⁹ Patients reported the least satisfaction with the waiting times at the walk-in service (60% very satisfied and 29% fairly satisfied) and the most satisfaction with the attitude of the doctor or nurse they saw in their consultation (78% very satisfied and 17% fairly satisfied). The level of patient

satisfaction with waiting times varied across the six services in this study, as did the average waiting time.

Most patients who used one of eight walk-in services co-located with an ED department reported high levels of satisfaction, with the co-located services being described as fairly convenient or very convenient.¹⁸ In the study by Salisbury et al (2002), the mean overall satisfaction score was higher among patients attending walk-in services than patients attending a nearby GP practice (among patients who completed the whole questionnaire: 85% versus 75%, adjusted MD 6.6%, 95% CI 5.0% to 8.2%).²⁰ Table 3 shows the percentage of respondents in the study by Salisbury et al who were very satisfied with various aspects of the walk-in service or GP practice they visited.

Table 3: Percentage of survey respondents reporting they were very satisfied with aspects of their walk-in service or GP practice visit²⁰

	Walk-in service	GP practice	p-value
Receptionist attitude	85%	71%	<0.001
Waiting time	61%	44%	<0.001
Doctor or nurse attitude	88%	79%	<0.001
Explanation of their problem	80%	69%	<0.001
Advice received	77%	69%	<0.001
Overall satisfaction with the service received (all participants who answered this question)	80%	66%	<0.001

Two of the survey-based studies evaluated which factors had a statistically significant effect on patient satisfaction with walk-in services.^{17, 20} Arain et al found that patient-reported waiting times were the most important factor affecting patient satisfaction, with longer waiting times leading to a lower chance of patients reporting they were very satisfied (OR 0.98, 95% CI 0.97 to 0.98).¹⁷ Satisfaction was also statistically significantly associated with age. Younger people aged 15–24 years were the least likely to report being highly satisfied (OR 0.4, 95% CI 0.24 to 0.75) and people aged 65 or older were the most likely to be highly satisfied (OR 3.4, 95% CI 1.36 to 8.46). Similarly, Salisbury et al found that high patient satisfaction across walk-in services was statistically significantly associated with older age ($p < 0.05$), white ethnicity compared with all other ethnic backgrounds ($p < 0.001$), education beyond 18 years compared with all other durations of education ($p < 0.001$) and shorter waiting times ($p < 0.001$).²⁰

In the survey by Arain et al, most patients at both walk-in services rated the opening hours (not reported) as excellent (41% and 39%) or very good (52% and 51%).¹⁷ Most patients also rated the service's location (one in a community health centre in a large town and one in a

bespoke building in a student city) as excellent (35% and 25%) or good (53% and 52%), with higher scores at the service that had free onsite customer parking.

In the survey-based study that assessed patient experiences at walk-in services co-located with ED departments, 35% of patients seen at a walk-in service said they would rather have been seen in the ED.¹⁸ Around half the survey respondents (55%) did not realise they had been seen in a walk-in service and not the ED. Despite this confusion, 65% of respondents described the care they received as being very good or excellent, with no statistically significant differences between patients who attended a site with a co-located walk-in service and those attending a standard ED department.

Salisbury et al reported that users of walk-in services found them more convenient than GP practices in terms of their location ($p<0.001$) and opening hours ($p<0.001$).²⁰ Walk-in service patients were less likely than patients attending nearby GP clinics to expect a prescription or medication (38% versus 70%, $p<0.001$), more likely to attend the service on their first day of illness (28% versus 10%) and had been affected by their health problem for a shorter time ($p<0.001$).

In the qualitative study based on in-person interviews, Jackson et al (2005) explored how and why patients chose to attend a walk-in service and their perceptions of the service quality.²⁹ Of the 23 people interviewed, there were two overarching reasons for using a walk-in service. The first was to gain access to treatment that the patient had already decided was necessary. The second was to seek advice on a health concern. The two groups of patients chose the walk-in service for different reasons. People giving the first reason chose the walk-in service because they believed they could easily access the help they wanted with minimal delay. People giving the second reason chose the walk-in service based on a personal assessment of how serious their issue was and whether they could delay seeking healthcare. Both groups seemed to view the NHS as offering a menu of services, from which they could select the most appropriate.

Interviewees saw GPs as a precious resource with a limited number of appointments that should be reserved for those with the greatest need. Participants reported feeling hesitant about being seen to waste a GP's time. Almost all participants (20 out of 23) described difficulties accessing their GP and seemed to view the walk-in service as a compromise between their preferences for GP-based care and their need for rapid access. Participants appreciated not needing to decide whether their problem was an emergency that required an urgent appointment, not having to negotiate with a receptionist for access to a GP and not being required to attend within a limited time slot.

Walk-in service users described the staff at the service as pleasant, with good communication skills. They felt listened to and valued, rather than viewed as a nuisance.

They appreciated avoiding the perceived difficulties with lengthy waiting times and travel issues associated with attending an ED department.

There was some uncertainty among interviewees about the exact purpose of the walk-in service and its role within the wider healthcare system. The interviewees were unsure which services were available within the service and whether a doctor would be available. More than half the study participants felt that the walk-in service could be improved by the continuous presence of a doctor.

Healthcare professional's perspectives

A qualitative study explored the views of healthcare professionals and managers about primary care walk-in services in England.²¹ Healthcare professionals and managers were purposively sampled and invited to participate in a 1-hour semi-structured interview. Eleven people were interviewed: two healthcare professionals working at a MIU, two GPs, one GP practice coordinator/manager, three emergency physicians and three health service managers. Thematic analysis of the interview transcripts identified seven themes:

- uncertainty about whether services at walk-in services were delivered by nurses or doctors
- lack of public awareness of the services provided by walk-in services
- uncertainty about the impact of walk-in services on the workload of other NHS services
- perceived increasing demand for healthcare generated by walk-in services
- concerns about the appropriate use of walk-in services, particularly when patients could choose to register with a GP at the walk-in service
- creation of patient choice but also confusion
- mixed views on the value for money offered by walk-in services.

Most healthcare professionals viewed walk-in services as GP services with extended opening hours. They did not approve of health services being provided by private organisations out-with the NHS. In relation to the impact of walk-in services on the workload at other NHS services, some participants were concerned that, while they perceived no effect on workload by having the walk-in service, closing it could increase the workload at other services because service users would seek alternative sources of care. There was also concern that the walk-in services might only be fulfilling the demand they had created, rather than meeting an unmet need. Most participating healthcare professionals were in favour of having all urgent care services in one place and having a 'one front door' service. They felt that patients got confused about choosing the right healthcare service for their

urgent health problems and this was not helped by offering an additional service, such as a walk-in service. Participants held both positive and negative views about walk-in services and most were concerned it was not offering good value for money. Overall, negative views and concerns about walk-in services were higher among GPs than healthcare managers.

Barriers and enablers to implementing primary care walk-in services

The evidence in this section is derived from two reports describing evaluations of walk-in services in NHS England,^{1, 2} one report and one primary study evaluating subsets of walk-in services in England,^{13, 16} and four primary studies describing individual primary care or community walk-in or drop-in service evaluations.^{22, 23, 27, 28} These evaluations identified eight key barriers or enablers to successful implementation of walk-in services.

Comprehensive local healthcare needs assessment

Primary care and community-based walk-in services are intended to address unmet health care needs in an area or population.² For this reason, it is beneficial to conduct a thorough local needs assessment ahead of introducing a walk-in service. The needs assessment should map existing healthcare provision in the area, determine whether people living in the area would benefit from the addition of a walk-in service and ensure that the services offered by the walk-in service complement existing local healthcare provision.

One of the main aims of the NHS England walk-in services was to offer primary health care services to communities that had a large population of commuters, workers, homeless people, tourists, travellers, low income families or other populations who can struggle to engage with primary care services.^{1, 2} In practice, demand for nurse-led walk-in services in 2000–2001 and commuter walk-in services was highest among young people in their 20s or 30s, men (who traditionally access health care less often than women), people working near the walk-in service and people living in socioeconomically deprived areas.^{1, 16}

Building strong relationships and referral pathways with local healthcare providers

Building strong relationships between walk-in services and other local NHS services, especially GP practices, was viewed as essential by many staff working at walk-in services.^{1, 2, 13, 23} Building these relationships facilitated signposting of people attending walk-in services to more appropriate NHS services where necessary^{1, 2, 13}. For example, referring people with acute urgent care needs to an ED department. This was felt to be a core function of the walk-in services by the staff working there.^{1, 2, 13}

Signposting was most effective when referral routes into other local NHS services were clearly defined and developed in collaboration with service providers.^{1, 2, 13} Some walk-in services in NHS England trialled developing shared triage systems with ED departments but encountered difficulties with agreeing an approach that did not duplicate the triage process for patients.^{1, 13} In the Australian walk-in service, which was co-located with an ED department, triage staff often referred patients to the walk-in service who then redirected the patient back to the ED.²⁵

One limitation of referrals from walk-in services in England was their inability to refer patients directly to specialists in secondary care, although there was disagreement across walk-in service staff about whether this should remain the purview of GPs.^{1, 2, 13}

Informal relationships between healthcare professionals and the signposting of patients to alternative services were most effective when the walk-in service was co-located with another NHS service, such as a GP practice or ED department.^{1, 2} Co-located walk-in services were also found to be the most effective and cost-efficient and had the highest patient throughput.^{1, 2, 13}

Selecting the best location for the walk-in service

Across all the walk-in service evaluations, increased access to healthcare, high patient volume and success of a walk-in service depended on where the service was located.^{1, 2, 13, 16, 22, 23, 27, 28} Services were generally the most successful when they were easy to find, located in a town service, near large residential areas or where a lot of people worked, where there was high foot traffic (for example, along commuter routes) or where there was a high level of need for additional healthcare services.^{1, 2, 13, 16, 22, 23} Co-location of walk-in services with other healthcare or community services in the area was associated with greater use of the service and perceived by patients as increasing accessibility since they were already visiting the location for other reasons.^{22, 23, 27, 28} In contrast, in the Australian evaluation, stakeholders felt that bringing people who needed primary care services into a hospital setting often resulted in inappropriate attendance at ED and that the walk-in service would be better located in areas where the need for additional primary care services had been identified, such as where GP services were known to be insufficient.²⁵

Walk-in service environment

In addition to the location of walk-in services, the internal environment was important for encouraging people to use the service.^{1, 2, 13, 22, 27, 28} The buildings selected to house walk-in services should be fit for purpose, in an accessible location and have capacity for future expansion.^{1, 2, 13} Community-based drop-in service evaluations noted the importance of having a welcoming environment that felt less intimidating to patients than traditional healthcare services.²² Patients who experienced long waiting times for a consultation at a

walk-in clinic suggested that the waiting room environment could be improved by providing sufficient seating, a television or background music and toys or books to entertain children.²⁸

Opening hours, waiting times and appointment duration

It is unclear what the best opening hours are for primary care walk-in services. Walk-in services in NHS England were originally required to have long opening hours that covered early morning until late evening on weekdays and weekends.^{1, 2} The first NHS England evaluation of walk-in services suggested that opening hours could be shortened or adapted to align with peaks and troughs in patient demand since there were relatively few patients attending walk-in services early on Sunday mornings or late in the evenings.² By the time the Monitor review was published in 2014, patients attending walk-in services were seeking longer opening hours and more availability at weekends.¹

Long opening hours come with their own set of problems. It can be difficult to sustainably staff a walk-in service that is open long hours, 7 days a week.^{1, 2} During busy periods, patients attending a walk-in service can end up waiting a long time to be seen.^{1, 2, 13, 25, 27, 28} Patients were frustrated by lengthy waiting times for what they viewed as being an immediate-access service.^{2, 28} Developing a triage process for patients arriving at a walk-in service to avoid long waiting times and delays in referrals to more appropriate services was felt to be beneficial.

Patients generally appreciated the longer duration of consultations at walk-in services compared with GP appointments which are limited to 10 minutes per patient.^{1, 2, 13, 23} At a Swedish drop-in clinic where consultations were restricted to 15 minutes, patients and healthcare professionals both expressed concerns that this limited the quality of care.^{27, 28} Healthcare professionals at this clinic felt that offering longer opening hours would allow them to offer longer consultations.²⁷

Locally adapted marketing and promotion

Most evaluations concluded that accurate, locally adapted, multimedia marketing and promotion of the walk-in service was important.^{1, 2, 13, 22, 23, 25} In particular, the NHS England evaluations noted that developing promotional materials at a national level was counter-productive because not all services offered the same services which led to confusion for patients.^{1, 2} At a minimum, promotional materials should clearly specify the location of the walk-in service, opening hours and the services available.^{1, 2, 13, 16} It is also important to make it clear to patients that they do not need to be registered with a GP practice in order to use the walk-in service (if this is the case).²³

Implementing effective data systems and software

In the NHS England walk-in service evaluations, the clinical decision support system implemented across the walk-in services was identified as a problem by many staff.^{1, 2} They felt that it was not suitable for use in face-to-face consultations and that it often proposed a course of action that was not appropriate for the patient in front of them. In Australia, nurses reported finding the clinical decision support system cumbersome and time consuming to use, which resulted in frustration and dissatisfaction with the level of autonomy they had in consultations.²⁵

Recording and reporting data for routine monitoring was dependent on walk-in services having a suitably robust system and staff who were trained to correctly input and extract data from the system.^{1, 2, 13} The English evaluation published in 2002 suggested that data systems in walk-in services should use a standard coding structure so that data could be compared across walk-in services and shared with other healthcare providers.²

Data sharing across walk-in services and NHS healthcare service providers was desirable.^{1, 2, 13, 25} This could facilitate referral of patients between services, continuity of care and completeness of electronic health records.

Providing professional development and training

The 2002 evaluation of nurse-led walk-in services in NHS England found that long opening hours and variation in the background of nurses employed at the services resulted in what services the walk-in service offered varying depending on the skills and expertise of the staff working at any given time.^{2, 13} These evaluations concluded that walk-in services needed:

- clear roles and management structures to ensure accountability
- a continuous programme of training and professional development for all staff
- processes to encourage staff to support each other with difficult cases.^{2, 13}

In the evaluation of a walk-in service in Australia, nurses felt unable to access ongoing education and the initial training programme (plus training for new employees) was considered inadequate.²⁵

Evaluation of primary care and community-based walk-in services

The evidence in this section comes from two reports describing the methods and results of evaluations of primary care walk-in services in NHS England,^{1, 2} one report and one primary study evaluating subsets of walk-in services in England,^{13, 16} and seven observational primary

studies describing the evaluation of individual primary care or community walk-in or drop-in services.²²⁻²⁸

Most evaluations used basic qualitative methods, such as interviews, to assess primary care and community walk-in services. The 'outcomes' evaluated included:

- descriptive data on individual walk-in services, such as opening hours, staffing and the services offered
- who uses walk-in services and why
- activity levels (number of patients attending)
- organisational and staffing issues
- costs of service provision
- identifying what works well and challenges to walk-in service provision
- impact on other health service providers, particularly primary care and ED services.

The most robust and comprehensive evaluation was the first evaluation of 39 nurse-led primary care walk-in services in England 2000–2001.² At the time of the evaluation, all walk-in services had been open for 12 months or less. These walk-in services were evaluated against five criteria: improved access to healthcare, quality, appropriateness, impact on other NHS providers and efficiency. The evaluation sought to identify factors associated with the success or failure of the pilot walk-in services. The evaluation framework used in this evaluation is summarised in *Table 4*. The final evaluation report consisted of nine component studies:

- *analysis of routine monitoring data* from all 39 primary care walk-in services and anonymised patient data from a subset of 12 walk-in services that used the same data recording software
- *a questionnaire and follow-up survey* among 4,555 users of walk-in services and 3,078 patients attending nearby GP practices on a same-day appointment basis. Consecutive patients from randomly selected time slots at the walk-in services and GP practices completed questionnaires before and after their consultation. A subset of patients received a follow-up survey 4 weeks later.
- *qualitative case studies* of 54 patients and the nurses they consulted. The case studies were supplemented with data from semi-structured interviews with walk-in service users and staff, and a short postal survey to local GPs. Four to six patients from 10 walk-in services were purposively selected to ensure diversity in patient demographics and the type of walk-in services, respectively.
- *analysis of the impact of walk-in services on the workload* of eight randomly selected GP practices, one ED department and one out-of-hours provider all located near one

of 10 walk-in services. Workload data were compared with data from NHS services in matched towns with no walk-in services for 12 months before and 12 months after the walk-in services opened.

- *a postal survey of health professionals working in GP practices or ED departments near walk-in services to gather their views on the effectiveness of the services and changes in their workload after the services opened.*
- *an assessment of care quality using standardised patients.* This involved 15 role players being trained to present at one of 20 walk-in services, 20 GP practices and 11 NHS Direct sites with pre-planned health scenarios.
- *appropriateness of antibiotic prescribing under patient group directions (PGDs) was compared with legal requirements for PGDs in NHS England.* At 10 walk-in services, case notes for 50 patients who had been prescribed an antibiotic were retrospectively reviewed to assess the appropriateness of the prescribing.
- *assessing the cost and relative efficiency of walk-in services* using routinely collected activity data and financial data provided by each walk-in service, supplemented with data about patients' intentions after their consultation that were gathered in other elements of the evaluation. Cost efficiency was compared across walk-in services and between walk-in services and other NHS services. Costs were calculated per 1,000 patients, from an NHS perspective and included only day-to-day running costs (no set-up costs).
- *interviews with 37 walk-in service managers to find out what worked well and what did not work well.* These interviews were conducted soon after the service opened and repeated approximately 1 year later.

In 2014, a second evaluation of primary care walk-in services in NHS England was conducted by Monitor (the regulator for health services in England at the time).¹ The English walk-in services opened between 2000 and 2010, so Monitor had access to data from a longer period of operation than the first evaluation.² The evaluation methods used by Monitor were less extensive than the first evaluation and by this time, most services had converted from nurse-led to GP-led services. The evaluation was based on submissions from patients, health care providers, GPs, care commissioners and other stakeholders. Monitor conducted a survey of 1,886 patients who had used one of 20 walk-in services and held in-person meetings with a sample of healthcare providers, representatives from commissioning bodies and other stakeholders. Outcomes measured in this evaluation included the number of patients using walk-in services, the proportion of walk-in service users who came from different socioeconomic groups (measured using the index of multiple deprivation), the

types of services offered by each walk-in service, opening hours, reasons for attending the service and patient demographics, such as age and sex.

O’Cathain et al (2009) evaluated six pilot commuter walk-in services in England that were targeted at people travelling to work by train.¹⁶ Commuter walk-in services in England opened between 2004 and 2007 and were evaluated in 2007–2008. Outcomes in this evaluation included location of the service, activity levels, descriptive data on services offered, patient characteristics and costing. The evaluation used a mixed methods approach involving visits to all six commuter walk-in services, semi-structured interviews with walk-in service users (n=28), a survey of patients using the walk-in services (n=1,828), basic costing of services, in-person interviews with service managers and telephone interviews with service commissioners (private sector organisations commissioned these walk-in services). A framework analysis was used but is not described in the published evaluation. O’Cathain et al were unable to use routinely collected data in their analysis because it was classed as commercially confidential by the private sector providers of the pilot services. Instead, they estimated walk-in service activity levels using data from the user survey and a cross-sectional analysis conducted during site visits. For similar reasons, the costing exercise was based on estimates of the contract price for the six services and activity data from the patient surveys. The actual costs of delivering the commuter walk-in services were not available because the services are provided by the private sector.

In 2001, the King’s Fund published an evaluation of primary care walk-in services in London in the first year after opening.¹³ This evaluation was based on face-to-face interviews with walk-in service staff and local NHS stakeholders from primary care and ED departments in London. The evaluation focused on describing why people were using walk-in services and organisational or staffing issues identified during implementation of this subset of walk-in services.

Table 4: Summary of the evaluation framework used in the first national evaluation of walk-in services in NHS England 2000–2001²

Dimension	Outcomes	Method of assessment	Source of data	Comparator
Access	Convenience of opening hours	Quantitative analysis of questionnaire responses	Survey of users	Patients attending general practice
	Convenience of location	Quantitative analysis of questionnaire responses	Survey of users	Patients attending general practice
	Waiting times	Analysis of routine monitoring data	Monitoring data returns; audit of selected walk-in services	None
	Reasons for choosing the walk-in service over alternative NHS providers	Quantitative analysis of questionnaire responses	Survey of users	None
Quality	Patient satisfaction	Quantitative analysis of questionnaire responses	Survey of users	Patients attending general practice
	Quality of clinical care	Proportion of essential actions undertaken	Study of simulated patients	General practice
	Adherence to PGDs	Extent of recorded compliance	Audit of PGDs	Standard directions
Efficiency	Cost per case	Number of contacts in relation to costs	Monitoring returns	Data on costs in other NHS settings
	Cases per nurse per hour	Number of contacts in relation to working hours	Monitoring returns	Data on costs in other NHS settings
Impact on other NHS providers	Number of users consulting another NHS provider with same problem within 4 weeks	Quantitative analysis of questionnaire responses	Follow-up survey of a subset of users	Patients attending general practice
	Change in users' intentions	Quantitative analysis of questionnaire responses	Survey of users	NHS Direct evaluation
	Referrals to other NHS providers	Analysis of routinely collected data	Monitoring returns	NHS Direct evaluation

Dimension	Outcomes	Method of assessment	Source of data	Comparator
	Change in workload at other local NHS providers	Analysis of workload statistics	Workload data from local NHS providers	Workload before and after local walk-in service opened
	Views of other local NHS providers	Quantitative analysis of questionnaire responses	Postal survey of local NHS providers	None
Appropriateness	Clinical conditions presented in relation to staff skills	Analysis of most frequently seen conditions by type of walk-in service	Monitoring returns	Conditions presented in general practice and to NHS Direct
	Users' expectations of care in relation to care provided	Quantitative analysis of questionnaire responses	Survey of users	Users' expectations before and after consultation; expectations of patients attending general practice
	Sociodemographic characteristics of patients seen in relation to target populations	Quantitative analysis of questionnaire responses; analysis of routinely recorded data	Survey of users; monitoring returns; interviews with walk-in service managers	Characteristics of patients compared with the stated aims of the walk-in service; data about patients consulting in general practice
	Appropriate contribution to coordination of care	Qualitative and quantitative analysis from the perspective of patients, health professionals at walk-in services and GPs	Qualitative case studies	None
	Added value or duplication	Qualitative and quantitative analysis from the perspective of patients, health professionals at walk-in services and GPs	Qualitative case studies; survey of users	None

In 2011, an evaluation report was published on an Australian primary care walk-in service that was established based on the NHS England nurse-led model.²⁵ The walk-in service opened in May 2010 and was evaluated over the first 12 months of operation. Outcomes included walk-in service activity levels, patient characteristics, patient access and satisfaction, nurse satisfaction, stakeholder views, the impact of the walk-in service on an ED department and costs. The Australian evaluation used a conceptual framework for performance assessment in primary health care (FPA-PHC) that used Donabedian's quality of care framework. This evaluation framework is summarised in *Table 5*. Efficiency was assessed in terms of time-efficiency, cost-effectiveness and satisfaction of staff and stakeholders. Equity was measured through assessment of processes of care and intermediate health outcomes derived from a clinical audit and cost estimates. Quality was measured in terms of patient satisfaction.

The evaluation had seven stages of data collection:

- a literature review of the international evidence on nurse-led walk-in services
- an audit of data from the clinical decision support software used at the service (activity levels, waiting times and services times, patient demographics, referral rates and reasons for attending)
- a patient satisfaction survey (n=246)
- a satisfaction survey and semi-structured interviews with clinical nursing staff (n=12) at the service (phenomenological analysis)
- interviews with 15 purposively selected stakeholders (phenomenological analysis)
- an assessment of the impact of the walk-in service on workload at a co-located ED department
- assessment of costs and cost implications of the service.

The satisfaction survey used with walk-in service staff was a modified version of the Index of Work Satisfaction (IWS) which is a validated tool designed to measure nurses' satisfaction with their workplace.²⁵

Table 5: Summary of the framework for assessing primary health care used in the evaluation of an Australian walk-in service²⁵

Regional healthcare provider (policy and strategy)	Health walk-in service (operational)		
	Assessment of efficiency: relationships between costs and health outcomes		
	Assessment of equity: is it the same for everyone		
Stewardship	Organisational structures and processes	Processes of care received by patients, families and communities	Intermediate outcomes for patients, families and communities
Background Policy development Financing and funding Implementation Workforce development Research and development	Nursing staff satisfaction (IWS satisfaction survey, face-to-face interviews) Stakeholder satisfaction (face-to-face interviews)	Clinical audit Costs	Patient satisfaction (satisfaction survey)

Two studies by Wardig et al (2019 and 2021) evaluated a primary care walk-in clinic based within a health service in Sweden.^{27, 28} The walk-in clinic differed from the English model because it only opened weekdays 8.00am to 1.00pm. It is situated in an area with a large migrant population, many of whom struggled to access healthcare because of language barriers. The clinic opened in 2012 and was evaluated in 2017–2019, providing data from at least 5 years of operation. The clinic was evaluated from two perspectives: that of healthcare professionals working at the clinic and Swedish-born patients attending the clinic. Both studies used an exploratory qualitative study design based on semi-structured in-person interviews. The participants in each study were purposively selected. Interview transcripts were analysed using content analysis and inductive category development.

One study evaluated community-based drop-in services offered at Healthy Living Services in Scotland.²⁶ These services varied in their aims but most offered health advice and signposting to healthcare services. Purposive sampling was used to select six Healthy Living Services out of 46 to evaluate. The evaluation used qualitative methods that included semi-structured interviews with staff and users of the services (12 to 14 at each service), discussion groups, documentary research, participant observation, formal and informal observation of activities and interactions (three or four at each service), mapping of the local area around the services, telephone interviews and email contacts. The evaluation findings were generated using grounded theory and the constant comparative method. Each service was regarded as a single case study in the analysis, with comparisons made between and

within services. Outcomes were defined as the aims and activities of the services, resourcing (physical and financial) and consumer involvement in managing drop-in sessions at the services. The timing of the evaluation in relation to when the services opened is not clear from the study description.

Two studies evaluated other community-based drop-in services, one aimed at people experiencing homelessness and the other at parents of preschool aged children.^{22, 23} Adams et al (2024) evaluated a drop-in service in Newcastle targeting people experiencing homelessness.²² The evaluation used participatory action research methods that are outlined in *Table 6*. The main purpose of this evaluation was to identify what was working well and not so well in delivering the service, make recommendations for change and present any lessons learned for the wider healthcare, social care and homelessness support system. The second study (Macnamara et al, 2026) evaluated a GP drop-in clinic within a community hub aimed at families with young children.²³ The evaluation assessed the use of the drop-in clinic, the experiences of parents and staff at the clinic and how the drop-in clinic might change health outcomes. The evaluation was conducted in the first 6 months after the clinic opened. Eight parents attending a baby play session at the community hub and nine staff members were purposively sampled and invited to participate in a semi-structured interview. The interviews were based on a topic guide and analysed using codebook thematic analysis with an iterative inductive approach.

One study evaluated a drop-in programme at a community service in San Francisco that was targeted at homeless and marginally housed women.²⁴ The drop-in programme started in 2004 and was evaluated 2 years later. The drop-in programme was offered one night per week from 6pm to 8pm. Medical services and human immunodeficiency virus (HIV) testing were offered once or twice per month as part of the drop-in programme. The evaluation used a qualitative feminist ethnography and social network theory approach to data collection. Qualitative interviews were conducted with eight women attending the drop-in sessions and five members of staff at the community service. All women attending the drop-in programme were invited to complete a self-administered survey and a researcher made observation-based field notes at nine drop-in sessions.

Table 6: Participatory action research methods used to evaluate a community-based drop-in service for people experiencing homelessness²²

Stage	Activities
Background	- Embedded placement in the community drop-in service - Developing relationships with agencies and providers involved in the service - Review of internal evaluations
Agreement	- Discuss existing gaps in knowledge to guide development of the service - Establish an agreed scope for the evaluation based on identified needs - Develop agreement on who will be involved at each stage of the evaluation - Apply for research funding to cover transcription and presentation costs
Choosing the questions	Brainstorm and refine the research questions to be addressed by the evaluation
Research methods and data collection	- Identify purposive sampling criteria to ensure inclusion of people from different providers within the service - Develop a preliminary topic guide and participant information sheets - Apply for research ethics approval - Interviews with 14 service providers
Data analysis	- Analyse data using inductive reflexive thematic analysis - Hold analysis workshop to share preliminary results and obtain feedback
Key findings	- Identify key quotes for illustration - Provide final report headings and hold discussions on content to include - Provide feedback on initial versions of the draft report - Develop a visual communication of the early findings to increase accessibility
Presentation	Co-facilitate an in-person knowledge mobilisation workshop to get wider feedback on the findings from the evaluation and develop recommendations
Action	Work with the lead agency at the service to finalise the report and refine recommendations

Translating lessons learned into practice

One study assessed the effectiveness of translating evidence in the form of lessons learned from the NHS England experience and evaluation of primary care walk-in services into practice at an Australian primary care walk-in service.³⁷ An analysis of the documentation used when planning and establishing the Australian walk-in services and qualitative

interviews of 13 nurses and 15 stakeholders were used to assess the success of translating evidence into practice. Three problem areas were identified:

- use of a clinical decision support system
- marketing the walk-in service
- location of the service.

Despite the NHS England evaluation highlighting widespread problems with using a clinical decision support system that was not designed for face-to-face consultations, the Australian service introduced software that was originally developed for use by a telephone helpline. It was mandatory for nurses at the Australian service to use the decision support system with every patient which led to nurses seeing fewer patients, taking longer for each patient and experiencing frustration and dissatisfaction because they felt like they had no autonomy.

Walk-in service staff and stakeholders felt that the marketing for the walk-in service and its location in a hospital resulted in patients who accessed the service being young 'worried well' and that this further increasing health inequalities.

The Australian walk-in service was co-located with an ED department which seems to have been because an influential group of GPs strongly objected to an independent nurse-led primary care service being offered because it might be perceived as replacing services offered by GP practices. Unfortunately, this resulted in some patients who could not be seen at the walk-in service presenting at the ED department instead of going to their local GP, causing a net increase in ED activity rather than reducing pressure on these services.

Conclusion

The current evidence suggests that primary care walk-in centres may improve access and patient experience, but the evidence that they reduce demand on ED or general practice is limited and inconsistent. Comparison between services is complicated by substantial variation in service models, workforce configurations, operating hours and patient populations.

For NHSScotland, the principal challenge may not be whether walk-in centres work, but identifying which models work best, for which populations, and under what local circumstances. Robust evaluation using a common minimum dataset and agreed outcome measures will be essential if lessons from the pilot programme are to inform future policy decisions.

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Abbreviations

CI	confidence interval
ED	emergency department
FPA-PHC	framework for performance assessment in primary health care
GP	general practitioner
IWS	Index of Work Satisfaction
MD	mean difference
MIU	minor injuries units
NHS	National Health Service
OR	odds ratio
PGD	patient group directions
RCT	randomised controlled trial
RD	risk difference
RR	relative risk/risk ratio
UK	United Kingdom
US	United States
USD	United States dollars

Appendix 1: Searching and screening methods

We searched multiple databases, including Medline, Embase, Cinahl and the Cochrane Database of Systematic Reviews. Key websites were searched to identify grey literature reports and health technology assessments.

Most searches were limited to studies published from 1999 to April 2026. All search results were limited to the English language.

We used Endnote reference management software to deduplicate and manage our search results. We screened the search results for relevance based on publication type, title and abstract or executive summary.

Concepts used in all searches included walk-in clinics/services/services, urgent care, drop-in clinics/services/services, same-day appointments/care, fast track or fast access, rapid access and one-stop clinics/services or services. A full list of the resources searched and the terms used is available on request.

We used the PICOS criteria outlined in *Table A* to select studies for inclusion.

Table A: PICOS inclusion criteria for selecting studies

Population	Patients of all ages needing immediate medical attention for urgent but non-emergency, non-life-threatening minor illnesses or injuries that cannot wait for a routine GP appointment
Intervention	Primary care or community-based walk-in or drop-in health services
Comparator	Any or none
Outcomes	Access to healthcare Workload at nearby ED or GP services Health inequalities and inequities (equity of access) Cost-effectiveness Lessons learned from implementation Evaluation methods and theories of change used to assess walk-in services Barriers and facilitators to implementation
Setting	Primary or community care

Appendix 2: Example search strategy

The Medline strategy below was adapted for each database searched for this topic.

Ovid MEDLINE(R) ALL <1946 to April 07, 2026>

1. (Walk-in adj3 (clinic* or service* or service*)).tw.
2. (primary care adj3 (Walk-in clinic* or walk-in service* or walk-in service*)).tw.
3. (GP led adj3 (Walk-in clinic* or walk-in service* or walk-in service*)).tw.
4. (nurse led adj3 (Walk-in clinic* or walk-in service* or walk-in service*)).tw.
5. urgent care service*.tw.
6. (Drop-in adj3 (clinic* or service* or service*)).tw.
7. (Same day adj3 (appointment* or care)).tw.
8. ((Fast track or fast access) adj3 (clinic* or service* or service*)).tw.
9. (Rapid access adj3 (clinic* or service* or service*)).tw.
10. (One stop adj3 (clinic* or service* or service*)).tw.
11. (Urgent access adj3 (clinic* or service* or service*)).tw.
12. or/1-11

From: [REDACTED] (NHS Healthcare Improvement Scotland)
To: [HIS executiveteam](#)
Cc: [REDACTED] (NHS Healthcare Improvement Scotland); [REDACTED]
Subject: GP Walk in Services - Evidence Review
Date: 30 July 2026 14:47:48
Attachments:

Dear Executive Team,

Please find attached the final **GP Walk-in Services Evidence Summary** for your information.

The review has been shared with SG colleagues.

Many Thanks

[REDACTED]

[REDACTED]

[REDACTED]

Personal Assistant to:

[REDACTED]

[REDACTED]

Healthcare Improvement Scotland

Evidence & Digital

Mobile: [REDACTED]

[REDACTED] [@nhs.scot](#)

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From: [REDACTED]
To: [REDACTED] (NHS Healthcare Improvement Scotland)
Cc: [REDACTED]; [REDACTED] (NHS Healthcare Improvement Scotland); [REDACTED] (NHS Healthcare Improvement Scotland)
Subject: Re: Academic from England with focus on GP Walk-in centres
Date: 05 May 2026 08:00:38

Some people who received this message don't often get email from [REDACTED]@bristol.ac.uk. [Learn why this is important](#)

Hi [REDACTED] and [REDACTED]

Thanks for the introduction. I'm very happy to chat, provide feedback on your ideas, or help in any way I can

Kind regards

[REDACTED]

[REDACTED]

[REDACTED]

Centre for Academic Primary Care, Bristol Medical School. University of Bristol, Canynge Hall, 39 Whatley Road, Bristol BS8 2PS

[REDACTED] [bristol.ac.uk](https://research-information.bris.ac.uk/en/persons/chris-salisbury)

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From: [REDACTED]@gov.scot <[REDACTED]@gov.scot>

Sent: 01 May 2026 17:10

To: [REDACTED]@nhs.scot <[REDACTED]@nhs.scot>; [REDACTED]
<[REDACTED]@bristol.ac.uk>

Cc: [REDACTED]@gov.scot <[REDACTED]@gov.scot>; [REDACTED]@nhs.scot
<[REDACTED]@nhs.scot>; [REDACTED]@nhs.scot <[REDACTED]@nhs.scot>

Subject: RE: Academic from England with focus on GP Walk-in centres

Hi [REDACTED],

I've copied him in and if he has capacity would strongly encourage reaching out to him. He was very generous with his time with us earlier this year and had valuable insight into evaluation approaches, given that he led a lot of the analyses of the English centres.

[REDACTED], I hope it's ok to share your paper and email. HIS colleagues are leading the evaluation and improvement work for our GP walk-in services pilot.

Best,

[REDACTED] | General Practice Policy Division | Primary Care Directorate | Scottish
Government | [REDACTED] |
[Book time with \[REDACTED\]](#)

From: [REDACTED] (NHS Healthcare Improvement Scotland)
[REDACTED]@nhs.scot>
Sent: 01 May 2026 15:43
To: [REDACTED] <[REDACTED]@gov.scot>
Cc: [REDACTED] <[REDACTED]@gov.scot>; [REDACTED] (NHS Healthcare
Improvement Scotland) <[REDACTED]@nhs.scot>; [REDACTED]
<[REDACTED]@nhs.scot>
Subject: Academic from England with focus on GP Walk-in centres

Hi [REDACTED],

You mentioned an academic yesterday who has an interest in Walk-in centres and did work with walk-in centres in England.

They sound like an interesting person to have a discussion with, not just for the evaluation, but in terms of lessons learned from England, etc that could use in the learning system.

Do you have their email address? And would you be able to share that with us?

Best wishes

[REDACTED]

[REDACTED]
[REDACTED]
Healthcare Improvement Scotland

[REDACTED]
[REDACTED]@nhs.scot
[REDACTED]
[REDACTED]

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Cc: [REDACTED]; [REDACTED] [\[NHS Healthcare Improvement Scotland\]](mailto:[REDACTED]@nhs.uk); [REDACTED]
Subject: RE: Evidence review - GP walk-in services
Date: 23 July 2026 17:28:36

Thanks [REDACTED] and colleagues,

This is a hugely impressive piece of work and I am grateful for it.

Can I just check the plans for next steps with it? Presumably it has been shared with the project team within HIS on walk-ins, so all the improvement colleagues etc. Has it gone out to the boards? If not, would you mind us sharing with the leads to help them understand the evidence base available?

Is there any plan to publish this on the HIS website as part of the evaluation reporting?

And finally – though maybe more one for [REDACTED] – do we have a final evaluation framework?

All the best,

[REDACTED] | General Practice Policy Division | Primary Care Directorate | Scottish Government | [REDACTED]
[REDACTED]

From: [REDACTED] (NHS Healthcare Improvement Scotland) <[\[REDACTED\]@nhs.scot](mailto:[REDACTED]@nhs.scot)>
Sent: 22 July 2026 07:47
To: [REDACTED] <[\[REDACTED\]@gov.scot](mailto:[REDACTED]@gov.scot)>
Cc: [REDACTED] <[\[REDACTED\]@gov.scot](mailto:[REDACTED]@gov.scot)>; [REDACTED] (NHS Healthcare Improvement Scotland) <[\[REDACTED\]@nhs.scot](mailto:[REDACTED]@nhs.scot)>; [REDACTED] (NHS Healthcare Improvement Scotland) <[\[REDACTED\]@nhs.scot](mailto:[REDACTED]@nhs.scot)>
Subject: Evidence review - GP walk-in services

Dear [REDACTED] and [REDACTED]

With huge thanks to [REDACTED], please find attached the final evidence review on effectiveness of GP walk-in services. It has been quality assured within our team and signed off by [REDACTED]

We hope it is useful in informing the next stages of this work, and look forward to receiving the next set of evidence support questions.

Kind regards



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To: [REDACTED] ([NHS Healthcare Improvement Scotland](mailto:[REDACTED]@nhs.uk)); [REDACTED]
Cc: [REDACTED] ([NHS Healthcare Improvement Scotland](mailto:[REDACTED]@nhs.uk))
Subject: RE: Evidence support request form
Date: 27 March 2026 13:11:12
Attachments:

Hi [REDACTED],

Thanks so much for this content with it – however the only edit I would make is to the bit in section 3

Addressing inequalities is not an official government aim for the initiative.

When we wrote to boards to ask for proposals, we explicitly asked boards to consider the potential impact on health inequalities, so I think it would be helpful to reword that section – certainly how we can design or improve services with inequalities in mind, is a key aspect of any potential future delivery.

Objectives

The First Minister announced plans to establish a new nationwide network of walk-in services, open seven days a week, providing easier access for people to see a clinician without the need for a prior appointment. The pilots will test and evaluate:

- The feasibility and sustainability of the walk-in model;
- Impact on access, patient experience, and system performance, including demonstrable contribution to reducing waiting times and alleviating pressure across the wider health and social care system;
- Specifically, alignment with and effect on emergency departments, in-hours general practice, wider primary care services and out of hours services, particularly in terms of sustainability, patient flow, relative value for money and opportunity cost;
- Impact on and evidence regarding continuity of care (e.g. communication with usual provider of care), clinical safety, access and health inequalities (including public sector equalities duties);
- Cost-effectiveness and resource requirements for potential future expansion.

Is there anything else you need from us that I can support with?

[REDACTED] | General Practice Policy Division | Primary Care Directorate | Scottish Government | [REDACTED]
[REDACTED]

From: [REDACTED] (NHS Healthcare Improvement Scotland) <[REDACTED]@nhs.scot>
Sent: 25 March 2026 06:31
To: [REDACTED] <[REDACTED]gov.scot>; [REDACTED]
<[REDACTED]gov.scot>
Cc: [REDACTED] (NHS Healthcare Improvement Scotland) <[REDACTED]nhs.scot>
Subject: Evidence support request form

Dear [REDACTED] and [REDACTED]

Please find attached an updated evidence support request form following the helpful discussion with [REDACTED] last week.

Please get in touch if any further amendments are required.

Look forward to working on this with you.

Kind regards

[REDACTED]

[REDACTED]
[REDACTED]
Healthcare Improvement Scotland

[REDACTED]
[REDACTED] [nhs.scot](mailto:[REDACTED]@nhs.scot)

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Cc: [REDACTED] [\(NHS Healthcare Improvement Scotland\)](mailto:[REDACTED]@nhs.uk); [REDACTED]; [REDACTED] [gov.scot](mailto:[REDACTED]@gov.scot);
[REDACTED] [gov.scot](mailto:[REDACTED]@gov.scot)
Subject: RE: Interim evidence summary - GP walk-in services
Date: 10 June 2026 09:29:46

Morning [REDACTED]

First up – huge apologies for the length of time it has taken me to get back to you on this.

Thank you for such an in-depth and thorough review of the available evidence, which is extremely helpful.

My general view, is that it would be helpful to have an executive summary, as well as an overarching summary paragraph of what the evidence is telling us, broken down into themes – so for an example – a summary heading setting out broadly what the findings are around impact on ED attendance, before then going into the existing sections, with the table and analysis.

This would be helpful in allowing us to shape conversations with stakeholders, without having to go study by study.

Very happy to meet soon – my diary (below) is up to date, so do feel free to slot some time in.

Best,

[REDACTED] | General Practice Policy Division | Primary Care Directorate | Scottish Government | [REDACTED]
[Book time with](#) [REDACTED]

From: [REDACTED] (NHS Healthcare Improvement Scotland) <[REDACTED]@nhs.scot>
Sent: 29 May 2026 07:31
To: [REDACTED] <[REDACTED]@gov.scot>
Cc: [REDACTED] (NHS Healthcare Improvement Scotland) <[REDACTED]@nhs.scot>; [REDACTED] <[REDACTED]@gov.scot>
Subject: Interim evidence summary - GP walk-in services

Dear [REDACTED]

Please find attached the interim report of this evidence summary. You'll appreciate that this is an interim draft, not for wider circulation.

It covers the impact of primary care walk-in services on activity at other NHS services (A&E or GP practices), evaluation methods used when assessing walk-in services

and lessons learned from walk-in service evaluations. [REDACTED] is hard at work building on this summary to address the other questions and areas of interest. We plan to share the full report with you later in June. This will include new sections on whether walk-in services improve access to primary care, cost effectiveness of walk-in centres and patient or healthcare professional perspectives on walk-in centres.

We'd very much appreciate your feedback and comments on this interim draft, especially as your thoughts may inform approach to the final report and to the design of the evaluation framework – colleagues in HIS have already used this report to identify some key aspects of the evaluation.

Could you suggest a few times that would suit you to meet in the next couple of weeks? In addition to [REDACTED] and myself, one or two other colleagues involved in developing the evaluation framework may wish to attend to confirm how the findings from this stage of the evidence summary and recommendations for the final summary will inform design of evaluation.

Look forward to hearing from you.

Kind regards

[REDACTED]

[REDACTED]

[REDACTED]

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Primary Care Walk-In Services Briefing

Evidence and experience of Walk-In-Centres and related models.

Introduction

There has been a history of primary care walk-in-centres (WICs) and an evolution of models of both urgent care and general practice access over the last 25 years in England, and more recently in Wales, which can help to inform the approach to delivery in Scotland. This paper summarises some key themes from the experience and evaluation of different models of walk-in and same-day primary care access in the UK and beyond.

There is no standard definition of an NHS walk-in centre. The terms “walk-in centres” “minor injury units” and “urgent care centres” are often used interchangeably by the public and healthcare providers. In England a variety of approaches has developed over time including nurse led walk-in-centres, commuter walk-in-centres, GP led ‘Darzi’ centres, urgent care centres (often co-located with ED) and Extended or Enhanced GP access programmes. Wales has an Urgent Primary Care Centre Pathfinder programme developing models which address urgent primary care at a practice, cluster and pan cluster level.

As there is no standard model, evaluation and outcomes inevitably vary. However, key themes and considerations are drawn out in this paper, including features of more successful models.

Policy Context

General practice and primary care are most people’s first point of contact with the healthcare system in Scotland, with 90% of healthcare encounters taking place in primary care¹. On 13 October, the First Minister announced plans to establish a new nationwide network of walk-in GP services, open seven days a week between noon and 8pm, providing easier access for people to see a clinician without the need for an appointment. This has since been publicly confirmed as Scottish Government policy, reaffirming that improving access to primary care and shifting more care into community settings are key priorities.

Following this clear ministerial commitment, the Scottish Government is requesting every NHS Board area to submit costed proposals to pilot urgent primary care walk-in services in their areas. 15 pilots should be operational by March 2026, with evaluation continuing through 2026–27.

¹ [Scottish Government, 2025. Primary care services.](#)

Health Secretary Neil Gray said:

“Improving access to primary care and shifting more care into the community is central for this Government

“As part of this, we are taking forward new and innovative ways to improve access to primary care, including the benefits of local walk-in GP clinics.

“These will be in addition to core GP services and will offer additional flexibility for patients. These will be designed in collaboration with NHS Boards, GPs and other partners to ensure they strengthen existing services.”²

Scottish Government’s policy aims of improving access to primary care, with a key focus on prevention and shifting care into the community, are reflected in several recent publications for Health and Social Care Reform. [Scotland’s Health and Social Care Service Renewal Framework \(SRF\)](#) sets out the need to improve access to services and treatments in the community through a rebalancing of the health and care system, with a greater proportion of resources being moved towards community settings³. Taking a preventative approach to health and wellbeing in Scotland is a shared responsibility of the whole system. This is reflected in the connection between the SRF’s Framework’s ‘Prevention’ principle and the [Population Health Framework’s](#) (PHF) Driver 4: Equitable Health and Care.

The GP walk-in model is being tested in Scotland to push forward the Scottish Government’s policy aims of improving access to primary care and alleviate pressure on existing GP and A&E services, particularly to tackle the “8am rush” for GP appointments⁴. The First Minister stated the walk-in centres aim to deliver over one million additional GP and nurse appointments, to provide greater flexibility for those who cannot attend appointments during standard working hours⁵.

The introduction of walk-in centres in England has stirred debate. Proponents argue that walk-in centres are important in providing easy access to primary care, particularly when some patients have difficulties getting timely or convenient appointments with a GP practice or accessing primary care more generally. Others believe that walk-in centres create demand for care for self-limiting, minor conditions, and that resources used to provide walk-in centres would be better spent on other priorities⁶.

² [Scottish Government, 2025. Improving access to primary care.](#)

³ [Scottish Government, 2025. Scotland’s Health and Social Care Renewal Framework.](#)

⁴ [BBC, 2025. GPs question SNP plans for new drop-in services.](#)

⁵ [The Independent, 2025. Swinney announces network of 15 walk-in GP centres to open ‘within the year’.](#)

⁶ [Monitor, 2014. Walk-in centre review: final report and recommendations](#)

The purpose of this review is to summarise some of the existing evidence and policy context on walk-in and same-day primary care models in the UK and beyond, with a focus on examining their impacts, equity considerations, implementation challenges, and evaluation frameworks to inform future policy decisions for Scotland. The review is not exhaustive, but draws on key published and grey literature on this topic over the past 20 years.

Evolution of Walk-In and Same Day Primary Care Models

There is no standard definition of an NHS walk-in centre. The terms “walk-in centres” “minor injury units” and “urgent care centres” are often used interchangeably by the public and healthcare providers. Monitor’s review of walk-in centres in England defines a walk-in centre as “a site that provides routine and urgent primary care for minor ailments and injuries with no requirement for patients to pre-book an appointment or to be registered at the centre or with any GP practice”⁷. While all walk-in centres provide basic advice and treatment for minor conditions, the full range of services on offer vary greatly by location.

Between 2000 and 2010, the UK Government launched initiatives to establish NHS walk-in centres throughout England as part of efforts to achieve three major policy goals:

1. Improving access to primary care
2. Modernising the NHS to make it more responsive to patients’ lifestyles
3. Offering more choice to patients

While walk-in centres were established primarily to provide and improve access to primary care, evidence suggests that several stakeholders working across the healthcare system viewed the main purpose of walk-in centres as reducing pressures on A&E departments⁸.

History of walk-in and same day primary care models in England

Most walk-in centres in England were established through three national initiatives described below.

1999-2004: Nurse-led walk-in centres

In April 1999, Prime Minister Tony Blair announced plans to establish a number of nurse-led walk-in centres that would provide information and treatment for minor conditions⁹. Services were to be provided without the need for a pre-booked appointment for extended hours (typically 7am to 10pm), 365 days a year. The

⁷ [Monitor, 2014. Walk-in centre review: final report and recommendations](#)

⁸ NHS Office of the Strategic Health Authorities, 2009. Emergency Services Review, Good practice in delivering emergency care: a guide for local health communities.

⁹ [Gov News, 1999. Up to £30 million to develop 20 NHS fast access walk-in centres.](#)

centres were to be sited in easily accessible locations, such as town centres or adjacent to A&E departments¹⁰.

An additional goal of the nurse-led centres was to maximise the role of nurses in primary care. Beginning with pilot sites, the Department of Health eventually established about 72 nurse-led walk-in centres throughout England¹¹. This included a final wave of centres established in 2004 that were mostly co-located with A&E departments as way to reduce pressure on A&E services¹². The centres had to be managed by an NHS body (such as an NHS trust) or GP co-operatives and were expected to build on, rather than duplicate, existing services, and to have links with local GP practices.

Although walk-in centres were new to the NHS, minor injuries units had already been established in several towns in the UK to serve patients with urgent care needs on a walk-in basis. Walk-in centres were already operating in several other countries, including the US, Canada, Australia and South Africa¹³.

2005-2007: Commuter walk-in centres

Building on the policies behind the first walk-in centre initiative, the government established six GP-led walk-in centres between 2005 and 2007 aimed at commuters in London, Manchester, Leeds and Newcastle¹⁴.

At the time, walk-in centres were viewed as part of a broader vision for primary care, as set out in Table 1.

Table 1: The government's vision in 2004 for primary care¹⁵

THE NHS IN 2000	THE NHS IN 2008
Patient has to make an appointment with a registered GP for advice, diagnosis and referral	Patient chooses whether to make an appointment with a GP or practice nurse, visit an NHS Walk-in Centre or Pharmacy Service Centre, or contact NHS Direct for advice and diagnosis
Patient may wait several days for an appointment with their GP	Patients see a primary care practitioner within 24 hours when they need to or a GP within 48 hours
GP makes decision about how, when and where patient is treated	Patient chooses how, when and where they are treated – from a range of providers funded by the NHS and accredited by the Healthcare Commission

¹⁰ NHS Executive, 1999. NHS Primary Care Walk-in Centres, Health Service Circular.

¹¹ [Nursing Times, 2008. The rise of the walk-in centre.](#)

¹² Salisbury et al, 2007. The impact of NHS walk-in centres on A&E services.

¹³ [Salisbury, C. and Munro, J. 2002. Walk-in centres in primary care: a review of the international literature, British Journal of General Practice, pp.53-59.](#)

¹⁴ [Department of Health, 2004. The NHS Improvement Plan: Putting People at the Heart of Public Services](#)

¹⁵ [Department of Health, 2004. The NHS Improvement Plan: Putting People at the Heart of Public Services](#)

The commuter centres were to be open from 7am to 7pm, 365 days a year and were to offer treatment for minor illness and injuries, prescriptions and pharmacy services, and other services such as physiotherapy and blood pressure checks¹⁶.

Six centres were contracted from independent providers using five-year contracts at a total cost of about £9 million a year.¹⁷ However, by December 2011, all six commuter centres had been closed upon contract expiration, mainly because they saw fewer than expected patients, were poorly located, or were not thought to represent value for money¹⁸.

2007-2010: Emergence of GP-led centres

In October 2007, as part of his Next Stage Review, Health Minister Lord Darzi announced new investment to develop 150 GP-led health centres that offered both:

- a list-based GP practice at which patients could register if they chose; and
- a GP-led service open to any member of the public, including those registered at GP practices elsewhere or those not registered with any GP practice. The service was to allow any member of the public to access GP services through pre-bookable appointments or walk-in appointments that did not require prebooking¹⁹.

The centres were to be open between 8am and 8pm, 7 days a week, and were to be situated in easily accessible locations. They were intended to be responsive to local needs, to foster integrated care, and were to be co-located where possible with other community-based services such as diagnostic, therapeutic (for example, physiotherapy), pharmacy and social care services²⁰.

The GP-led health centres – commonly referred to as “Darzi centres” – were commissioned between 2008 and 2010. Under the Equitable Access to Primary Medical Care (EAPMC) programme, each Primary Care Trust (PCT) was expected to commission at least one GP-led health centre in their area.

Primary Care Trusts procured the centres primarily through competitive tender for Alternative Provider Medical Services (APMS) contracts, which allowed bids to provide the services from the independent sector, GP-formed companies, traditional GP practices, social enterprises and NHS trusts²¹.

¹⁶ [Department of Health, 2004. New surgeries offer commuters fast-track to treatment.](#)

¹⁷ Bureau Investigates, 2011. Get the data: Commuter walk-in centre closures.

¹⁸ [Yorkshire Evening Post, 2011. The Light: NHS Leeds walk in centre to close](#)

¹⁹ [Department of Health, 2007. NHS Next Stage Review Interim report.](#)

²⁰ Department of Health, 2008. Equitable Access to Primary Medical Care, Commercial Strategy, Framework and Provisions Guidance for PCTs.

²¹ J. Ellins, C. Ham, & H. Parker, 2008. Choice and Competition in Primary Care: Much Ado About Nothing?, University of Birmingham Health Services Management Centre.

The emergence of GP-led health centres proved controversial, with the British Medical Association (BMA) stating they “supported establishing these centres where there was a proven need for the services they offered” but also that ““the resources invested in walk-in centres would be better targeted at existing GP services, which have been stretched for many years”²².

Monitor’s review of several GP-led health centre contracts suggests that some PCTs contracted their centres to offer non-registered patients close to the full range of services provided for registered patients²³. Some went even further to try to target certain high need populations. Providers of GP-led services shared that, in practice, the main difference between services offered to registered and non-registered patients is the ongoing nature of care for registered patients. Non-registered patients do not, for example, receive regular treatment for chronic conditions, but may be encouraged to see their GP practice or to register with the centre’s GP practice for further care.

A 2013 review of patient experience and satisfaction with GP-led health centres found that these centres increased access to GP care and most patients were satisfied with the service²⁴.

2010-2017

Since 2010, policy objectives in England have evolved to focus on improving access to 24/7 care and managing demand, with a focus on redesigning urgent care and emergency services. Improving access to primary care also continued to be a major policy goal. In early October 2013, the Prime Minister announced a proposal to implement seven-day 8am-8pm GP access to “help thousands who struggle to find GP appointments that fit in with their family and work life²⁵.”

2017 Onwards: Urgent Treatment Centres in England

A 2017 review of urgent treatment services in England found that the range of walk-in centres, minor injury units, and urgent care centres created confusion for people seeking urgent primary care. As a result, many opted to attend A&E in the first instance, even though it was often less convenient and involved long waiting times²⁶.

As part of this review, NHS England introduced Urgent Treatment Centres (UTCs) with the aim of standardising the range of urgent care services, including walk in centres, minor injury units and urgent care centres:

- “Roll-out of standardised new ‘Urgent Treatment Centres’ which will open 12 hours a day, seven days a week, integrated with local urgent care services.

²² BMA submission to Monitor review, June 2013.

²³ Monitor, 2014. Walk-in centre review: final report and recommendations

²⁴ [Arañ, M., Nicholl, J., Campbell, M. 2013. Patients’ experience and satisfaction with GP led walk-in centres in the UK; a cross sectional study](#)

²⁵ [UK Government, 2013. Seven day, 8am – 8pm, GP access for hard working people.](#)

²⁶ [NHS England, 2017. Next steps for urgent and emergency care.](#)

They offer patients who do not need hospital accident and emergency care, treatment by clinicians with access to diagnostic facilities that will usually include an X-ray machine. We anticipate around 150 designated UTCs, offering appointments that are bookable through 111 as well as GP referral, will be treating patients by Spring 2018.”²⁷

In 2023, as part of refreshed guidance, NHS England published Principles and Standards for UTC implementation, to provide a consistent urgent treatment offer to the public, to reduce attendance at emergency departments and to improve patient access, experience, and care nationally. These principles and standards set out the typical operating patterns for UTCs, including which conditions UTCs can assess and treat.

Core Standards for UTCs in England²⁸

UTCs, wherever they are located, should be able to treat patients of all ages for minor ailments and injury, with senior clinical leadership, in line with these standards. As a priority, UTCs are expected to:

1. **open 7 days a week, 12 hours a day** as a minimum, typically increasing to **24 hours a day when co-located**
2. see both **booked and walk-in** patients
3. see both **minor injuries and minor ailments**
4. see patients of **all ages, including children under 2**
5. have a named **senior clinical leader** supported by an appropriate multi-disciplinary workforce
6. have a **basic consistent investigative and diagnostic** offering on site (with clear protocols if not on site)
7. accept appropriate **ambulance conveyance**
8. have **access to patient records and the ability to send a post event message (PEM)**
9. report as a **Type 3 daily on Emergency Care Data Set (ECDS)**
10. have an up-to-date **directory of services (DoS) profile**
11. clearly communicate to the public what the service is for via **consistent urgent treatment centre nomenclature**, to ensure the service provision is understandable and accessible to all.

UTCs can assess and treat²⁹:

- Sprains, strains, and suspected broken bones
- Cuts, bruises, and minor injuries
- Stomach pain, vomiting, diarrhoea
- Skin infections and rashes

²⁷ [NHS England, 2017. Next steps on the NHS Five Year Forward View](#)

²⁸ NHS England, 2023. [Urgent treatment centres – principles and standards](#)

²⁹ [NHS England: When to visit an urgent treatment centre \(UTC\)](#)

- High temperatures in children and adults
- Mild chest or abdominal pain, headaches, back pain
- Mental health concerns
- Emergency contraception and prescriptions

Investigation and diagnostic standards for UTCs

NHS England defines “urgent primary care” investigations as the following:

“All UTCs must have access to investigations including:

- Swabs, pregnancy tests and urine dipstick and culture.
- Timely blood testing (near patient testing when appropriate), such as glucose, haemoglobin, and electrolytes.
- Electrocardiograms (ECG), and in some UTCs D-dimer, troponin and CRP testing.
- If D-dimer, troponin, and CRP testing are unavailable within the UTC, where this has been agreed as part of exemption status with ICBs, clear referral pathways into same day emergency care (SDEC) and alternative clinics should be in place, with ICBs reviewing referral rates into these alternatives and into EDs to address any high referral rates.
- Access to bedside diagnostics and plain X-ray facilities. Plain X-ray facilities, particularly of the chest and limbs, will increase the assessment capability of a UTC.
 - Where facilities are not available on site, clear access protocols should be in place for post X-ray review to avoid duplication. The DoS should reflect service availability.
- An appropriately skilled clinician must be available to analyse and interpret the results through the UTC opening hours.
- UTCs and ICBs should consider within future planning that, as a minimum, plain film X-ray facilities are available on site where it is not currently available, in accordance with capacity and demand planning.”

Principles for all UTCs³⁰

1. UTCs provide access to urgent care for a predominantly local population. They encompass a range of services, which may have been previously named walk-in centres, minor injury units, urgent care centres, and all other similar facilities.
2. UTCs can provide an alternative to EDs and provide treatment for minor injuries and illnesses that are urgent but not life or limb threatening for people of all ages.

Based on existing utilisation, a UTC patient is therefore typically:

³⁰ NHS England, 2023. [Urgent treatment centres – principles and standards](#)

- ambulatory or mobile
 - in need of same day treatment
 - not in need of constant monitoring, though may need investigative tests to be undertaken
 - requiring 'urgent primary care' level of investigations.
3. UTCs may be co-located with acute facilities, including Type 1 EDs. There is an increasing expectation that EDs will move towards a model where a UTC acts as the front door to ED.
 4. UTCs may be co-located with primary care facilities (including GP enhanced access hubs or integrated urgent care clinical assessment services) or other community urgent care services, such as mental health crisis support, community pharmacy, dental, social care and the voluntary sector.
 5. Some UTCs may be standalone services; it is for local systems to determine whether a UTC is co-located or standalone based on the local population and services.

Clinical standards

- An essential requirement is that all UTCs accept all ages and both minor injury and illness. Clear protocols must therefore be in place to manage critically ill and injured adults and children who arrive at a UTC unexpectedly. At least one member of staff trained in adult and paediatric resuscitation must be present in the UTC at all times. This should all be part of an approach of 'design for the usual, and plan for the unusual'.
- UTCs must have access to clinical advice and guidance from a local ED (on or off-site) within their ICB.
- All UTCs must ensure that the Child Protection Information Sharing system is in use to identify vulnerable children on a child protection plan (CPP), looked after child (LAC) or in utero.
- **All UTCs must have full independent prescribing capability available through the UTC opening hours** (which may include FP10, PGD and e-prescribing).
- All UTCs must be able to provide emergency contraception, where requested.
- All UTCs must have direct access to local mental health advice and services along with local substance misuse advice and support services.

Workforce standards

- **An appropriately trained multidisciplinary clinical workforce must be deployed whenever the UTC is open.** The staff profile and skill set must enable a consistent service throughout the UTC's opening hours and must be able to treat patients of all ages for both minor injuries and illnesses.
- The UTC must be led and governed by an appropriate named senior clinical lead who will take responsibility for general oversight, governance, audit, staff

training and the strategic development of the service. This leadership and governance may be on site, remote or a mixed model. While GPs have often been the default, this leadership can be provided by a GP, ED consultant or other appropriate senior clinical lead.

- All UTCs must, wherever possible, provide support to educational programmes for a range of professions and specialties, including GPs, doctors, and paramedics.
- All healthcare practitioners working in UTCs must complete all statutory training and must receive training in the principles of safeguarding children, vulnerable and older adults, and identification and management of child protection issues³¹.

This section has outlined the evidence on walk-in and same-day primary care models in England, showing how these services have evolved into a standardised Urgent Treatment Centre (UTC) model. UTCs are multidisciplinary team (MDT)-led and designed to improve patient access and experience across urgent care pathways. For the purposes of this review, the term walk-in centre refers to any site offering routine and urgent primary care for minor ailments and injuries without the need for an appointment or GP registration.

The **Delivery Plan for recovering urgent and emergency care services** sets the expectation that UTCs should increasingly be co-located with emergency departments (A&E). This approach aims to relieve pressure on emergency departments and allow emergency medicine specialists to focus on seriously ill patients. Evidence indicates that, despite early efforts to co-locate walk-in centres in community or primary care settings, policy has shifted toward co-location with acute services - primarily hospital and A&E sites.

A key recommendation from this review is to address data gaps on the extent to which UTCs are co-located with primary care facilities in England. Ideally, walk-in centres would not only be integrated within acute facilities but also distributed across primary care and community urgent care settings, in line with NHS England's UTC principles. An overview of identified models, along with learning from Wales, is provided below.

Extended and Enhanced GP Access

The current policy focus in England in relation to General Practice access is on network level models, with funding available to networks (groups of practices) through the GP contract to provide additional same day access and extended access in evenings and weekends³². There is a range of neighbourhood models in place,

³¹ NHS England, 2023. [Urgent treatment centres – principles and standards](#)

³² NHS England, 2022. [Enhanced Access to General Practice services through the network contract DES](#)

with practices coming together to run access hubs or similar which provide appointments when practices have reached capacity, or when practices are otherwise closed. These are largely managed through triage and booking via GP practices or 111 rather than walk-in arrangements.

The development of Urgent Primary Care Centres in Wales³³

A key commitment in the long-term [A Healthier Wales](#) is the development and implementation of models that address urgent primary care patient activity at a practice, cluster, and pan-cluster level to deliver care closer to home.

The implementation of urgent primary care centre (UPCC) pathfinders aims to address these challenges by simplifying local urgent healthcare provision. This will enable better management of demand, and avoid 'hand-offs' and multiple entry points. The implementation of these facilities along with local development of 'Phone First/Contact First' model is a clear opportunity to transform the way urgent primary care is delivered in Wales. This will enable the provision of the right access point for large cohorts of patients, ensuring patients only attend hospital when they need to. The result will be an optimising of the patient experience and improving clinical outcomes.

To support the sustainable transformation of the provision of care in line with A Healthier Wales, The Welsh Government has made up to £4million national funding available for Health Boards to develop and deliver local urgent (same day) primary care centre pathfinders.

Standards for UPCCs in Wales

Patients and the public will:

1. Be able to access UPCCs that are open at least 12 hours a day, GP-led, staffed by GPs, nurses and other clinicians, with access to simple diagnostics, e.g. urinalysis, ECG and in some cases X-ray.
2. Have a consistent route to access urgent appointments offered within XX hrs and booked through NHS 111 (or possibly the Phone First service), ambulance services and general practice.
3. Increasingly be able to access urgent and same-day appointments, and out-of-hours general practice, for urgent appointments.
4. Know that the UPCC is part of locally integrated urgent and emergency care services working in conjunction with the ambulance service, NHS111, local GPs, hospital A&E services and other local providers.

³³ [LITERATURE REVIEW TO SUPPORT THE DEFINITION OF URGENT PRIMARY CARE AND URGENT CARE CENTRE. For National Urgent Primary Care Pathfinder Panel](#)

Table 2: Summary of Walk-In and Same Day Primary Care Models in England

Model	Key features	Access	Location	Benefits	Limitations
Nurse-led WIC Introduced 1999-2004	Open daily, extended hours, nurse-led (no GP registration required), protocol driven care	Walk-in	Standalone	• Rapid access for minor illness/injury • High patient satisfaction due to convenience and longer consultations	• Higher cost per consultation than GP • Duplication of services for registered patients • Limited continuity of care
Commuter WIC Introduced 2005-2007	Nurse-led, 7am to 7pm, located near transport hubs	Walk-in	Near transport links, city centre	• Convenience for mobile populations • Extended hours beyond GP availability	• Same duplication and cost issues as above • Limited integration with local GP records • Low activity levels
GP-led health centres Introduced 2007-2010	GP-led, open to any member of the public (registered or non-registered)	Walk-in or pre-bookable appointments	Often within GP practices or health centres	• Continuity of care plus walk-in flexibility • Extended days/hours • Better integration with primary care records	• Commissioning complexity (funding overlaps) • Risk of destabilising local practices
Urgent Treatment Centres (UTCs) 2017 onwards	MDT-led; diagnostics, open 12 hrs/day	Walk-in and referral – through NHS 111 or any other care setting (GP referral, ambulance services etc)	Mostly hospital sites within/near EDs, some community/ GP co-location	• Standardised urgent care offer • Access to diagnostics (X-ray, blood tests) • Reduces pressure on A&E for non-emergency cases	• Transition challenges from older models • Public confusion about where to receive care • Higher infrastructure cost • Limited available data on co-location with other PC services
Co-located UTCs/Minor Injuries Units	Integrated urgent primary care with minor injury unit	Walk-in	Hospital sites near EDs	• Efficient triage and patient flow • Shared workforce and diagnostics	• Complex governance between acute and primary care • Potential duplication if GP access remains poor

Extended access (2016: Discontinued)	PCN-led Offer of pre-bookable appointments outside of core contractual hours; early morning, evening or weekends	Pre-bookable appointments via GP practice or 111	Delivered in practice or hub clinics	• Improve access for full-time workers • May reduce ED use • Meets routine and urgent demand through flexible same day/pre-booked options	• Limited impact on continuity of care • Little overall patient gain; main benefits for full-time workers • Not well integrated with core GP
Enhanced access 2022 onwards	PCN-led Enhanced access appointments between Mon-Fri 6.30 – 8pm, 9-5 on Saturdays For PCN to decide format and no. appointments and which services to offer	Pre-bookable appointments via GP practice or 111 Face-to-face, video or telephone	Hub locations designated in PCN Enhanced Access Plan	• Standardised nationwide provision via PCNs • MDT approach increases service variety (e.g. screening, vaccinations) • Improved patient access • Reduced A&E and urgent care pressure • Digital options improve patient flexibility	• Wastage concerns across EA hours due to underutilisation of the service³⁴ • Risks to continuity of care • Delivery challenges including interoperability and staffing

³⁴ BMA. [focus-on-use-of-enhanced-access-appointments.pdf](#)

Impacts and Outcomes of Walk-In Centres

Access and patient experience

From a policy perspective, walk-in centres have been introduced with the aim of providing easy access to primary care. An early review of international literature on walk-in centres in primary care highlighted the following areas related to access and patient experience:

Patient satisfaction: Studies from the USA and Canada have demonstrated high levels of satisfaction among patients attending walk-in centres. This appears to be strongly related to the interpersonal aspects of care, such as doctors' or nurses' behaviour³⁵³⁶.

Quality of care: An early UK study found people were very satisfied with the quality of care they received in both walk-in centres and general practice, but people were more satisfied with walk-in centres³⁷. In a study using standardised patients, walk-in centres provided a quality of care which was at least as high as in general practices.

Continuity of care: Evidence suggests placing more emphasis on accessibility across urgent primary care may be at the expense of personal or longitudinal continuity of care.

Only 47% of walk-in centres in Toronto routinely informed GPs of patients attending the clinic³⁸. However, evidence suggests patients appear unconcerned about the lack of continuity of care in a walk-in centre. Findings of a study from Wakefield, in England, found some people positively preferring the anonymity offered by a walk-in centre³⁹. Other UK evidence suggests continuity of care is not a large concern for patients attending walk-in centres because many feel they have an urgent one-time need and simply want to see a doctor or nurse⁴⁰.

This contrasts with several studies from UK General Practice which have shown that continuity of care from a doctor who knows them is an important concern for many people⁴¹. This suggests that people have different expectations of a walk-in centre compared with general practice. It is also consistent with the findings of another recent study, which showed that patients consulting in general practice value

³⁵ Cashman SB, Ash A, Parks CL, Bicknell WJ. The patient population of a major chain of investor-owned ambulatory care walk-in centers. *J Ambulatory Care Management* 1991; 14: 66-77.

³⁶ Chesteen SA, Warren SE, Woolley FR. A comparison of family practice clinics and freestanding emergency centers: organisational characteristics, process of care and patient satisfaction. *J Fam Pract* 1986; 23: 377-382.

³⁷ Salisbury C, Manku-Scott T, Moore L, Chalder M, Sharp D. Questionnaire survey of users of NHS walk-in centres: observational study. *British Journal of General Practice* 2002;52:554-60

³⁸ Miller GB, Mah Z, Nantes S, et al. 2013-2015. Ontario walk in clinics: a preliminary descriptive study. *Can Fam Physician* 1989; 35.

³⁹ Chapple A, Halliwell S, Sibbald B, et al. A walk-in? Now you're talkin'. *HSJ* 2000; 4 May: 28-29.

⁴⁰ The King's Fund and Nuffield Trust, 2012. Securing the future of general practice: new models of primary care.

⁴¹ Freeman G, Hjortdahl P. What future for continuity of care in general practice. *BMJ* 1997; 314: 1870-1874

personal continuity of care for serious health problems more than for less serious ones⁴².

During the initial implementation of walk-in centres in England, GPs and other health professionals initially voiced concerns that the walk-in centres would adversely affect continuity of care because they do not have access to patients' general practice medical records, or that the centres would increase demand and duplicate urgent care efforts⁴³.

Impact on GP, Out-of-Hours, and Emergency Departments

Walk-in centres in England were introduced with the aims of improving access to primary care and reducing pressure on other urgent and emergency care services. Some of the effects of walk-in centres on GP, out-of-hours, and emergency services have been highlighted below.

Impact on GP workload: studies have found limited significant change in GP workload because of the introduction of walk-in centres. Due to the convenience and accessibility of walk-in centres, as well as the relatively minor clinical nature of conditions they treat, this has led to concerns that walk-in centres create demand unnecessarily and would only be fulfilling the demand they create rather than meeting unmet needs.

Duplication: There are concerns that walk-in centres have duplicated care efforts. One study in Canada found that 67% of patients attending walk-in centres attended a GP within the following seven days⁴⁴. This compares with a UK study which found only 21% of patients attending a minor injuries unit consulted a GP within 14 days⁴⁵. As many patients still follow up with their GP after attending a walk-in centre, this limits the productivity of the service.

There is also potential for duplication if a high proportion of people consulting in a walk-in centre must be referred for further advice to another health provider, such as a GP or an A&E department.

A commonly cited concern among commissioners of walk-in centres is that they are "paying twice" for services because most patients attending are registered with a GP practice elsewhere, and those GP practices are already paid to provide those patients with primary care services through the capitated payment structure. Commissioners argue that walk-in centres duplicate services already provided

⁴² Kearley KE, Freeman GK, Heath A. An exploration of the value of the personal doctor-patient relationship in general practice. *Br J Gen Pract* 2001; 51: 712-718

⁴³ Monitor, 2014. Walk-in centre review: final report and recommendations

⁴⁴ Bell NR, Szafran O. Use of walk-in clinics by family-practice patients. *Can Fam Physician* 1992; 38: 507-513.

⁴⁵ Paxton F, Heaney D. Minor injuries units: evaluating patients' perceptions. *Nurs Stand* 1997; 12: 45-47

because patients attend the centres for the same reasons that they would see their GP, often during GP core hours⁴⁶.

Other noted effects of walk-in centres on GP include integration challenges with incompatible IT teams and a negative effect on providing continuity of care across the wider primary care system.

Impact on Out-of-Hours. Current evidence indicates that walk-in centres have had little to no measurable impact on out-of-hours services. This remains a significant gap in the evidence base and is under-prioritised in both policy and research, highlighting the need for further investigation.

Impact on A&E attendances: Although reducing A&E attendances is viewed as a key purpose of the implementation of walk-in centres in the UK⁴⁷, the literature on their effect on emergency departments is mixed.

An early study reported a 24% reduction in attendances at the local A&E department during the three months following the opening of a walk-in centre⁴⁸. In contrast, a large U.S. study found no measurable impact on emergency department usage in areas with walk-in centres.⁴⁹ One more recent UK study found no evidence of any effect of the implementation of a co-located walk-in centre on A&E attendance rates, processes, costs, or outcome of care⁵⁰.

While some evidence suggests walk-in centres can divert a small proportion of minor cases - particularly when co-located with EDs - most studies report negligible or no significant reduction in overall demand for EDs. Their ability to relieve pressure on A&E is therefore limited and highly context-dependent.

Overall, the evidence indicates that walk-in centres improve patient convenience but do not substantially reduce ED workload. One commonly cited reason for closures of walk-in centres in England is their failure to reduce A&E attendances⁵¹.

Cost, productivity and system efficiency

Evidence on the costs, productivity and system efficiencies of walk-in centres is mixed. Early international evidence from Canada suggests the cost of care in walk-in

⁴⁶ Monitor, 2014. Walk-in centre review: final report and recommendations

⁴⁷

⁴⁸ Heaney D, Paxton F. Evaluation of a nurse-led minor injuries unit. *Nurs Stand* 1997; 12: 35-38

⁴⁹ Ferber M, Becker L. Impact of freestanding emergency centers on hospital emergency department use. *Ann Emerg Med* 1983; 12: 429-433.

⁵⁰ Salisbury C, Hollinghurst S, Montgomery A, Cooke M, Munro J, Sharp D, Chalder M. The impact of co-located NHS walk-in centres on emergency departments. *Emerg Med J*. 2007 Apr;24(4):265-9.

⁵¹ For example, the Stockport walk-in centre opened in October 2009, and the PCT had hoped that the centre would help reduce the number of patients attending Stepping Hill's A&E for non-emergency treatment. But reports suggest that attendances at A&E had increased by about 5% and commissioners felt they could not justify the amount spent on the walk-in centre. See www.pulsetoday.co.uk/darzi-centre-closes-due-to-duplication-in-services/11042967.article and <http://alternativeprimarycare.wordpress.com/2010/10/27/walk-in-centre-to-close-stockport-pct/>; See also NHS Salford, Urgent Care Engagement, 30 September 2010

centres was similar to costs in general practice and lower than the costs of hospital EDs⁵².

One other study found that the cost of providing care in walk-in centres was higher than the cost of the alternative that patients specified they would have used if the walk-in centre did not exist, and considerably higher than the cost of a typical consultation within general practice⁵³.

One comparative cost analysis found that co-located walk-in centres are less costly compared to EDs (cost saving: £3.06 per patient)⁵⁴.

In 2014, Commissioners in England cited annual costs for a walk-in centre as being between £450,000 and £1.5 million⁵⁵.

Recent evidence suggests the average cost for someone who attends a walk-in centre and receives the lowest level of investigation and treatment in 2025/26 is £114⁵⁶. This has been compared with estimated average costs of a standard GP appointment and A&E visit below⁵⁷.

Service	Average Cost per Visit in 2025/26	Details
Urgent Treatment Centre / Walk-in Clinic	£114	For the lowest level of investigation and treatment. An earlier figure from 2022/23 was £86.
Major A&E Department	£173 to £563	Costs vary widely depending on the complexity of the case, with an overall average for an A&E attendance around £139 in earlier data.
GP Consultation	£37	A GP visit is the least expensive option for minor issues.

Evidence suggests that the average cost of a walk-in centre visit is less costly than an A&E visit but more costly than the average cost of a GP consultation in England.

The potential for walk-in centres to reduce healthcare costs by diverting people from other agencies is an important consideration. This potential is likely to be realised

⁵² Weinkauff DJ, Kralj B. Medical service provision and costs: do walk-in clinics differ from other primary care delivery settings? Can Public Policy 1998; 24: 471-484.

⁵³ Salisbury C, Chalder M, Manku-Scott T, Nicholas R, Deave T, Noble S, et al. The National Evaluation of NHS Walk-in Centres: Final report wOnlineX. Bristol: University of Bristol; 2002 July. woted 2003 Mar 12x. Available from: URL:<http://www.epi.bris.ac.uk/ywicypdf/WIC%20Evaluation%20Report%20-%20Final.pdf>.

⁵⁴ <https://www.ncbi.nlm.nih.gov/books/NBK564925/>

⁵⁵ Monitor, 2014. Walk-in centre review: final report and recommendations

⁵⁶ <https://www.kingsfund.org.uk/insight-and-analysis/data-and-charts/key-facts-figures-nhs>

⁵⁷ <https://www.kingsfund.org.uk/insight-and-analysis/data-and-charts/key-facts-figures-nhs#:~:text=What's%20the%20cost%20of%20a,1%2C093%20for%20an%20adult%20colonoscopy>.

only if centres divert patients rather than duplicate care, if the cost of the walk-in centre is less than the alternative, and if a high proportion of those people consulting a walk-in centre would otherwise have gone elsewhere rather than managed the problem themselves⁵⁸.

System efficiency

An early analysis of NHS walk-in centres in England, examining their role as a model of integrated care, identified several challenges related to system efficiency, including:

- **Accessibility trade-off:** Providing a “no-wait” service requires high staffing levels, leading to high cost per consultation.
- **Triage efficiency:** Only efficient if cheaper than other providers and successfully diverts patients - evidence of walk-in centres shows the opposite.
- **Allocative efficiency concern:** Questions whether investing in walk-in centres is the best use of limited NHS resources.
- **Policy trade-off:** Balancing improved access for minor illnesses against competing priorities like reducing hospital waiting times for serious conditions.
- **Overall system efficiency:** Walk-in centres often act as an additional service or substitute for existing care at a higher cost, reducing overall system efficiency⁵⁹.

Equity, Population Reach and Behavioural Insights

Who uses walk-in centres?

Monitor’s 2014 report highlights the demographic characteristics of populations who most frequently utilise walk-in centres. Although this varies by locale; evidence on the use of walk-in centres suggests that:

- Younger people are the predominant users, with people between 16 and 45 attending at higher rates than other age groups;
- There are slightly higher proportions of women attending, compared to men at most centres (although some centres show higher proportions of men attending);
- People from lower socio-economic groups tend to be the most common users of walk-in centres;
- Most patients attend on their own behalf, although people often attend on behalf of their child particularly at some centres;

⁵⁸ Salisbury C, Chalder M, Scott TM, Pope C, Moore L. What is the role of walk-in centres in the NHS? BMJ. 2002 Feb 16;324(7334):399-402. doi: 10.1136/bmj.324.7334.399

⁵⁹ Salisbury C. Do NHS walk-in centres in England provide a model of integrated care? Int J Integr Care. 2003;3:e18. doi: 10.5334/ijic.84.

- Populations served often depend on locations. City centre sites often cater to working people. Sites on residential estates often serve young families. Some centres see high numbers of university students, who tend not to be registered with a GP in the area in which they are attending university⁶⁰.

The demographic characteristics of populations who most frequently use walk-in centres has changed over time. During their initial implementation, walk-in centres attracted predominantly men of working age, and fewer children and the elderly. Those initially attending also had higher levels of education and affluence⁶¹.

Impacts on health inequalities and unmet need

Monitor's 2014 report recognises some walk-in centres appear to be successfully reaching people who ordinarily would find access to GP services difficult and for whom uptake and interaction with primary care has generally been poor. The following key points about the impact of walk-in centres on reducing health inequalities are important to highlight:

- The characteristics of patients using walk-in centres have changed somewhat since the centres were first introduced, at least in some locations. While younger adult groups are still the predominant users of walk-in centres, women and those from lower socio-economic groups often account for a higher percentage of users than men and those of affluent status.
- Walk-in centre closures may risk increasing health inequalities if suitable alternatives are not put in place.

Examples of walk-in centres were found serving:

- People who find it difficult to schedule and keep GP appointments, inc. homeless patients, traveller communities, those experiencing substance misuse and ex-offenders.
- Asylum seekers, refugees, and other groups facing language and cultural barriers.
- Workers and students; given extended and weekend opening hours of walk-in centres.
- Minority ethnic groups.
- Patients not registered with a GP practice.

As such, evidence suggests that while walk-in centres mostly serve people with minor conditions, some centres are providing an important route into primary care for high-risk groups. However, some commissioners of walk-in centres have raised concerns that the centre created inequity of access because they were mostly used

⁶⁰ Monitor, 2014. Walk-in centre review: final report and recommendations

⁶¹ ⁶¹ Salisbury C. Do NHS walk-in centres in England provide a model of integrated care? *Int J Integr Care*. 2003;3:e18. doi: 10.5334/ijic.84

by people who lived close by, rather than by groups from areas of high deprivation or those with significant health needs⁶².

Public communication and patient decision-making

A 2013 patient survey, commissioned by Monitor, asked patients who were not registered at the walk-in centre the main reasons for choosing to visit the centre that day:

Table 50: Main reasons for choosing to visit the walk-in centre when not registered at the centre

	Main reasons
	%
It's close to home	48
It's close to work/place of education	13
Ease of getting to the centre	18
Parking at the centre	1
Not having to phone ahead to book an appointment	27
Short expected waiting times	6
The time of day or week that appointments are offered	7
The range of services that are offered at the centre	8
Clinical expertise of the staff at the centre	4
Cleanliness and comfort of waiting rooms and facilities	3
Friendliness and attentiveness of staff	4
Unlikely to see anyone I/we know	0
Prefer not to give personal details	1
Newly arrived in the area/country	1
Only in the area on a temporary basis	2
Not having to register with a GP practice	1
Needed to see someone urgently	7
Didn't know where else to go	1
Just stumbled across it/walked by	1
Could not get an appointment with a GP	11
Other	6
Base: All respondents who are not registered at this centre and were not directed to visit it by other healthcare providers	1,098

Just over a third stated that the most important reason was that the centre was 'close to home'. The other main reason stated by just under a fifth was 'not having to phone ahead to book an appointment'. This was more common for patients aged under 16 years of age, those who had visited the centre more than 12 times and male respondents.

Nearly seven in ten patients registered with a GP practice had not tried to contact their own GP before attending the walk-in centre, and most patients who attended the walk-in centre, but were not registered there, had not contacted any other healthcare provider before going to the walk-in centre.

Purpose of attending the walk-in centre

There was a vast number of medical reasons why people visited their walk-in centre, the most commonly cited ones being:

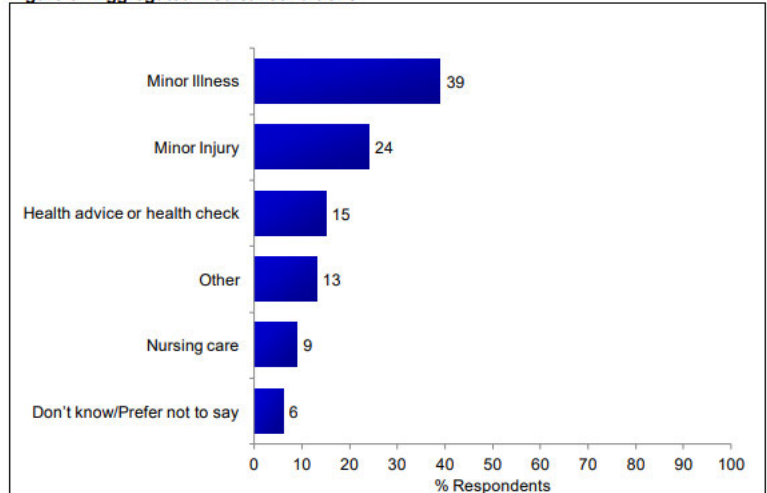
- Flu-like symptoms (i.e. colds, coughs and sore throats: 8%)
- Various skin conditions (8%)

⁶² NHS Nottinghamshire County, Walk-in centres review (public consultation document).

- Sprains or strains (6%)
- Ear/eye infection (7%)
- Cuts, bruises or abrasions (5%)
- A blood pressure check/general health check (6%).

The health conditions were summarised into 6 overarching medical conditions, with minor illnesses (39%) the main reason for attending the centre, followed by minor injury (24%) and health advice or health check (15%). Just over half of the patients described their healthcare condition as urgent and requiring immediate attention.

Figure 6: Aggregated medical conditions



Base=All respondents

What patients would have done if the walk-in centre was not available

When patients were asked where they would have gone if the walk-in centre had not been available:

- One in five said they would have either gone to the A&E Department or to their own GP practice.
- Almost three-fifths would choose to visit a GP, while one in six would have chosen to attend another walk-in centre.
- For two-fifths of patients it would not have made a difference if they had to visit a different healthcare provider that day; however, for just over half it would have made a difference if alternative arrangements had to be made.
- For those for whom alternative arrangements would be impactful, just over half said they would have to wait much longer to see someone, whilst just under half felt they would have further to travel⁶³.
- Research from the Nuffield Trust found 16% of people attending walk-in centres reported that they would have done nothing if that service had not been available, and 46% of patients could be seen to have had additional encounters that they would not have had if the direct access, unscheduled service was not available⁶⁴.

⁶³ Monitor, 2013. Patients' Use of Walk-In Centres

⁶⁴ Nuffield Trust, 2014. Meeting need or fuelling demand?

Implementation Considerations: Risks, Challenges and Enablers

A review of walk-in centres in England found many key features, such as where they are sited, opening hours, skill-mix of staff, the range of services provided, and the degree of co-location with other health and social care services vary by walk-in centre.

The names of walk-in centres also vary and are not necessarily indicative of the services provided. Labels include NHS walk-in centre or simply walk-in centre, GP-led health centre, equitable access centre, open access centre, 8 to 8 centre, same day centre, health centre, medical centre, primary care centre, and urgent treatment centre. This was raised previously, raising a risk of confusion among the public and those accessing care via a walk-in centre.

Monitor's 2014 review found that walk-in centres are most valued today where they were introduced following a careful assessment of local needs, located in an area of the community where the services could be conveniently accessed by those who needed them, and procured using a sound process that resulted in value for money⁶⁵.

Integration with existing GP, NHS 24, and urgent care pathways

From a policy perspective, walk-in centres in England are intended to be well-integrated with other services and providers, but evidence suggests the extent of this integration varies.

NHS England's refreshed 2023 guidance on UTCs states:

"UTCs should operate as part of a networked model of urgent care, working closely with system partners including primary and community care to flow patients to the most appropriate service according to their need. UTCs should have referral pathways into EDs and specialist services as required. UTCs must allow for both pre-booked and 'walk-in' attendances; however, patients and the public should be actively encouraged to contact NHS 111 when an urgent care need arises."

The Fuller Stocktake report includes a similar recommendation, to "Develop a single system-wide approach to managing integrated urgent care to guarantee same-day care for patients and a more sustainable model for practices"⁶⁶.

The approach to establishing integrated neighbourhood teams has been well defined in the Fuller Stocktake. Such teams bring a wider range of expertise together, from across health, social care, VCFSE and wider partners to benefit a shared population. This approach outlines the need for multidisciplinary coordination of care for population cohorts with complex health and care or social needs who require support

⁶⁵ Monitor, 2014. Walk-in centre review: final report and recommendations

⁶⁶ [Fuller, C. 2022. Next steps for integrating primary care: Fuller Stocktake Report](#)

from multiple services and organisations. They are expected to deliver proactive, planned and responsive care, and prioritise care based on individual people's needs and the opportunity for greatest impact.

However, in practice, integration of walk-in centres with other health services is mixed. Some walk-in centres appear to be well integrated, while others operate mostly in isolation. Monitor's report highlights how walk-in centres integrate with other services across the following areas:

Co-location

Co-location varies by walk-in centre. Some have a pharmacy on site; some are co-located with diagnostics, such as x-ray services. Some are housed in a facility with a range of other services such as other GP practices, GP out-of-hours, and dental services. Walk-in centres may also operate or may be co-located with a variety of community clinics, such as sexual health or family planning. Co-location in some instances has led to stronger links between providers, such as shared working among staff.

Through the introduction of standardised UTCs from 2017 onwards, evidence suggests a shift to walk-in centres being co-located within acute settings, however this may be due to a lack of available data on the co-location of walk-in centres within primary urgent care settings.

Relationships with GPs

Walk-in centres typically have contact with GP practices because often they are contractually required, subject to a patient's permission, to send a report of an attendance to the patient's GP practice.

In addition, walk-in centre providers say that some GP practices advise patients to attend walk-in centres when they have no same-day appointments available. Some walk-in centre providers suggested that this might work better for patients if the centres could work with GP practices to enable GPs to use phone triage to direct appropriate patients to walk-in centres (those with one-time minor conditions) instead of using a "first-come, first-served" approach to scheduling same-day appointments. This would prevent patients who need care for chronic or complex conditions from being directed to a walk-in centre.

GP practices may also direct their patients to walk-in centres for certain services, such as blood tests or DVT services.

Integration with Emergency Departments

Walk-in centres send patients needing emergency care on to A&E departments, although evidence indicates that the proportion of walk-in patients sent to A&E is low. Some A&E departments will direct patients with minor conditions to a walk-in centre during times of pressure; however, several stakeholders told us that A&E

departments can be reluctant to redirect patients and do not refer as many patients as they could to walk-in centres or other primary care services.

Some walk-in centres have agreed with ambulance services to receive their non-emergency patients, or patients with minor injuries that can be treated in primary care, directly into the walk-in centre. In one example of walk-in centres building relationships with emergency services, Malling Health has agreed to station a GP and a nurse from one of its walk-in centres at a nearby A&E department to provide triage and treatment for less serious conditions⁶⁷.

However, recent examples of referrals from A&E to UTCs have also been seen in England⁶⁸.

Reasons for walk-in centre closures in England

Monitor's report found several reasons for the closure of various walk-in centres in England, including:

- Funding pressures
- Failure to reduce A&E attendances
- "Paying twice" or duplicating services
- Walk-in centres created unnecessary demand
- Concerns over confusion and duplicative use of services
- Inequity of access⁶⁹

Closing already established walk-in centres risks widening health inequalities by limiting the ability of primary care to reach groups who find it difficult to engage with the traditional model of GP services.

Closure of New Cross Walk-In Centre

The New Cross Walk-In Centre permanently closed on March 31, 2018, despite strong local opposition, including a petition to save the centre and a public consultation where 82% of respondents did not support the closure. NHS Lewisham's Clinical Commissioning Group noted the following as reasons for closing the walk-in centre:

- They believed the walk-in model did not provide the best health outcomes for Lewisham residents and was generating extra demand for services.
- Urgent care in this area was already accessed through several services including an Urgent Care Centre, Primary Care Assessment Service, GP Extended Access, through GPs, Integrated Urgent Care, and Pharmacies.

⁶⁷ [Urgent treatment centres – principles and standards](#)

⁶⁸ [Warren Farm UTC](#)

⁶⁹ Monitor, 2014. Walk-in centre review: final report and recommendations

- Due to the number of urgent care services already available, this confused public messaging and as such patients were not always seen in the right care setting at the right time⁷⁰.

Data sharing and digital infrastructure

UTC Principles and Standards set out that UTCs are expected to have access to patient records⁷¹.

But shared access to patients' full medical records continues to present a challenge to the NHS, in part because providers may use different technology platforms. Even where walk-in centres use the same system as other GP practices or urgent care providers (such as SystmOne), commissioners and providers of walk-in centres have shared that the centres do not always have the required access permissions from the providers holding the records⁷².

Digital infrastructure is still a key barrier to full implementation of GP walk-in centres. Fragmented digital systems and poor interoperability undermine the efficiency of walk-in centre operations.

Lessons from successful pilots and service transitions⁷³

From Monitor's 2014 review of walk-in centres in England, several lessons and recommendations were published to help commissioners procuring walk-in centres to reach decisions which will provide the best support and care for local patients. This includes:

- **Setting a clear purpose & objectives:** Define what the service aims to achieve (e.g., improved access, reduced ED pressure).
- **Population Needs Analysis:** Assess local demographics, health needs, and gaps in current provision.
- **Location & accessibility:** Choose sites that maximise convenience and are accessible to the public.
- **Integration with existing services:** Ensure coordination with GPs, urgent care, NHS 111, and community services.
- **Clinical governance & safety:** Establish protocols for triage, referral, and risk management.
- **Workforce planning:** Secure appropriate staffing (e.g. nurse-led, GP-led, MDT-led), training, and supervision.
- **Digital infrastructure & data sharing:** Enable interoperability with NHS systems for records and reporting.
- **Financial sustainability:** Model costs, funding sources, and long-term viability.
- **Evaluation framework:** Set KPIs for access, outcomes, patient experience, and cost-effectiveness.

⁷⁰ Healthier Communities Select Committee – Recommendation to close New Cross Walk-In Centre

⁷¹ Monitor, 2014. Walk-in centre review: final report and recommendations

⁷²

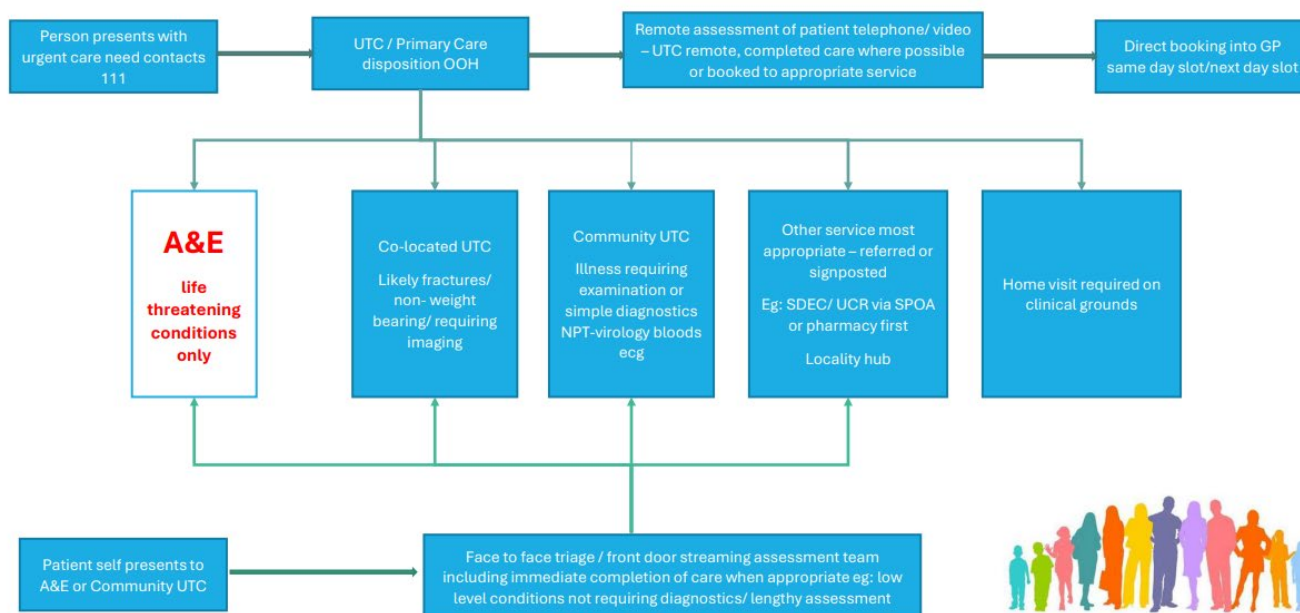
⁷³ [Monitor, 2014. Advice and recommendations for commissioners: deciding the future of walk-in centres](#)

- **Public engagement & communication:** Inform patients about service scope and limitations to manage expectations.

The guidance also suggests the following when choosing a service model and provider for the walk-in centre:

- Identifying the best service model to meet patients' needs includes evaluating which model offers the best value for money. Commissioners should also examine the impact of any potential changes to walk-in centre services on other services. This might involve:
 - Considering the location, opening hours, capacity, and quality of local GP practices, pharmacies, other walk-in or urgent care centres and A&E departments, and the nature of services available from these providers.
 - Analysing likely patient flows under each possible model of care and the potential impact on the costs and quality of other services within the local health care economy (for example, modelling the potential costs associated with increased use of A&E, urgent care centres, or other services if a walk-in centre were to close).
 - Looking at data on the impact of walk-in centre closures in other locations with similar local health economies and examining the effectiveness of any alternative models put in place.

Case study – Patient Pathway: Birmingham and Solihull UTC Clinical Model



Warren Farm UTC - Example of referrals from A&E to UTC⁷⁴

- Warren Farm UTC was relocated on a temporary and emergency basis from Warren Farm to Erdington High Street and it was renamed North Birmingham UTC.
- North Birmingham UTC is currently located, on a temporary and emergency basis, at Good Hope Hospital (GHH) near to its A&E department.
- Previously Warren Farm/North Birmingham UTC only accepted referrals from NHS 111.
- Analysis of Ambulatory and Paediatric Emergency Care attendances at GHH suggested that there were patients who attend each day with minor illness that can be managed safely at North Birmingham UTC.
- Since March 2025, further improvements have been made to referrals pathways to North Birmingham UTC.
- Good Hope Hospital's A&E can now stream appropriate patients to North UTC - supporting patients to be seen by the right service in the right place at the right time.

⁷⁴ [Warren Farm UTC](#)

- Streaming of patients to the UTC also supports improved 4-hour waiting time performance at GHH A&E.
- Since introducing a referral pathway from GHH Emergency Department to North Birmingham UTC there is an average split of 65% of cases being referred by NHS 111 and 35% of cases being referred from the Emergency Department.
- Since North Birmingham UTC relocated to Good Hope Hospital, demand at Erdington UTC at Stockland Green Primary Care Centre has reduced. Between 4 February 2025 and 23 June 2025, Erdington UTC at Stockland Green Primary Care Centre averaged 75 consultations per day - a 24% decrease in daily consultations.

This case study shows through relocating and integrating North Birmingham UTC with Good Hope Hospital's A&E, referral pathways have expanded beyond NHS 111 to include referrals from A&E, which has improved performance metrics like 4-hour waits, and reduced demand at nearby Erdington UTC—demonstrating the benefits of co-location and pathway redesign for urgent care efficiency.

Despite national guidance and standards for a UTC Model, commissioners often tailor walk-in centres to reflect local needs and priorities. To understand some variance by local area, a range of local service specifications have been reviewed below.

Synthesis of local service specifications of walk-in services in England

Location	Opening hours	Skill-mix	Range of services	Degree of co-location	Onward Referrals
Boscombe and Springbourne Weekend Walk-In Service ⁷⁵	Saturdays and Sundays 08.00 – 20.00	Mix of GP and nurse practitioners	(Non-exhaustive) - Accidental injuries (excluding possible bony tenderness/fractures etc) - Minor medical emergencies - Infected wounds - Treatment for wound stitching, sprains and minor fractures - Suspected DVT - Bites or stings - Rash with fever - Breathless or wheeze - Minor scalds and burn	Standalone walk-in service	Discharge may include to GP, Pharmacy or other community service Transfer to ED only when clinically necessary
Halton Urgent Treatment Centres ⁷⁶	08.00 – 21.00, 7 days a week, 365 days a year	GP-led, staffed by GPs, nurses and other clinicians	Minor illnesses and injuries. This excludes : - haemodynamically unstable and/or arrhythmia or significant risk of this significant trauma - fluctuating level of consciousness - breathing unsafe or abnormal (compared with patient's normal breathing) - acute severe abdominal pain - suspected stroke (as per local stroke pathway) - non traumatic chest pain for high risk groups - acute severe headache - suspected injury preventing ambulation above knee	Guidance states "Urgent treatment centres are to be led by general practitioners, and are ideally co-located with primary care facilities, including GP extended hours / GP Access Hubs or Integrated Urgent Care Clinical Assessment Services (formerly known as "GP out of hours" services)" but no data on UTC co-location.	Onward referral only if clinically required (e.g. Assessment units, speciality services within Acute)

⁷⁵ https://nhsdorset.nhs.uk/Downloads/aboutus/finance/02_GMS_0191%20B%26S%20Weekend%20Walk%20In.pdf

⁷⁶ <https://councillors.halton.gov.uk/documents/s60926/Service%20Specs%20UTCs.pdf>

			• overdose with risk of compromising circulation, consciousness level or breathing • Patients who are presenting with a condition who have been referred by a GP - when their clinical condition warrants their presence in an ED. These conditions are classed as Major and will be seen in an acute setting.		
London Urgent Treatment Centres ⁷⁷	Locally determined, required to be open for a minimum 12 hrs per day	MDT: at least one registered medical practitioner (GP) and at least one other registered healthcare practitioner. Specified clinical lead.	• minor illness and injury in adults and children of any age, including wound closure, removal of superficial foreign bodies and the management of minor head and eye injuries. • Diagnostics inc. plain film x-ray, blood testing.	UTCs should be co-located with Emergency Centres, however, standalone centres will also exist.	Integrated clinical pathway allowing onward referrals to: • Patient GP practice/ OOH service • UTCs • Eds • Assessment/ambulatory care units • Mental health crisis services • Specialist services/clinicians
Cornwall GP-led Urgent Treatment Centre ⁷⁸	TBC based on local need, minimum requirement 09.00 – 22.00, open 365 days a year	GP-led model supported by ED Doctors and other qualified non-medical staff, inc. nurse/pharmacists	• Emergency Care for the '5 plus 1 conditions' (Cardiac chest pain, acute shortness of breath, FAST-positive strokes, head injury with loss of consciousness, severe abdominal pain and all severely ill children) are excluded and will be delivered at Emergency Departments • Diagnostics inc. X-Ray, ECG, CT Scanner, Point of Care Testing Equipment	The service will be co-located wherever possible with primary care services (GP/ OOH) and there will be transfer protocols in place between the two services	Onward referral pathways: Local in-hours GP practices including arrangements for temporary residents requiring on the day primary care Out of Hours GP service (currently via the Health Care Professional Line)

⁷⁷ <https://www.transformationpartners.nhs.uk/wp-content/uploads/2015/11/London-UEC-facilities-and-system-specifications-November-2017.pdf>

⁷⁸ <https://spr4cornwall.net/wp-content/uploads/DRAFT-Specification-GP-led-UTC-Service.pdf>

					Mental Health services Local pharmacies
Peterborough Urgent Treatment Centre ⁷⁹	Minimum 12 hrs, 7 days a week inc. bank holidays	MDT but under clinical leadership of GP	Urgent minor injuries or illnesses	Co-located with GP Out of Hours in Peterborough City Hospital	“Refer those who require ED or primary care in line with their clinical need to those services. Where clinically appropriate, this may include arranging a patient's rapid transfer to specialist services on site at Peterborough City Hospital.”

This analysis shows although walk-in centres in England must adhere to national standards and principles for implementation, there is a degree of variance by local area across centre opening hours, skill mix, services provided, co-location, and onward referral pathways, which is based on local need.

⁷⁹ <https://democracy.peterborough.gov.uk/documents/s43661/5.%20Appendix%20five%20-%20service%20specification%20for%20UTC.pdf>

Evaluation and Data Frameworks

Walk-in centres have previously been evaluated in different ways. In 2002, the Department of Health commissioned a team from the University of Bristol to undertake an independent evaluation of the first wave of NHS walk-in centres⁸⁰. This evaluation gathered data from several sources, including:

- Walk-in centre monitoring returns and anonymised patient data
- Patient survey of walk-in centre experiences
- Qualitative case studies
- Survey of local health professionals
- Analysis of activity and financial data provided by walk-in centres
- Questionnaires and interviews with walk-in centre managers

Key indicators for measuring the impact of walk-in centres included:

- Attendance volumes at the centre
- Waiting times
- Cost per consultation
- Impact on ED attendances
- Patient satisfaction and experience

More recently, the 2014 Monitor Report, which has been regularly cited in this report, reviewed the provision of walk-in centres in England. This evaluation gathered data from the following sources:

- Public consultation responses on walk-in centre provision
- Patient survey
- Interviews with walk-in centre providers and commissioning bodies
- Information and data gathered from walk-in centre providers and commissioning bodies

This patient survey did not focus on patient quality of experience but instead analysed the type of patients who attended, the types of services available to patients, the reasons for choosing a walk-in centre, and what the patient would have done if the walk-in centre was not available⁸¹.

⁸⁰ [Salisbury, C.J., Chalder, M.J.E., Manku-Scott, T., Nicholas, REC., Deave, VAM., Noble, SM., Pope, C.J., Moore, LAR., Coast, J., Anderson, E.J., Weiss, MC., Grant, CM., & Sharp, DJ. \(2002\). The national evaluation of NHS walk-in centres: final report. University of Bristol](#)

⁸¹ Monitor, 2014. Advice and recommendations for commissioners: deciding the future of walk-in centres

Conclusions and Policy Implications for Scotland

This briefing has summarised the variety of walk-in care models developed in England, including nurse-led walk-in-centres, commuter walk-in-centres, GP-led 'Darzi' centres, urgent treatment centres and Extended or Enhanced GP access programmes.

This report has also considered the patient profile of people who are most likely to attend walk-in centres, with young people aged between 16-45 appearing to be the predominant users, with slightly more men than women at most centres. The socio-economic profile has changed over time, with early walk-in centres attracting mostly affluent populations but a growth in people from lower socio-economic groups over time, particularly where this was specifically targeted. Demographic profile varies significantly depending on location. The focus on minor episodic illness may exclude those with complex conditions, most likely to be older and from areas of higher deprivation.

Evidence from evaluation of existing walk-in centre models suggests that centres that were strategically located and offered services tailored to the population they serve have been most effective in reaching groups less likely to engage with traditional GP services. This targeted approach has the potential to reduce health inequalities, though concerns around inequity of access have been raised as centres were mostly used by people who lived close by, rather than by groups from areas of high deprivation or those with significant health needs.

Adherence to national standards combined with flexibility for service development based on local need is necessary for successful implementation. Walk-in centres were most valued when introduced following a robust assessment of local needs, situated in accessible community locations, and procured through processes ensuring value for money. Ensuring integration and coordination with other healthcare providers, including through co-location with other services, is vital to ensure system efficiency and prevent duplication of care efforts.

However, challenges remain. Despite attempts to streamline services through the introduction of standards and principles for UTCs in England, there is still no standard definition of an NHS walk-in centre. Terminology remains inconsistent, which causes confusion for the public and complicates evaluation efforts.

Duplication and poor integration with existing services were raised as key barriers to successful implementation throughout the literature. While walk-in centres offer rapid access and convenience, they may hinder continuity of care traditionally provided by GPs, though this appears less critical for minor injuries. Evidence also indicates walk-in centres have had a limited impact on reducing GP workload or A&E attendance. In many cases, walk-in centres function as an additional service or substitute for existing care at higher cost, reducing overall system efficiency.

Significant data gaps persist, including the number and impact of co-located centres (particularly the number of those co-located with other primary care services), and

the effects of walk-in centres on GP out-of-hours services. Policy efforts to standardise through the introduction of UTCs have shifted the focus toward relieving pressure on acute services, particularly A&E, with less emphasis on supporting primary care.

As included above, several lessons and recommendations were published in Monitor's 2014 report to help commissioners procuring walk-in centres to reach decisions which will provide the best support and care for local patients. This includes:

- **Setting a clear purpose & objectives:** Define what the service aims to achieve (e.g., improved access, reduced ED pressure).
- **Population Needs Analysis:** Assess local demographics, health needs, and gaps in current provision.
- **Location & accessibility:** Choose sites that maximise convenience and are accessible to the public.
- **Integration with existing services:** Ensure coordination with GPs, urgent care, NHS 111, and community services.
- **Clinical governance & safety:** Establish protocols for triage, referral, and risk management.
- **Workforce planning:** Secure appropriate staffing (e.g. nurse-led, GP-led, MDT-led), training, and supervision.
- **Digital infrastructure & data sharing:** Enable interoperability with NHS systems for records and reporting.
- **Financial sustainability:** Model costs, funding sources, and long-term viability.
- **Evaluation framework:** Set KPIs for access, outcomes, patient experience, and cost-effectiveness.
- **Public engagement & communication:** Inform patients about service scope and limitations to manage expectations.

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28 November 2025

Appendix 1: Features of different healthcare providers offering routine and urgent primary care⁸²

Service options	Routine primary care	Urgent primary care	Services accessible on a walk-in basis	Opening hours ⁽¹⁾	Service lead
Walk-in centre	✓	✓	✓	Extended	Nurse or GP
Urgent care centre	? ⁽²⁾	✓	✓	Extended or 24/7	GP
Minor injuries unit	X ⁽³⁾	✓	✓	Extended or 24/7	Emergency Nurse
A&E department	X ⁽⁴⁾	✓	✓	24/7	Consultant
NHS Direct / 111 services	X	✓	X	24/7	Nurse / GP / non-clinical adviser
Out-of-hours (OOH) GP services	X ⁽⁵⁾	✓	X	OOH	GP
GP services (in hours)	✓	✓	? ⁽⁶⁾	Core ⁽⁷⁾	GP
Community pharmacy	✓	✓	✓	Extended ⁽⁸⁾	Pharmacist
Self-care and self-management	✓	X	X	24/7	-

Notes: (1) Opening times are defined as either: Core, OOH, Extended, or 24/7. Core is 8:00 to 18:30 weekdays (not including bank holidays); OOH is 18:30 to 8:00 weekdays, 24 hours on weekends and bank holidays; Extended will vary by location, eg, 8:00 to 20:00 or 7:00 to 22:00 every day of the week (including bank holidays). (2) Not all urgent care centres treat routine primary care cases, eg, some centres will direct non-urgent cases to other services (such as patients' registered GP practice). (3) Minor injuries units only treat minor injuries and will often re-direct patients with routine care needs to other services. (4) A&E departments are not intended for patients with routine needs, however these patients are often accepted if they present. (5) Services are accessible by telephone; after a clinical assessment, the caller will be directed to a service that best suits their needs (eg, an OOH GP appointment may be booked for patients with urgent needs). (6) Some GP practices offer walk-in appointments for their registered patients. (7) Some GP practices offer extended hours one or two evenings a week or on the weekend; similarly other practices may offer more restricted hours (eg, they may also be closed one or two afternoons during the week). (8) Some pharmacies may have more restricted opening hours, eg, some high street community pharmacy

⁸² Monitor, 2014. Walk-in centre review: final report and recommendations