

Is there an opportunity for health promotion intervention (smoking cessation, weight management and alcohol intervention) to clients that present to Minor Injuries/Illnesses Unit: a feasibility study.

Abstract:

NHS walk-in centres (WICs) were opened in 2000 to modernise the NHS and increase accessibility to health care. They are rapidly developing and successfully being utilised by the public, however little is known about the clients presenting and even less information on health promotion and disease prevention strategies in these centres.

This review aimed to explore through client profiling if there is an opportunity for health promotion service delivery in WiC's and Minor Injuries/Illnesses Units (MIU's).

Data collection took place between 1st and 31st July 2015.

Results revealed that, of the 2818 clients between 16 and 75 years of age, 49% were male. Of these presentations, 27% were smokers, 42% had a BMI of 26 and over and just under 4% used alcohol over 28 units per week.

The study concluded that clients presenting to MIU are similar to those presenting to GP's and ED's, inherently there is a need and an opportunity to utilise these centres for health promotion in conjunction to the presenting minor injuries or illnesses more so in the local MIU where the population of the city is stated to have poorer health and lifestyle choices in comparison to the rest of England health (Healthprofiles, 2014).

Keywords- NHS Walk in Centres, Minor Injury/illness Unit, Health Promotion.

Summary

The study sought to explore if there were high risk clients (smoker, overuse of alcohol and overweight) that present to the local Minor injuries/illness Unit by screening all clients between the ages of 16 and 75, on smoking status, alcohol consumption per week, their weight and height.

Permission to utilise anonymous client data was also requested. The study formed part 1 of a feasibility study which is in progress. Ethical and governance approval were attained in June 2015 through IRAS and the data was collected between 1st and

31st July 2015. Data input was done on excel, transferred and analysed on IBM SPSS version 20 software.

The results revealed that there is a high number of young people and workers, furthermore there are high numbers of smokers, clients that overuse alcohol, overweight and obese clients.

The study concluded that there is an opportunity to provide health promotion on a number of issues by educating, giving written information and offering referral to free health promotion services around Portsmouth.

The proposal is to engage management and clinical practitioners working in the local MIU to screen clients, provide health promotion intervention (education, information and offer of referral to free services) as part of the consultation with every presenting client.

Background

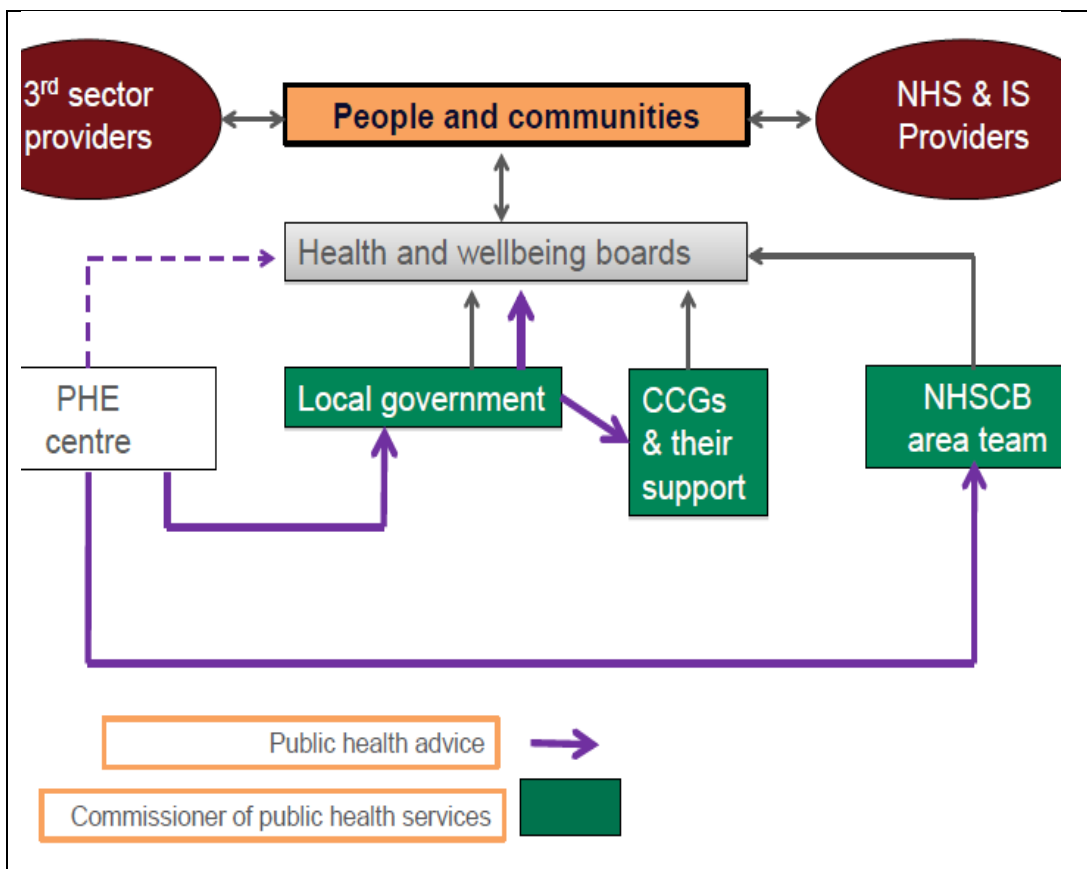
Around 170 000 people die prematurely every year in England (WHO, 2014) with over 15.4 million people affected by Long Term Conditions (LTC) specifically heart disease, type 2 diabetes, cancers (namely oral, lung, breast, gastric) some skin conditions, circulatory disease and respiratory disease, especially Chronic Obstructive Pulmonary Disease (DH, 2010). These diseases have been strongly linked to unhealthy lifestyle choices, explicitly poor diet, inactivity, smoking, obesity and alcohol (DH, 2010). WHO (2014) observe that Britain has the worst rate of obesity in Europe with 17% stated to be overweight and 21% obese. According to the Office of National Statistics (2012) there were 21% smokers and 27% that consume alcohol on five or more days a week that year.

In this country, health promotion has always fallen within GP surgeries, mostly provided by practice nurses within the practice; a paid service (King's Fund, 2010). Challenges and practices in GP surgeries are however not the focal point of this review.

Workload, pressure faced by GP's and Emergency Departments (ED), the increase in the rate of non-accidental premature deaths and Long Term Conditions has highlighted the importance of disease prevention, health promotion and focus on

Primary Health Care (PHC), consequently, current public health agenda has implemented radical changes in the prevention of disease, delivery of services and increased access to PHC, making it everybody's business; focussing now on public health (Public Health England, 2013) with reinforcement in the prevention of disease and promotion of health.

Furthermore, the New Public Health System: an integrated whole system approach (DH, 2014) now requires local authorities to make every contact count, to take steps to protect the health of the population by taking responsibility for offering services namely tobacco control, alcohol and drug misuse, tackling obesity, health checks and many others. The responsibility of commissioning these services has been given to the local governments, Clinical Commissioning Groups (CCG) and the NHSCB local teams as illustrated in table 1 below (Public Health England, 2013).



Equally, the local CCG is fully responsible for commissioning services at the local Walk in Centre Unit for Minor Injuries and Illnesses (MIU).

Coincidentally, in 1999 when the Department of Health proposed to open 20 pilot walk-in centres within six months, with a budget of 30 million pounds, health promotion was one of the key features (Department of Health, 1999), as viewed in table 2.

Key WIC features defined by the DH (1999)
<i>A patient/population needs assessment which supports the development of an innovative primary care centre and is sensitive to age, culture and lifestyle of patients.</i>
<i>One of two accredited NHS Direct decision support protocols for patient management and a clear commitment to provide a service to consistent national standards.</i>
<i>Effective management systems to predict and manage patient demand.</i>
<i>Skill mix which maximises the skills and experience of nurses and meets patient needs in the most cost-effective way.</i>
<i>Provision of a range of high quality minor ailment/treatment services (and possibly medical minor injuries services) to all patients.</i>
<i>Provision of information about NHS, social services and other local statutory and voluntary services.</i>
<i>Provision of information and advice about self-care, healthy lifestyles, such as smoking and diet, which should be met by pilot sites</i>

Table 2

Now, inadvertently health promotion is brought forward in the radical public health changes, bringing together more professionals to deliver and focus on health promotion services (Public Health, 2013).

A literature review conducted in 2013 (Chacha-Mannie, 2014) concluded that the role of WIC's and MIU's was not clear, there was lack of clarity in terms of structure (Jackson et al, 2005), lack of clarity of services provided (Salisbury, et al, 2002), and lack of clarity of educational and skill requirements of nurses working in these centres (Taylor, 2008). The rapidity by the Department of Health from proposal to opening was further blamed for lack of clarity of Walk in Centres (Chandler et al, 2003).

The review revealed however that there is increased access to health services (Pope et al, 2005), concurred by Anderson, (2002) and Salisbury, et al (2002). It was also found that clients/ patients were satisfied by the level of care (Anderson, 2002) with Pope (2005) concluding that WIC's were highly regarded by most of the patients who utilised them and by other healthcare providers. Clients were satisfied because they felt that the nurses had listened to them and there was anonymity (Chapman *et al* 2004). Grant et al, (2002) commends WIC's in that they are a great opportunity for nurses to develop their autonomy and to utilise their skills. It is co-incidentally nurses that are traditionally known for providing health promotion and education within GP surgeries, more so practice nurses. The autonomy of nurses is further revealed in most of the WIC's/ MIU's as they are mostly nurse- led (Monitor, 2014).

There are some gaps on Walk in Centres and Minor Injuries/Illnesses Units as highlighted above however there is a gap in a very essential service, health promotion in WIC's and MIU's more so in the local MIU's where the population of the city has been found to have poorer health compared to England average health (JSNA, 2010).

The health of people in Portsmouth and level of deprivation are generally worse than England average (Public Health Observatory, 2014). Portsmouth, one of the most densely populated cities in England outside London, has a high number of premature deaths, disabilities and generally poor health. Life expectancy is recorded to be below that of the national average more so the male gender. Life expectancy is 10.8 years lower for men and 6.1 years for women in the most deprived than in the least deprived areas (Portsmouth PCT, 2012). Inequality gap and deprivation have led to poverty in most areas (Public Health Observatory, 2012).

Sixty two percent of the population of Portsmouth are aged between 20 and 64, a high percentage of a potentially economically active population.

While there have been health improvements, Portsmouth continues to perform low on key outcomes including smoking, alcohol related admissions, obesity among adults and children (Portsmouth Clinical Commissioning Group, 2014).

Similarly to England, leading causes of non-accidental premature deaths in Portsmouth are heart disease and cancer. The high rates of poor health, poverty and deprivation are attributed to poor healthy lifestyle choices explicitly smoking, alcohol, drug misuse, obesity, poor diet, poor access to health services and lack of education (Public Health Observatory, 2012& Portsmouth PCT, 2012). Estimated levels of adult healthy eating, smoking and physical activity are worse than England average.

There are 27% smokers compared to 21% England average, the main reason for the gap in life expectancy in the city (Healthprofiles, 2014). Twenty four percent (24%) are overweight, slightly better than England average of 24.2%, however, according to the local CCG report (CCG, 2014), 52% in Portsmouth are classed as obese.

Figures publicised by Healthprofiles (2012) showed that 24% of the adult population in Portsmouth use alcohol that could harm their health compared to 22% of England

average, 22% over the age of 16 are defined as binge drinkers and 8% drink at higher risk levels (Healthprofiles, 2014).

Priorities by Portsmouth City Council Wellbeing Service (2014) include reducing obesity, physical activity, better nutrition, tackling alcohol and smoking.

In conclusion, there is lack of scientific literature on the deliverance of health promotion in WIC's and MIU's.

The local MIU aspired to make a difference and contribute to the improvement of the public health of Portsmouth by integrating health promotion to clients presenting for illnesses and injuries, in a city with a high rate of poor health, further made necessary by the fulfilment of "every contact counts" (Public Health England, 2013) for every presenting client and by every working health professional. In the 10 years that the MIU in Portsmouth has been open, it has not been involved in health promotion.

The study aim

To explore the kind of clients that present to MIU/WIC, to establish if there is a high risk population (smokers, obesity and overuse of alcohol) and if there is a necessity and opportunity for health promotion services in MIU's and WIC's

Literature review

A number of databases were used to search for literature on health promotion in MIU's and WIC's including Cinahl, Ebsco, PubMed and others. Boolean operators and MeSH terms including WIC, MIU, Health Promotion, Smoking, Weight, Alcohol and similar were used.

There was only one study found on health promotion in WIC's/ MIU's, with a two others specifically Salisbury (2003) merely stating that "WIC's have a role in health promotion, some run courses to support people wanting to give up smoking or lose weight" with no other explanation or elaboration.

The only relevant paper was that of Patton and Vohra (2013), titled "hazardous drinking in patients attending a Minor Injuries Unit". This pilot study in an MIU, observed that of the 70% clients that presented to A&E with hazardous drinking, 20% were classified as minor injuries, more appropriate to be seen in a MIU by emergency

nurse practitioners who are more likely than doctors to offer health related advice and information. Participants were included in the study if they attended the MIU near a major London hospital, were over 16, English speaking, and consumed at least double the daily recommended units the recommended Department of Health recommendations (male 8 units, female 6 units) or if they admitted to alcohol related MIU presentation. Data was collected over 4 weeks on age, gender, reason for attendance and previous attendance to ED. After interaction with a 1000 clients that presented during the study period, 315 were approached and 192 consented to taking part in the study. Paddington Alcohol test screening was conducted with written advice. Only 3% of the identified 36% hazardous drinkers accepted the offer of help or advice. Patton and Vohra (2013) concluded that very few of the participants that could benefit from help and advice accepted such offer as they did not associate the attendance with their drinking.

Due to limited Health Promotion in WIC's and MIU's, literature was sought to explore implementation of HP services in similar organisations, in this case ED (Emergency Department), similar in that they have 4 hour targets, not paid for health promotion and see clients/patients as a one of encounter (Monitor, 2014).

A randomised controlled trial on multicomponent smoking cessation strategy in ED by Bernstein, Bijur, Cooperman et al (2011) observed that there were very few published clinical trial interventions for smoking in ED. The 338 participants in their study were patients that were contemplating to quit smoking, from a low socio economic group. The study concluded that smoking cessation intervention is feasible at Emergency Departments however physicians required training to utilise teachable moments and to incorporate services into practice.

An American based literature review by Woolard, Cherpitel and Thompson (2011) on brief motivational alcohol intervention in ED explored the Frames model (feedback, responsibility, advice, menu or choice, empathy and self- efficacy) of brief motivational intervention and negotiation interviewing which takes about 20-30 minutes. The review concluded that progress was made in ED to meet public health goals of reducing alcohol misuse. The authors observed that the ED is an important setting for

initiating a teachable moment brief intervention however it had to form part of routine care.

Over 50% of the reviewed studies were on nurses. The similarities were that the nurses were positive in recommendations to implement health promotion in their settings however, it was observed that as positive as most of them were, there appeared to be common barriers in implementation of health promotion. The barriers were time, education, training and management support (Cross, 2005).

Ibid, co-incidentally conducted a qualitative study on ED nurses 'attitudes towards health promotion and found that there is very little or "not at all" research on health promotion in nurses that work in A&E/ED. Similar findings were identified by Bensberg, Kennedy & Bennetts, (2003) in direct interviews with nurses, identifying the opportunities for health promotion in Emergency Departments. The researchers concluded that there was little literature on how to integrate health promotion into ED's organisational structure and that ED staff are not educated on health promotion. Identified barriers were similar to those highlighted by Cross (2005).

There were no studies found on weight management in ED's, WIC's or MIU.

The focus on public health has highlighted an imperative aspect of one of the major responsibilities of Primary Care, which is health education and health promotion. World Health Organisation have clearly defined Primary Health Care guidelines, including the promotion of health and prevention of disease, advice, and strategies that can be applied to promote these, namely 'tobacco cessation' (WHO 2014). However, it would appear from lack of evidence that WHO, PHC guidelines and the DH's WIC key features are either not being delivered or there is not enough published research on HP in these centres.

There is a need to evaluate how health promotion a key feature by the DH was implemented within these new WICs and to establish if the WIC's and MIU's presenting clients would benefit from health promotion services further underpinned in the plight for local demand of health care services, and a need to focus on targeting health and wellbeing issues more so in in Portsmouth where the researcher is based

and where the health of people is poorer compared to the health of the nation (Portsmouth Clinical Commissioning Group, 2013).

There appears to be gaps in scientific literature, raising a number of questions including, is health promotion being offered at WiC's/MIU's, is there a need for these services, could presenting clients benefit from these services, who are the clients that present to these centres, would there any efficacy in implementing health promotion at our local MIU.

The local MIU

The local busy MIU is centrally located in Portsmouth, accessible to clients by walking, public (train, taxi, bus) and private transport seeing over 3300 clients a month of all ages. The unit is nurse led with a minimum of 2/3 nurses in the morning, 5 in the day and 3 in the evening. It is open daily from 07:30-08:00 to 21:30. The nurses with wide knowledge, different skill mix and experience come from different backgrounds including emergency department, primary health care and orthopaedics. Recently, paramedic practitioners have been employed (Care UK, 2015).

Ethical Approval

A doctorate research proposal was successfully submitted at University of Portsmouth School of Health Sciences and Social Work, to implement health promotion services (smoking cessation, weight management and alcohol intervention) at the local WIC for minor injuries and illness. The proposal was peer reviewed at University of Portsmouth. NHS Ethical approval was approved via IRAS in June 2015 and clinical governance was approved by the local CCG and Care UK.

Methodology

Phase I of the study aimed to develop a presenting client/patient data profile to determine if there was a need for health promotion and if there was a need for I, II or all III of the identified health promotion strategies.

Data collection commenced 1st to 31st July 2015.

The mandatory booking in form for all clients was adapted to include smoking status (including e-cigarettes and occasional smokers), weight, height, and alcohol

consumption per week. Alcohol screening scratch cards were also used to help with alcohol consumption.

Request to use data for research purposes was included in the booking in form with a simple yes or no tick answer. Inclusion criteria were all clients between 16 and 75 years of age. All nurse practitioners were trained and requested to screen all clients in this age group.

Anonymous data was collected from the booking in form and captured onto excel. Holiday makers, mental ill health, emergencies namely cardiac chest pain, severe acute illnesses, and others were excluded from the high risk figures.

All excel daily spreadsheets were exported onto IBM SPSS version 22 for data cleansing and analysis.

Simple descriptive analysis was done on SPSS specifically breakdown of age group and gender. Cumulative analysis of smoking, BMI and alcohol intake in units was performed. Clients were classed as overweight and obese if the BMI was 26 and over.

Results

Age	Total	
0-15	970	
16-75	2818	
76+	237	=4025

A total of 4025 clients presented in July 2015. Among the target group for this study (n 2818), 1385 (49%) were male and 1433 (51%) were female.

Clients presented with a diverse group of complaints ranging from simple cuts, fractures, sprains, skin conditions, motor vehicle accident injuries, eye injuries, minor infections, and many more including alcohol related injuries.

High risk screening was done by asking for the smoking status including occasional smokers and e-cig smokers. Weight and height were asked to calculate the body mass index (BMI) and so was alcohol consumption per week.

Daily attendances	Male	Female	Smokers	BMI 26 and over	Alcohol > 28 units
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2818	1385	1433	771	1192	98
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Discussion:

It was found that the presenting clients are similar to those that present to GP surgeries and ED. It is however well documented that GP services provide a paid health promotion service as documented in the GMS contract and QUAFS (DH, 2013 and NHS England, 2014), it nonetheless raises questions of the sufficiency of a 10 minute appointment to include the presenting medical complaint, management thereof and health promotion intervention in the same 10 minute consultation. Studies to extend GP opening times and extension of consultation times and have been documented but they refer to dealing with patient complex medical issues and do not refer to the inclusion of health promotion during consultation (Oxtoby, 2015). The findings are similar to that of Peckham and Exworthy (2003) who observed that GP's continue to practice a medicalised system of primary medical care and emphasise treatment over prevention of disease and promotion of health. However, GP services are not the focus of this study.

There is a large number of client/GP missed opportunities if 2818 clients are presenting to an MIU per month, there are health promotion opportunities that have to be utilised and explored. It is acknowledged that there are a number of services that can be promoted, including chlamydia screening, teenage pregnancies and many others however the focus was condensed to smoking cessation, weight management and alcohol intervention for this study.

Table 3: lessons

What is already known about WICs	What the paper adds
<ul style="list-style-type: none"> *NHS WICs were introduced in 2000. *WICs are progressively expanding. *There is lack of clarity on services, roles in these units. *WIC's are successful, with high number of attendances and patient satisfaction. *HP was a key feature by DH but no clear indication of its implementation. 	<ul style="list-style-type: none"> *WIC's see similar patients to that in GP surgeries and Emergency Departments. *Minimal literature is available on HP service delivery in WIC's *Pilot studies in alcohol prevention and smoking cessation have been successful in ED's. *There is opportunity for Health Promotion intervention in WIC's.

*There are high rates of premature deaths and LTC in the UK.

*Making every patient/client contact count to improve lifestyles and reduce health inequality.

Conclusion

There appears to be an opportunity for health promotion services in the local WIC/MIU.

WICs have been proven to increase access, they are successfully managed by nurses and they are widely used by clients/patients. There is, however, no clarity on their role and services; it would appear that services are dependent on the commissioning body. Co-incidentally, the local MIU services are commissioned by the CCG and subsequently there is a duty to provide health promotion and health education. Furthermore, the onset of LTC may be prolonged with minor lifestyle changes, namely smoking cessation, reduction in alcohol intake, healthy balanced diet and exercise. This can be done through education, health promotion and by providing information which should be available at first point of contact and at primary care stage to enable individuals to look after their health and that of their families (WHO, 2012).

For various reasons outside the scope of this paper, clients present to MIU and WIC's as their first point of call, health promotion opportunities must be utilised to contribute to holistic care.

There are missed opportunities in the provision of services provided by WICs and MIU's.

Proposal for next phase

*Involvement of management in integrating health promotion in service delivery.

*Training of emergency nurse practitioners to make health promotion part of the consultation with every client contact.

*Conduct further studies to explore the best time, approach and effectiveness to implementation of HP during the client's presentation in MIU.

*Conduct nurse interviews on their experiences and perspectives of health promotion in a unit for Minor Injuries and Illnesses.

*Collect data from service users/clients/patients on their views of Health Promotion in an MIU.

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