Patient views of  
the emergency and urgent care system  

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Summary

The aim of this research was to explore patient views of the emergency and urgent care system (EUCS). Qualitative research, consisting of focus groups and individual face-to-face interviews, was undertaken with people who had recently had an unexpected health problem and used the EUCS. 47 people participated in eight focus groups and 13 face to face interviews were conducted with patients.

Accessing the system

- Awareness levels of different services in the system varied enormously between participants, impacting on their ability to make use of the full range of services in the system.
- People reported difficulties entering the system – both knowing where to enter it and specific difficulties with some entry points. For example waiting at A&E, waiting between referral and seeing a hospital specialist, finding an NHS dentist, and negotiating access to see a general practitioner.
- Negotiating access to a service sometimes required feeling entitled to a service, assertiveness, and having access to transport.
- Physically accessing a service sometimes required efforts on the parts of individuals to balance social responsibilities such as caring for their families with accessing care.

Communication

- People valued coordination between services, informational continuity across services, and good communication with health professionals.
- When people had to wait for services they wanted more information about how long they would wait and why.

Speed of access versus other preferences

- People valued speedy access but they also valued other aspects of care such as good communication, feeling that their health problem had been dealt with, and interpersonal continuity (that is, seeing the same health professional). The wider literature shows that some groups value these other attributes more than speed of access.
Proactive services

- Proactive behaviour by health professionals, in terms of offering explanations and information, and sorting out a smooth transition through a service or series of services, emerged as a key attribute of a good EUCS.

This work is the first phase of an ongoing programme of research on the EUCS. It is important to view it as helping us to understand the patient perspective of the EUCS. Service providers and patients may hold different views of the urgency of events and different views of what works and does not work within the current EUCS. Attention will need to be paid to wants, needs and value for money when considering how best to address the issues identified in this research.
1. Background

Most health services research focuses on a service, but patients experiencing an episode of ill-health may not attend or consult a single provider. Instead they may make several contacts with the same or different services, interacting with a number of clinicians and support staff. This is particularly true of patients contacting emergency and urgent care services. Therefore it is important to understand the patient perspective of the emergency and urgent care system (EUCS) as well as the services within it. It is also important to be able to monitor the effect of any changes to this system from the patient perspective. The Department of Health is currently planning changes to this system as discussed in recent policy documents on emergency and urgent care.

2. Aim

The primary aim of the research reported here was to develop a survey instrument for use by service commissioners and providers to monitor the EUCS from the patient perspective. This survey development work is ongoing and progress is not reported here. A secondary aim of the research was to increase understanding of the system from the patient perspective. This report addresses the second aim of this work.

3. Methods

A qualitative approach was undertaken using a combination of focus groups and individual face-to-face interviews with recent users of the system. Focus groups are a form of group interview using interaction between participants to generate data, and have been used extensively to gain views and experiences of health services. Their strength is identifying the breadth and variety of issues through interaction between participants. Individual interviews are the most commonly used qualitative technique in health care settings. They can be used to explore views and experiences in depth, and are suitable for more vulnerable groups who may find focus groups difficult to attend or participate in. The two approaches to data collection were complementary and were used to facilitate a more rounded picture of the patient perspective of the system. The focus groups were undertaken to identify the range of issues important to be people. The interviews were undertaken to generate depth of understanding about issues. The two types of data collection were undertaken concurrently. Focus groups were recruited and
facilitated by researchers at the Centre for Research and Evaluation at Sheffield Hallam University. The interviews were undertaken by a member of the MCRU research team (PC).

3.1 Focus groups

Eight focus groups were purposively sampled to cover a range of demographic, geographical and system configuration characteristics. The groups consisted of people in a rural area (defined as people living at a distance from hospital based services), people in an urban area, parents of young children (with an emphasis on under 5s), older people (65+), people without children, socially deprived people, affluent people, and black and ethnic minority people. They were undertaken in a range of geographical areas in Yorkshire, including Sheffield, Wakefield, Barnsley and Penistone. Some homogeneity was attempted within each group to capitalise on people’s shared experiences. However, the EUCS is so diverse that even highly homogeneous groups - like the parents group - had considerable diversity of experiences.

3.1.1 Recruitment

Members of the general public were recruited using face-to-face recruitment in different geographical areas. For example, the rural group was recruited by a researcher approaching people at a market in a small town; the affluent group was recruited by a researcher approaching attendees at a sports meeting in an affluent part of Sheffield. People were screened for inclusion using a recruitment questionnaire to identify those who had had an unexpected health problem in the previous four weeks and attempted to contact any of a range of services including NHS Direct, walk in centres, dentists, maternity services, pharmacies for advice, emergency ambulances and minor injury units as well as the more common services of general practice and accident and emergency departments. Potential participants read an information sheet before agreeing to participate. Over-recruitment was undertaken to ensure that groups were well attended. People were offered travel expenses and £15 as a token of appreciation.
3.1.2 Participants

103 people were recruited and 47 attended and participated in the eight groups (see Table 1). The aim was to seek the views of a diverse adult population. Both sexes and a full age range of adults participated. Five participants had English as a second language, with one participant using an electronic word translator to aid participation in the group. Two participants had physical disabilities - one was a wheelchair user and another used a walking stick or wheelchair depending on circumstances. Three participants discussed using services for mental health problems.

In six of the focus groups, participants who arrived early were asked to complete a draft questionnaire about the EUCS prior to the group discussion and feed back problems with understanding the questions to the researcher individually. The group discussions were led by an experienced facilitator using a topic guide (see Appendix 1). Discussions lasted between one hour and one and a half hours. They were tape recorded and transcribed verbatim.

Table 1 Description of focus group participants

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3.2 Individual interviews

All the participants in the interviews were recruited from patients registered with three general practices in one primary care trust. All the interviews were conducted by the same researcher and most were undertaken in the participants’ own homes. In some cases, family members who had been involved in the recent decision to seek care urgently were present and they also contributed to the interview process. To validate the details of the events described by the participants, with permission from the patient, the notes held at the general practices covering the episodes of urgent need described in the interview were also reviewed.

3.2.1 The GP setting

It is helpful to understand the approach to urgent care taken in the three general practices in the study:

In Practice One, each day one-third to a half of GP appointments can be pre-booked, and the rest are available for urgent problems on the same day. Additionally, the GPs will see ‘extras’ if a person is too unwell to wait for the next available appointment. Every morning, and in three out of five afternoons, there is a ‘nurse-led acute clinic’. Patients can book in for these from 8:30 am and the practice nurse has a range of clinical options including giving ‘same day’ appointments to see a GP.

In Practice Two, as well as being able to book appointments in advance, the GPs all have unblocked ‘same-day’ appointments set aside. These can be booked daily from 8.30 am. Additionally, every morning patients may contact a GP-led telephone triage system for advice and the GP on duty may offer a same-day full appointment to see another GP. On three days per week there is a nurse practitioner-led minor illness clinic.

In Practice Three, between 10.30 and 12.00 noon, patients can attend a GP-led ‘three minute’ surgery with appointments bookable from 8.30 am. On arrival for an appointment a health assistant will carry out simple health checks such as taking blood pressure, and changing minor dressings. If the health problem needs
a longer consultation than ‘three minutes’ the GP may give the patients a ‘same day full appointment’ to see one of the other GPs or ask the patient to book an appointment for another day. Additionally, the Health Centre offers a range of nurse-led clinics and allied health practitioner services.

The Out of Hours (OOH) cover for all three general practices is provided by a GP cooperative based at one of the teaching hospitals. All three also include access to NHS Direct. However, each practice has a slightly different system of accessing the OOH cover. The emergency telephone number for Practice One connects the caller to a menu-driven electronic system that provides two telephone numbers, either NHS Direct or the GP OOH service, for the caller to ring. In Practice Two the emergency telephone number connects to an electronic menu which gives the caller the option of replacing the receiver and ringing the NHS Direct number, or waiting on the line to be connected to the GP OOH automatically. Callers to the emergency number of Practice Three are connected automatically by an electronic menu to NHS Direct which directs the caller to the appropriate care pathway.

3.2.2 Sample

A purposive sample of potential participants was selected from the patient records held by each practice. For patient confidentiality, in each practice, the sample was selected on our behalf by one of the GPs or a member of their staff. The ‘minimum’ criteria for individual inclusion in the selection were:

- contact with the health care system during the previous four weeks for a health problem that either the patient or their carer felt required urgent attention or advice;
- when the invitations were sent out, the potential research subject should be reasonably well and the approach was not expected to cause undue distress.

An attempt was made to maximise variation by including people of different ages, gender and ethnic background; a range of different care pathways into the system (for example A&E or GP OOH service), and minor and more serious symptoms.
3.2.3 Recruitment

Letters inviting those meeting the criteria to take part in the study, together with an Information Sheet and Consent Form, were mailed out by practice staff. If the recipient of the invitation agreed to take part, the letter asked the person to sign the Consent Form and send it together with his or her contact details, to the university research team using a pre-stamped envelope. On receipt of the signed Consent Form, the Researcher contacted the respondent and arranged a convenient appointment for an interview to take place.

We achieved interviews with thirteen people who had contacted the EUCS in the previous 4 weeks. Five were recruited from Practice One, and four each from Practices Two and Three. Six participants were male and seven were female. They were all adults with ages in the range of 19 to 84 years. Three of the thirteen participants were not white English. The first point of contact to ‘urgent care’ covered almost the whole range of pathways available in the area. One participant had self-referred to a nurse-led walk-in centre (WIC); three had self referred to NHS Direct; three were directed to NHS Direct through the GP OOH emergency number. One was attended by a 999 emergency ambulance called by someone else, and there were three ‘in-hours’ GP appointments. Two presented to A&E; of these one self-referred and one was referred to A&E by a hospital clinic. All the symptoms attributed to triggering the decision to seek urgent care were physical. The symptoms of nine were non-trauma and four were trauma. In two cases, the participants had been admitted to hospital for immediate surgical procedures.

3.3 Analysis

The first stages of Framework were used to analyse both focus group and interview transcripts. This was an appropriate approach because there were a priori issues of importance to the research such as information sharing and accessibility of services. Framework also allows for the emergence of themes which have not been previously identified as important to the research question. Analysis involved reading transcripts to identify themes, constructing a thematic framework, and applying this to all the transcripts. Focus groups and interviews
were analysed separately so that attention could be paid to the strengths of each approach.

It was important to analyse the focus groups as groups rather than as sets of individual interviews. People do not walk in to a focus group with a ready made ‘patient perspective’ – it emerges and changes in the group, and the group ‘consensus’ depends on individuals’ dominance within the group. Thus any emerging consensus is a result of context-dependent social interactions within the group. Therefore attention to interaction between group members was a part of the focus group analysis.

3.4 Ethics

Ethics approval was obtained for the research. The interview component was approved by Doncaster NHS Ethics Committee because recruitment occurred via general practice. The focus group component was approved by the University of Sheffield Ethics Committee because people were not recruited through the NHS. All participants gave written informed consent.

4. Findings from the interviews

4.1 Validation of events with patient’s notes

We were concerned that people would not be able to accurately recall the details of the services they had accessed and therefore we compared their accounts of events with details recorded in their GP notes. All thirteen participants who were interviewed gave permission for the researcher to examine their GP notes relating to the episode and processes of help-seeking behaviour they described. We knew from the interviews that some participants had difficulty in recalling dates accurately. Others had no such difficulty because either the decision coincided with a ‘marker event’ which aided recall, or they kept diaries which included all contacts with the health services. However, the GP notes enabled us to confirm that all the episodes and symptoms described in the interviews were also recorded in the GP notes, all had occurred within the four week period required to
be included in the study, and the times of the day, the contacts made and 
subsequent pathways into care described by the interviewees, were reliable.

The comparison of patient interviews with the GP notes confirmed that the patient 
accounts were correct. It also confirmed that notwithstanding that all the 
interviewees described seeking help urgently for physical symptoms, in two 
cases, the contacts with the urgent care system coincided with stressful life 
events which the participants had also disclosed to the researcher during the 
interviews.

4.2 Knowledge

Knowledge about the availability of services ranged from almost no knowledge 
whatsoever, characterised by the subject believing there was no out of hours care 
when the GP surgery was closed, resorting to the Yellow Pages for information 
and happening to come across NHS Direct, to a detailed knowledge of all the 
hospital and primary care services throughout the area, including when and 
where they were available.

“I didn’t realise it was a Call Centre, I just thought I was 
ringing a practice of some sort.” (Interview 12)

A factor that seemed to account for the wide variation in knowledge about urgent 
care provision in this sample was familiarity with the NHS system due to the 
frequency of contacts for other illnesses.

“Because we go regularly to the rheumatology, and that’s only 
like across the corridor, right next door to that place and we 
know where everything is” (Interview 4)

4.3 Access

All three practices in our study have same-day clinical appointments set aside for 
patients who need to be seen urgently. When these are full there is also 
‘emergency access’ for those too poorly to wait until another day to be seen.

Some participants in our sample described how they had used the ‘same day’ 
provision and appreciated its availability. However, patients have to be aware of
what is and is not available, and also to ring early before the reserved slots are
taken. They also have to be willing to challenge the authority of staff where the
presumption may be that an urgent appointment is not available or necessary.
That this may be a barrier to accessing in-hours care for some patients is
demonstrated in our interview data by ‘passive’, ‘active’ or ‘avoidance’ health-
seeking behaviours. ‘Passive’ was where a patient was prepared to wait two
weeks for an appointment for a problem that in the meantime became worse
because of an infection and required urgent attention.

“But before the two weeks was up, I rang [GP] and told him. I said I don’t really know what... I didn’t know whether to take him up to the hospital or not. And [GP] said ‘No, I ought to see him. You know if you come down, I’ll see him’. And I said ‘Oh yes’. But he couldn’t have gone on the bus or anything, we rang a taxi to go (Interview 4)

‘Active’ was evident in a patient report of arguing vigorously with the reception staff that a medical opinion was needed urgently, and feeling vindicated when the GP confirmed in the same-day consultation she secured that the problem did need to be seen urgently.

“They said there were no appointments and so I said well I’ll have a call out, and they [Reception] said I couldn’t do that.... The doctor came on, listened to what I had to say.... I said... it must be today... then [doctor] eventually agreed to see me if I’d go after five o’clock and was prepared to wait... We waited till ten minutes to six. [The doctor] did say ‘Mrs xxxx” you did need to see a doctor today’.” (Interview 1)

‘Avoidance’ behaviours were apparent when patients reported bypassing a nearby GP service that could have dealt with the problem appropriately, to travel a considerable distance to self-refer to another service and wait knowing they would be seen by a nurse or a doctor on the same day. This behaviour was reported by those who had to travel to the other service by public transport (two buses) as well as by private car.

“So he was in a mess with that you know wondering what to do, ... We wrapped his finger up ever so tightly, and then what did we do next? ... We went up to that little A&E at the hospital and we told the girl on the desk and we just waited and you know they saw to him.” (Interview 4)
4.4 Patient Choice

At a service level, behaviours interpreted as taken to ‘avoid’ perceived barriers to GP in-hours care may also indicate ‘empowerment’ and the self sufficiency necessary to exercise ‘patient choice’.

“They are not actually doctors there...they are nurses. But they are good aren’t they? We’ve got a lot of faith in that hospital and that’s a lot isn’t it.” (Interview 4)

Those in our sample who were familiar with the urgent care system exhibited clear preferences for one service rather than another. Their choices were backed up with reasons. The factors emerging as important were:

- retaining control over where and when to present;
- previous positive experiences of the service;
- confidence in the clinical staff;
- the ethos and general attitude of the staff;
- security from knowing the service contacted initially would provide or offer transport to another provider if the health problem was not one it was able to deal with;
- cleanliness;
- location and convenient links with public transport.

The ‘positive’ reasons underpinning the choices made were reinforced by ‘negative’ views of the alternatives available based on experience, general perceptions (which may be misconceptions) and fears.

At the individual level of the GP-patient relationship, we found that potentially where ‘patient choice’ (always exercised in one direction) is overtaken by necessity, pre-held perceptions may be altered. Of course, this could be favourably or unfavourably. A favourable change appeared in our interview data when a patient required a ‘same day full appointment’ and his usual and preferred GP was unavailable. Necessarily this meant the patient had to see one of the other GPs. The patient reported being equally impressed with the other GP as with his usual GP and that the experience had increased his confidence in the general practice generally.
4.5 Communication

Currently, the general practices in our study hold consultation and investigations data on computers in the medical centres. Patient contacts with the NHS Walk-in Centre, OOH Centres, Minor Injuries Units (MIU), A&E, hospital clinics, are notified to the GP and are also entered into the practice database. Only NHS Direct contacts activated through the emergency OOH number of the practice are recorded on these systems routinely. However, other NHS providers based in different premises cannot access this information remotely.

It may be that, organisationally, a ‘live link’ information system between general practice and non general practice-based services would improve the overall quality of care wherever the patient presents. An example in our interview data was provided by an interviewee who reported an unsatisfactory encounter with OOH after being asked to attend without an offer of transport and had been unhappy to have to inconvenience a family member to drive there. An OOH consultation informed by the GP-held data may have contributed to a more satisfactory experience of OOH for this patient than that recalled subsequently in the interview.

“I found the doctor quite dismissive, very inpatient, not willing to listen, to what I had to say to what basically was the reason why I came to that state, and how it all happened.... I’ve been exhausted, and he said all we can do is so and so. And I said but I feel awful, and I was trying to tell him, but no, he said ... we are here for emergency treatment. And I thought what am I then?” (Interview 13)

However, at an individual level, the participants in our interviews did not find it particularly onerous to have to repeat their health needs to different health providers. In some cases, potentially, where many different services and professions may be involved in delivering the care needed, the view was that relying solely on the information held on the system being accurate, and the information being read properly by different staff, may raise safety issues. There were circumstances when participants felt that it was important for patients to repeat themselves to keep the person providing the care fully informed and up-to date.
In ‘one-to-one’ communication between the patients and providers it was clear that most patients seeking urgent care in our sample were in a heightened state of anxiety. The sorts of expressions they used to describe their feelings were “frightened” and “scared”. When the health problem arose at night or the weekend when their general practice was closed, or if the patient was alone at the time, the sense of isolation increased the anxiety.

“I was just frightened...you know I live on my own. It’s a bit scary, you know when things like that happen and that’s about it”. (Interview 12)

When seeking help urgently, when and how the NHS staff, call handlers and the health professionals involved interact with the patients’ requests for help can fuel this anxiety or relieve it. The types of communication in our interviews that appeared to fuel patient anxieties were:

- comments made during a consultation, interpreted by the patient as reason for uncertainty or doubt in the professional opinion received;

  “And she (doctor) said I managed to get a look in that eye but I couldn’t see in the other one, due to surgery light and her (doctor’s) own eyesight” (Interview 5)

- diagnosing or prescribing over the telephone;

  “I believe that based on what you’re telling me that you’ve had a mild stroke.....Well of course, the alarm bells started ringing....well I daren’t go to sleep, I may not wake up. If you know what I mean...I just wanted the reassurance that I hadn’t had a stroke and there wasn’t a danger that this was going to develop into a full blown stroke...” (Interview 9)

  “… prescribed dressings for something that he didn’t even look at...didn’t even know...even despite me saying that I was in terrible pain” (Interview 1)

- insensitive comments trivialising the patient’s concerns;
- patronising the patient;
- not listening to the patient;
uncritical reliance on the patient’s ‘diagnosis’ or prescribing without taking what the patients felt were appropriate measures to confirm whether their inexpert view was accurate;

“I got the feeling I was like, come on in, come on get out now, next one….It was like I was telling (doctor) what I thought was up with me, instead of the (doctor) telling me….I said on the way home….that didn’t seem right, I could have made a misjudgement, I’m not a doctor” (Interview 6)

After initial contact with a call handler, long waits for call-back for a telephone consultation.

“ And the second time the waiting limit came back and said something like four hours, ring back in four hours….we actually got called back about one o’clock. I was in bed…it didn’t make any difference because I wasn’t asleep.” (Interview 5)

Factors that fuel anxiety also invoke costs both to the NHS and patients as the patient seeks reassurance from the same or another provider, sometimes on more than one occasion.

“…by having two GPs assess the situation, and reassured me that it was muscular, that was good enough.” (Interview 9)

I went to the doctors on Monday, straight into hospital and they operated that night at 12 o’clock.” (Interview 1)

“I’ve had several appointments with my own doctor, phoned NHS Direct up twice and spoke to somebody, who have like reassured me. The walk in centre errr They were quite good with coordination tests (Interview 5).

Communication associated with calming anxieties, encouraging confidence in the advice received and providing reassurance, were the reverse of what ‘fuels’ anxiety above. Being given a thorough physical examination or tests was seen as important.

“[GP] told me to take a urine sample, he had a feel around, and he was a lot more reassuring than what they were. I felt a lot better coming out….I felt 100 per cent better coming out of there”. (Interview 6)

“[GP] really put me through the paces, you know, pulled my arms...[GP] said I don’t think you’ve had a stroke, take some exercises, take some painkillers,...if that doesn’t move we’ll see about getting some physio” (Interview 9)
Other factors associated with good communication were:

- being kept informed about any delays.
- sensitive approach to the needs of the families of the patient

### 4.6 Patient satisfaction

The key factors influencing patient satisfaction in our interview data were:

- Previous experiences of urgent care;

  “Twelve years ago, a doctor came straight out and gave me an injection straight away...told me what was up and admitted me to the hospital. Whereas this time it was totally different. So my [recent] experience, I didn’t think it was very good to be honest” (Interview 6)

- Reliability of information;
- Easy access to appropriate care or advice when needed;
- Safe progress through the system irrespective of number of 'hand-offs' to maintenance or resolution of the urgent need;
- Physical examination and appropriate testing;
- Being treated with respect;
- Being kept informed;
- Undue delay;
- Consideration being given to patients’ needs and those of their families;

  “They let me go and my son as well. We couldn’t leave him on his own. They were really good. Very helpful. They explained what would happen when we got there and where we would have to go.” (Interview 2)

- Receiving an offer of transport to where the urgent care service is located;

  “So phoned the father in law...he came down, and mother in law - she looked after the kids. Bundled in the back of the car, I looked like something out of Iraq, I’m laid in the back in a right tangle.” (Interview 6)

Experiences of the NHS response to their need for urgent care in the past were important factors in how satisfied patients were with response to their recent
requests for help. Recent encounters that compared unfavourably with previous experiences were a source of considerable dissatisfaction. For example people may in the past have received a home visit from the GP or been offered a car to the OOH centre (which is located a considerable distance from all three practices), thus avoiding the additional pressures of disturbing the family or neighbours, or arranging childcare. Recent encounters that compared favourably with previous experiences were a source of considerable satisfaction. For example, one phone call to the OOH emergency number made in the late afternoon on a weekend triggered a rapid seamless process whereby the patient was transported from home by 999 ambulance (accompanied by his family), admitted through A&E, and a surgical procedure performed during the early hours of the next day, compared to a previous experience of ‘conservative treatment’.

Patient satisfaction generally was associated with continuous and safe progress through the urgent care system. The patient had to be confident that he or she was getting the ‘right treatment in the right place at the right time’. In our data, a patient journey to receiving the urgent care sought that was distracted, protracted or terminated by a health professional before the patient’s perceived or actual urgent needs had been met, was a major source of dissatisfaction. Potentially, this also raises safety issues. From the patient journeys and patterns of presentation observed in our sample, discharge of a patient from the pathway or a break in the continuity of care before the symptoms were resolved or explained satisfactorily to the patient was associated with costs, anxiety and dissatisfaction as the patient presented the unmet need (by choice or necessity) again to the same or different service providers.

Delay, either in an anticipated response following initial contact with the system for example, receiving a call-back from NHS Direct, waiting for a consultation, or progressing to an appropriate and timely endpoint by referral to another provider, was a source of dissatisfaction.

“I mean if you went with a broken leg, or broken arm, or something like that, then you would know. But something up here and you don’t know what it is. You can imagine the wait of two, two and a half hours sort of thing just builds up the stress…”(Interview 9)

Our interview data indicated that the influence of delay on patient satisfaction can be moderated or exaggerated depending on whether the patient considers what happens next to be of ‘good quality’.
I was really growing concerned about how soon they would get in touch with me, it was an hour that I had to wait before they contacted me. But what I thought was quite good they sent a taxi for me, which was really good, and I really appreciated it. (Interview 13)

5. Findings from the focus groups

5.1 Labels for the system

Health professionals, commissioners and researchers are interested in care which has been labelled ‘unscheduled’, ‘unplanned’, ‘emergency’, ‘first contact’, ‘immediate’ and ‘urgent’. This is where care is provided outside the routine, planned and booked appointment systems of the NHS. Typical examples of services only providing this type of care are accident and emergency departments and out of hours general practice. We explored in the focus groups what people understood by some of the labels we wished to use to describe the EUCS, and listened for any labels they themselves used.

There was consensus that the term ‘emergency’ meant blue flashing lights and an ambulance, and we will see later on that the use of this term in general practice can be a cause of difficulty to some patients. Terms which encompassed the less urgent end of health problems, which patients felt required immediate attention, were more difficult to reach consensus on. We began the research using the term ‘unexpected health problem’ on the draft questionnaire which people completed prior to the focus groups. We found that this was mainly acceptable to people and seemed to communicate the relevant health problems with the exception of ongoing illness with infrequent flare-ups. For example, people with ongoing asthma, who had severe asthma attacks which might lead to hospitalisation, expected these flare-ups to happen and therefore felt they would exclude them when completing the questionnaire.

We discussed the term ‘unplanned’ in a number of groups and this received low level approval with some comments that no one ever planned to be ill. There was no strength of feeling behind the approval of this term. We then tested the term
‘urgent’ on a draft questionnaire completed by focus group participants but there
was confusion over what was meant by urgent, with some people feeling it
communicated more serious problems and others that it encompassed the whole
gamut of health problems that they perceived needed immediate attention. One
focus group really took this issue on and eventually reached the consensus that
different people would have their own interpretation of any term and examples of
what we meant by urgent would help people to decide whether our questionnaire
was relevant to them. In particular, they felt that specifying the range of services
we wanted people to think about would help. No ‘lay label’ emerged as people
talked about what researchers and commissioners of services call unscheduled or
unplanned care.

5.2 Knowledge of services in the system

Where people enter the EUCS can depend on their knowledge of which services
are available and how to access them. Awareness of services is almost a
prerequisite for accessing them.

5.2.1 Varying levels of awareness

As in the interviews, the variety of levels of awareness of different services in the
system was considerable. In some focus groups, such as parents of young
children and people with no children, where participants tended to be younger,
the participants discussed NHS Direct, walk in centres, minor injury units and
NHS Direct Online as well as the more traditional services of accident and
emergency, pharmacy, and general practice. Yet in other groups, when the
facilitator asked about these newer services, there was silence. This occurred in
the rural focus group where the participants were mainly older people and who
may not have come across walk-in centres and minor injury units because they
were not part of their local system. Participants sometimes exchanged
information about different services known to them but not others in the group.

People wanted to know about the different services in the system and what they
offered. For example questions such as “How does the health visitor fit into the
NHS? Are they social services?” (Affluent group, P2) were asked. Even when they
were aware of services, they wanted to know which service was appropriate for
which type of problem. They could feel confused as services around them changed over time.

P2: From my point of view, from an adult side of things [since the local hospital] lost its A&E it seems a lot more different services like minor injuries, GP cooperative I'm never sure what covers what....

P1: No I'm not.

P2: If you broke your wrist can you go to minor injuries or do you need to trek all the way over to [A&E] particularly from [the local hospital where minor injuries is situated]? I'm not sure what covers what.

P1: And when you go in, there is the walk in centre and when my brother had an accident we didn't know where to take him to A&E or minor injuries.

P2: I went to minor injuries and needed the A&E. I could have gone there in the first place. It's knowing what they cover at the [local hospital]. (Parents group)

A proposed solution was a map of the system so people knew where best to enter it, although some people felt they had been given this information through their letterbox already.

Then secondly, the system is different and when the system is changed it's no good sending child to his school and don't know which is the gate, which way to get in. (Black and ethnic minority group, P3)

And a road map of the NHS would be useful, how is it laid out, what does what, what services are available rather than randomly relying on leaflets in doctor's surgeries or posters on walls. So actually being able to understand the layout of the thing, how it operates, how do you get an appointment. (Nokids group, P2)

5.2.2 Accessing services with no knowledge or the incorrect knowledge

An interesting case was of a person who had only been in the UK for a year. He was making great efforts to learn English but was not yet proficient. He was concerned that he did not understand how to access a GP service out of hours. Yet when he attempted to do so he found the number, was driven up to the out of hours service, offered treatment, and driven home again. That is, the system worked extremely well for him without him being aware of how it worked. This is
a sign of a system working well, yet his ignorance of how it worked still concerned him because he was not confident about how to deal with things the next time he might need the service.

As people described their recent use of services it was evident that they confused one service with another because of the co-location or integration of services. For example, when describing phoning the GP out of hours, some interviewees described calling NHS Direct, NHS Direct out of hours, or an out of hours helpline, and described attending the walk-in centre for a GP out of hours visit. This has implications for our proposed survey in that some people may be unable to accurately describe the service they used.

5.3 The services in the system – the centrality of the GP

Although there was variation in people’s levels of awareness about services in the system, how these services worked, and what they provided, focus group participants discussed a range of services in the EUCS. These included pharmacy, general practice in and out of hours, accident and emergency, minor injury units, walk in centres, 999 ambulance, paramedics, hospital inpatients, rapid response teams, health visitors, maternity services, mental health services, NHS Direct, NHS Direct Online, and outpatient visits with a specialist. We found inclusion of this last service rather surprising because it was not in our own map of the system. People described waiting between referral by a GP and seeing a specialist in the same way that they described waiting for urgent care, that is, waiting a long time and being anxious as they waited because they considered their need for advice to be urgent. The facilitator introduced social services and voluntary services into the discussions and some participants had contributions to make about these.

The GP was a key part of the system of urgent care. Everyone knew where their practice was and how to access it because of the frequency of using it compared with other parts of the system. When they discussed making choices about where to go for different types of health problem the GP was usually mentioned in the pathway even if only to dismiss this service as an option. Participants expressed high levels of satisfaction with GPs once they accessed them; GPs were perceived as being able to ‘sort things out’ for people. However, access to GPs was perceived as a problem.
5.4 Access to services in the system

5.4.1 Choosing where to access the system

It was not an aim to explore in detail the decision making mechanisms involved in choosing where to enter the system. However, in the focus groups we offered some groups a set of scenarios of types of conditions which we felt were typical of urgent care conditions in an attempt to explore the language they used to describe such conditions. People discussed which service they would choose and why. In some groups, like the Affluent Group, the No Kids Group and the Parents Group, participants named a range of services such as walk-in centres, pharmacies, minor injury units and NHS Direct whereas people in the Older Group and Rural Group talked about hospital, pharmacy and general practice. As discussed above, awareness of services clearly affected the choices people could make (see section 5.2.1).

Participants raised a number of issues which affected their choice of service. These included the type of problem – injuries to A&E and illnesses to the GP – the seriousness of a problem, uncertainty about the seriousness of a problem, time of day and day of week, the cost of one service over another e.g. a prescription from a doctor may be free but they might have to pay if they go to a pharmacy only, and preference for continuity of care and availability of their medical notes with the GP. People also discussed attempting self care and waiting to see if their health problem improved before attempting to enter the health care system. This has been found elsewhere - people reported preferring to manage minor illnesses by self care and community pharmacy advice because of the lack of waiting time and reduced cost of this approach.

When participants knew about alternatives to traditional services, that is walk-in centres and minor injury units, they tried to use them if they were perceived as more accessible than the GP or A&E. One aspect of accessibility was convenience, with convenience of travel as a key issue. Hospitals were at a distance from most people. Travel required driving with resulting car parking problems, or getting the bus when buses did not necessarily go directly to hospitals from rural areas. People liked general practice because they did not have to travel far, although even this was reported as being difficult for some disabled and elderly people.
5.4.2 Perceiving some services as inaccessible

In a number of focus groups, participants discussed the frustrations of finding an NHS dentist and in two groups this was the focus of much discussion between participants. There was a low level cry of ‘how do you find an NHS dentist?’. Many of these participants had ended up at the public clinic of the local dental hospital when they had emergencies. The problem did not appear to be a local one as participants described family and friends in other parts of the country facing a similar situation.

P4: Oh, right. Dentists, here we go. Unfortunately, I'd not had a check-up for some time and I was struck off at my dentist’s. I had toothache, I thought I needed to see a dentist … Getting to see a dentist is like trying to win the lottery, it's that hard. In the end I had to settle for that — where they train them? […] Yes and now, blasted heath, that's the resources of it, but trying to find a dentist is a nightmare nowadays.

P1: I can say exactly the same. (Urban group)

Day time GP appointments were also sometimes seen as inaccessible. ‘Advanced access’ style GP appointment systems which limited the number of booked appointments available and meant that the appointments were balanced towards same day appointments seemed to cause difficulties for people. For urgent appointments they described having to call on the day and if the surgery was fully booked then they had to call back the next day. However, not all practices used this system and some participants described how open access and emergency clinics at the end of a surgery eased access. Some practices also used triage systems in daytime general practice for same day appointments, for example nurse triage. Generally, participants appreciated these measures although they felt they did not help when an illness occurred after 12 noon.

5.4.3 The effect of waiting – a vacuum of information

Participants in the focus groups discussed having to wait a long time for two services – A&E, and an outpatient appointment to see a specialist. As in the interviews, an issue common to both of these waits was the anxiety engendered not simply by the wait but by the lack of information while waiting. People wanted
information about three aspects of their wait - why they were waiting, how long they would wait, and confirmation that they had not been lost in the system. At A&E they were happier waiting if they could see that the department was busy but very unhappy if they waited when there was hardly anyone there.

I know A&E they have these four hours waiting and all that lot, but it's difficult to understand a four-hour wait when there's three of you sat there. Probably what's happening behind is there's some emergency going off, which is fair enough, but just a little note saying we've had an emergency, please bear with us, you know. (Affluent group, P5)

The concern about being lost in the system applied to both waiting at A&E and waiting for referral to a specialist. Focus group participants reported worrying about whether staff at A&E had forgotten about them or whether their referral letter to a specialist had been ’lost in the system’. One participant likened waiting for an outpatient appointment to waiting for a parcel delivery and wanted to be able to track the progress of his parcel/appointment through the system.

Yes, I think it does come down to information and being able to get hold of information and being told where you are as you say. It's almost like a DHL 'where is my parcel' kind of thing - 'where's my operation'? (Nokids groups, P2)

5.5 Coordination between services

For the system to work from the patient perspective, participants described the need for services to talk to each other and work together, and the need for patient records to pass between services.

5.5.1 Communication between services

Coordination between services was raised in the focus groups as an issue in need of improvement. Incidences were described of hospital services not linking with voluntary services, health and social services not working together, hospital specialists and GPs not communicating, and hospital specialists being unable to refer between each other. In this last case, people described being discharged from the hospital system, back to their GP, when one hospital specialist identified the need for a patient to see another hospital specialist. When they described
positive experiences of services they described them as working well together, or
patients moving easily from one service to another.

So I phoned NHS Direct and they were fantastic and put me through to [the next service] straight away and they asked me what the product was what had gone in her eyes and they were straight on the Internet seeing what any adverse reactions and other possibilities. And it can burn their eyes so they said get her straight down to A&E. So straight to A&E and I was there in ten minutes and as soon as we walked in we were expected and I took the product with me and they checked it and you know and they put some stuff in her eyes and within say 2 hours from happening to being home and sorted. (Parent group, P2)

5.5.2 Informational continuity – the importance of patient records

Participants in the focus groups were frustrated that their hospital patient records were sometimes unavailable, and that one service did not share their patient records with another service. Examples given were records from one hospital not being available in another hospital (in the same city); health visitors, midwives and GPs having no record of what had happened in the maternity hospital; and records not being available at outpatient appointments so that patients would have to return weeks later when records had been located. Although this was discussed in contexts outside the EUCS, people described being taken to one hospital for an emergency when their records were at another hospital and how their records remained unavailable throughout their hospital stay.

It's the fourth specialist and it's like who's got the records? You go to an appointment, the records won't be there, they could be at [one hospital] or [another hospital] or somewhere else, and they can't see you, even though we've waited six months, because they haven't got the records. (Deprived group, P1)

Records were important to people because if they saw lots of different health professionals then the records maintained continuity of information and stopped them needing to repeat themselves. They also stopped people having to have more tests, or return to a health professional at a later date because the test results were unavailable. One participant described a friend making her own records in order to ensure her movement through the system – that is, taking responsibility for informational continuity because the system did not.
5.6 Taking responsibility for movement through the system

In the previous section, and in the interviews, we discussed patients taking responsibility for informational continuity. There were other situations where participants described the need for someone in the system to take responsibility and sort out a problem i.e. take a proactive role.

Participants described situations where they felt they bounced between services rather than someone taking responsibility and sorting out their problem.

I feel that I have been referred backwards and forwards to half a dozen different departments. I must have spoken to a dozen or more people to get to this stage and it still hasn't solved the problem. So I mean it's not just in the last few weeks, but it's only in the last few weeks I feel they have got to the bottom of the problem and they are now doing something about it. (Rural group, P5)

In both scenarios in the quotes above a health professional took control from the patient’s perspective and sorted a problem out for the patient. Some participants
described their GPs as doing this all the time. Proactive behaviour by a health professional or service was appreciated in the extreme (see section 5.8.2).

5.7 Personal resources

People’s personal resources affected their use of the system.

5.7.1 The need to push

Empowerment and personal confidence were clearly important factors in people’s ability to access the system and work their way through it. Focus group participants explicitly discussed pushing for access to services and described events where it seemed that their acceptance of the situation meant that they waited longer or were bounced between services. This was also apparent in the interviews where people used active, passive or avoidance behaviour when attempting to access services (see section 4.3). Pushing was most explicitly discussed in the context of seeking GP appointments for children. Focus group participants felt that children were given fast access to GP services, which is a priority of parents with children under the age of five. They also discussed being willing to push for appointments on behalf of their children if this was not the case. However, they felt less able to push on their own behalf and were more likely to accept that they would wait longer for an appointment or undertake self care. Older people were described as being less likely to ask for services or to push for them.

I phoned NHS Direct a lot [about my child]. I know they say come in straight away, whereas for yourself you would have to push it. (Parent group, P4)

If it had been one of my children I would have sort of insisted but it’s yourself, you don't sort of push it. (Rural group, P7)
As well as pushing, participants described using strategies to make the system work for them. When getting a day time urgent GP appointment was difficult they 'worked the system' by saying something was an emergency even if they themselves did not feel it was, or by asking for a home visit.

I think if you find you are told you can't get an appointment, if you ask for a home visit you are more likely to get an appointment. [...] You've got to work them, haven't you? (Rural group, P3)

There are often gatekeepers to services and a significant gatekeeper in urgent care is the GP receptionist. These were often discussed in the focus groups as barriers to access, especially if they asked someone calling for an appointment 'is it an emergency?'. Participants described feeling uneasy about saying 'yes' to this question when the issue was urgent rather than an emergency, and felt unhappy explaining their condition to a receptionist. This could lead them to working the system to gain access.

P2: They ask you what is wrong with you, why do you think it's an emergency? [...] P6: You feel very tempted to say if I knew it was an emergency I would go straight to A&E. (Rural group)

For me, my phone call was actually okay. They didn't ask me what the issue was, which was I wanted an appointment and the second question was, "Is it urgent?" which I thought was a reasonable question. (Affluent, P6)

Pushing was helped by knowing someone in the NHS who could explain how the system worked, or by being part of the NHS and using this knowledge to ask for a better service. Without a friend 'in the know' one participant described how she would have waited passively for a letter from a hospital specialist to arrive - "I would have cried my eyes out until the letter came" (Affluent, P2). Pushing also required being articulate, feeling confident, having an expectation of entitlement, and feeling deserving enough for a service.
5.7.2 Feeling guilty about using services

Participants reported feeling guilty about pushing for access to, and movement through, the system. They knew that by pushing they were taking someone else’s place. This was a sign that they were aware of demand outstripping supply in a busy NHS. Older people were considered to be more susceptible to this. Participants described feeling guilty accessing services which they perceived as trying to keep them out:

I made a GP's appointment. They are pretty good at having the same day appointment for little kids and stuff but I do find them ‘how sick are they, are they really sick, is it an emergency?’ They try to weed you out sort of thing...(Parent group, P4)

There were many references to other people wasting the time of busy health professionals, needing permission from NHS Direct to contact another service, services being overloaded, and messages in the system about the importance of self care rather than using services.

5.7.3 Needing help to use a service urgently

People sometimes needed a second party to get them to A&E or the GP, or someone to look after their children if they needed to leave the house at night. Participants felt that health professionals did not necessarily take these issues into consideration.

5.8 Causes of satisfaction

5.8.1 Speed of access

A quick response from any service was very important to people. Participants described positive experiences of speedy access, for example a 999/paramedic team arriving very quickly, being seen by a dentist within two hours of calling with an emergency, and being fitted in to a morning GP clinic. When they described experiences of quick responses from services they were “really surprised”, “amazed”, and “impressed“. Their expressions indicated that a quick
response was not an expectation. It was however something they really valued and wanted.

    I needed to see a dentist, phoned up at nine o'clock and went at 11 the same day and to me, that's exceptional. Perhaps I have a good dentist, I don't know. (Affluent group, P9)

    I find that if I have to pre-book it's at least three or four days waiting which is when you've got something that you're anxious about, you don't know how urgent something is, you maybe know you don't have to go to hospital, you know it's quite serious, it's quite hard then. (Nokids group, P4)

Facilitator: What do you think is the most important thing you want from the health service when you have an unexpected health problem?
P3: Definitely a quick response.
P2: A quick response and not to be pushed from pillar to post. (Older group)

5.8.2 Proactive health professionals

The issue of health professionals being proactive has been mentioned earlier and is picked up here in more detail because of its importance to patient satisfaction. System failures left the patient out of the system trying to get in, or feeling lost in the system, or being discharged early from the system, or being bounced around the system. Patients did not feel happy about taking the active role in these circumstances, perhaps because they were feeling anxious and ill. They were very grateful, and impressed, when health professionals, other staff, or systems dealt with their situation and sorted them out. Any active role from services made them feel cared for and looked after. For example doctors, pharmacists and nurses explaining about a condition and a medication reduced patient anxiety; information about delays reassured patients whereas a lack of information caused anxiety; and doctors sorting out a patient's transition through the system ensured perceptions of an efficient and highly satisfactory service.

    The other thing – my wife went for a blood test on Tuesday, blood test was at four o'clock. Dr xxx rang her at five past nine the next morning to give her the results of that blood test and then she went back to see him again today. I can't fault that – an absolutely brilliant service. (Rural group, P5)

    You just want some action when you're not feeling well. (Older group, P2)
One thing which I thought might have been useful is to have some kind of almost champion - don't have to be a GP or anything, just somebody who's on your case, somebody who's with your case, who understands your case and can assist you in going through the system, understanding how the system works. (Nokids group, P2)

5.8.3 Other important aspects of services

There were many other issues which influenced satisfaction with a service or the system. These included seeing an expert rather than a trainee, convergence of the health professional view of the urgency of the problem with the patient’s point of view, having enough time with a doctor, the reliability of a service, getting a correct diagnosis, the convenience of a service, and the caring attitude of staff. Another was interpersonal continuity - people valued their own GP who they knew and trusted, and who knew about them and their medical history. They felt more comfortable going to the same GP but also felt that this continuity ensured safety so that different drugs were checked for adverse interactions and that unusual acute episodes were taken seriously because they were seen in the context of the medical history of the patient. Interpersonal continuity was also valued from other health professionals such as physiotherapists and hospital specialists so that people did not have to keep repeating their medical problems to them.

5.9 Urgent care for specific groups

Findings relating to specific groups are presented alongside evidence from previous research because the research was not set up specifically to address these groups.

5.9.1 Black and ethnic minority groups

There is considerable variability in language skills, educational status and cultures between and within different black and ethnic minority communities. We had little hope of attending to this diversity within and between ethnic minority groups within our research. However, we held a focus group specifically to gain the views of black and ethnic minority groups about urgent care. Altogether 6 people from different black and minority ethnic groups participated in any of the focus groups.
It is clear from the literature that ethnic minority groups face barriers when using health services, and that these barriers are more than the ones usually called to mind – that is, language and cultural issues. Many barriers are universal problems faced by all groups, some are related to the fact that ethnic minority groups are often part of the most deprived communities, and some problems are specific to these groups. Barriers can operate at a patient level, provider level and a system level.

**Personal level barriers**

Barriers operating at a personal level include low levels of acculturation or familiarity with health practices, differences in beliefs about health and health care, lack of local language skills, communication difficulties which are not necessarily linked to language, difficulties with translation by informal or formal interpreters, and poor knowledge of health services and how to use them. These are often exacerbated by social deprivation, for example a lack of transport. There were certainly examples of this in our study.

A major solution to language barriers within the NHS is translators. However, people can be suspicious that a professional interpreter is economical with the truth and again this was evident in our study.

**Provider level barriers**

At a provider level, people from ethnic minority groups may face discourteous behaviour, particularly if they do not speak the language fluently. A focus group participant discussed this occurring.

I am facing some problem with the person who work in the GP, especially the receptionist the fact is some of them is ok. My wife just to get appointment she doesn't speak English ok and she tried to speak and another lady ‘I don't understand you please bring in somebody else to help you’. She started to realise that she wanted to book an appointment with the doctor, [...] anybody who works in the reception not take more attention for this job. This is very important that the system works to deal with other people very important in my opinion. (Parent group, P5)
**System level barriers**

System barriers are particularly important to our research and include policy, organisational and structural factors. At a system level, people may be used to going straight to a health specialist whereas in the NHS they need to be referred. Indeed a focus group participant from Europe was very frustrated by the long wait to see a specialist – a service which was instantly available in her country. Other system differences can include the existence of appointment systems, longer waiting times, and shorter consultation times.

Barriers may be specific to the service under research and to the individual. Therefore it is important to consider barriers faced by black and ethnic minority groups which may be specific to emergency and urgent care. Language and cultural issues may be difficult to sort out quickly in an emergency or urgent situation. Also there may be different thresholds for seeking care - some ethnic minorities are more concerned about some symptoms and more prone to seek immediate care for an ailing child. There is some evidence that they are less successful at obtaining care with the attributes they prefer in primary care.

**5.9.2 Workers**

Working people, and commuters in particular, felt that the appointment systems currently operating in some general practices discriminated against them. General practices which required people to call at 8.30 for a same day appointment were difficult to negotiate because people needed to book time off work.

> When you are working you can't take the whole morning off and sit and wait for an appointment, you don't know what time that appointment is going to be because I work in [distant town]. (Rural group, P7)

It is unusual to consider a group which does not fall in to the ‘vulnerable’ category of the population. It is more usual to see people who do not work highlighted as having problems obtaining the types of primary care they want. However, it has been suggested in previous research that ‘advanced access’ style appointment systems cause difficulties for working people and indeed that the choice of time of appointment is six times more important than a shorter waiting time for workers, with workers willing to wait a day extra for choice of time. This difficulty for workers accessing urgent GP care is present in other research even though it is not explicitly discussed.
5.9.3 Other groups

Some participants were caring for elderly relatives and friends and found this a struggle. They felt that services did not always see the difficult situations they were facing, and that both patients and carers had needs which might not agree. For example, elderly patients who did not want to go into hospital or care but who could not manage at home had their views listened to but the family and friends who had to help them felt that they received no support. The situations described by people were both chronic crises and acute crises. They wanted more support for, and recognition of, the difficulties of being a carer.

A few of the focus group participants had experienced mental health services either directly or through family members. Their views varied from feeling extremely satisfied with services which acted in coordination, to feeling very dissatisfied with having to wait eight weeks to access a service when they felt they were in crisis. That is, they discussed issues such as coordination of services and waiting times which have already been highlighted as important within the EUCS.

6. Discussion

6.1 Key findings

Accessing the system

People reported experiencing problems accessing the EUCS. This was due to a lack of knowledge of the range of services available, how to access them, and which service was most appropriate for different urgent health problems. Other access problems were specific to the entry point into the system - long waits for A&E and hospital specialists, a shortage of NHS dentists, or the need to negotiate access to general practice. Urgent access to daytime general practice required negotiation of appointment systems and receptionists as gatekeepers. Despite measures in the general practices to make same day appointments available, participants in the focus groups and the interviews perceived there to be difficulty
accessing this service. This was most evident when their ability to access services depended on local appointment systems, personal resources in terms of assertiveness, transport and family support, and competing work-related priorities.

**Ability to negotiate access**

'Candidate' is a theory which has emerged from recent synthesis of the evidence on access to services\(^\text{14}\) and is highly relevant to access to the EUCS. This is where people's eligibility for medical attention is jointly negotiated between individuals and health services. Accomplishing access to services can require considerable work. People attempting to access out of hours GP services have described the onus on them to convey the urgency of a situation.\(^\text{15}\) This has been described elsewhere when patients wanted to see their own GP - some practices were organised to provide this, whereas in other practices patients had to work at getting their own GP and learn what to say.\(^\text{13}\) This need to negotiate access, and prove oneself as a suitable candidate for a service, is related to the theme of 'time wasters' apparent in our focus groups which has also been found for individual services in the EUCS, namely out of hours GP services,\(^\text{15}\) A&E\(^\text{16}\) and NHS Direct.\(^\text{17}\) Thus people's ideas of entitlement and assertiveness can affect their access to the EUCS.

**Resources available to obtain access**

Other issues affecting access to the EUCS were people's social circumstances such as the availability of a car to travel to services and of family to help with physically accessing a service, and their family responsibilities which needed to be attended to as well as accessing services. Transport issues and social responsibilities have also been highlighted as barriers to easy use of GP out of hours services.\(^\text{15}\)

**Communication**

Communication between different services in the system, and between health professionals and patients within any service within the system, was very important to recent users of the EUCS. Where a number of services were involved
in an episode of health care, people discussed the need for coordination between services. Good communication between health professionals and patients has always been identified as an important attribute of individual services within the NHS but has been identified here as an important attribute of the system of emergency and urgent care because poor communication could activate repeated presentations by patients to service providers, that is, increase the length and variety of a patient pathway through the system.

In the focus groups, people discussed the importance of services having access to patients’ medical records. This has been found elsewhere for patients with chronic health problems who had used GP out of hours services; they expressed frustration at the need to repeat their history to different health professionals. Yet in the interviews there were examples of people acting as their own personal medical record and being happy to take this role to ensure the information was accurate and up to date. Thus people may have their own preferences for how informational continuity is obtained.

People expressed the need to have information about why they were waiting. This has been identified elsewhere for individual services within the EUCS, such as A&E, and GP out of hours services. People were also concerned that they had been forgotten when experiencing a long wait for a service. This has also been found for GP out of hours services. A sense of not making progress through the system, and being unable to take action to make progress, has been termed ‘left in limbo’ in a study of the interface between primary and secondary care. Feeling ‘left in limbo’ is increased by an indefinite period of waiting at the interface between services or professionals, and is specific to the healthcare system as well as the services within it.

**Speed of access versus other preferences**

People valued speed of access to services as well as many other issues such as interpersonal continuity. When focus group participants discussed what they valued about seeking treatment and advice for unexpected health problems they identified issues which were sometimes in direct tension with one another. They were sometimes aware of these tensions, for example balancing speed of access and seeing their own GP for urgent problems. This highlights the importance of preferences and whether people are willing to trade one issue they value against
another in the light of limited resources. Health economists employ a technique known as Discrete Choice Experiment to explore preferences and trade-offs. A number of such studies have been undertaken on parts of the EUCS. In terms of who people prefer to see, patients prefer a doctor to a nurse, and prefer a nurse to a paramedic. Although patients value shorter waiting times, some would wait more than two hours longer for a doctor than a paramedic. Patients will not only trade speed of access for who they see, but also for continuity of provider. This shows that speed of access is important but is not the only issue of importance to people.

Nor is there one set of preferences for service provision in the general population; preferences vary by type of individual and by the reason for consultation. In day time general practice, some people value speed of access, some value interpersonal continuity, and others value convenience. Concerns have been expressed that the emphasis on some aspects of the service such as speedy access means that others such as interpersonal continuity of care – that is seeing the same health professional throughout care - are ignored. The recommendation emerging from this body of literature is that a flexible approach to meeting needs is required rather than a uniform one.

**The need for proactive services**

The system could operate smoothly for people or they could find themselves outside the system wondering how to get in, not making progress through the system, being bounced around the system, or being discharged from the system before they felt their problem had been resolved. Efforts on the part of patients and their carers could influence this but we found that people appreciated a proactive health professional or gatekeeper who sorted things out on their behalf. This seemed to be important to them because uncertainty about the seriousness of a health problem caused anxiety. This anxiety could be increased by long waiting times or poor communication.

**Costs**

The balance of responsibility between health professionals and patients for the patient moving through the system was also apparent in the displacement of
financial costs and time onto the patient. Sometimes the cost of the system working smoothly from the perspective of the health professionals or management was placed on patients as they paid to travel to distant health services by taxi.

6.2 Strengths and weaknesses

The aim of the research was to identify the diversity of issues important to recent users of the EUCS and to inform the development of a survey of patient experiences and views of the EUCS. It is tempting to quantify the findings, interpreting them as ‘most people think these things’. However, the interviewees were a self-selecting group of 13 people who agreed to be interviewed possibly because of their extremely good or poor experiences. The focus groups were not selected to be representative of the general population and participants may have agreed to attend the groups again because of good or poor experiences of the system. The strength of this research is the diverse and vivid accounts of recent experiences of emergency and urgent care services which help to identify what is important from the patient perspective.

It is important to view this research as helping us to understand the patient perspective of the EUCS. Service providers and patients may hold different views of the urgency of events and different views of what works and does not work within the current EUCS. Attention will need to be paid to wants, needs and value for money when considering how best to address issues identified in this current research.

6.3 Future research

This is the first phase of a study designed to obtain users’ views of the EUCS. The second phase will be a survey based on this qualitative work which will attempt to study the views and experiences of a representative sample of the general population. In the qualitative phase we identified that no term fully explains to the general population what researchers, policy makers, and commissioners call ‘unscheduled’ or ‘unplanned’ care. Thus we will need to offer examples of the types of contacts we feel are relevant. We have some confidence that patients accurately remember recent events, and we understand that sometimes people
may not know which service they have actually accessed due to integration and co-location of services. We have also identified a range of items relevant to the EUCS to seek views on:

**Entering the system**
Did people know which service they needed?
Did people know how to contact the service they needed?
Did people need to negotiate or push for a service?
Was transport a problem?

**Waiting**
Did people feel that they waited too long?
Were people informed about waiting if they had to wait?

**Movement through the system**
Did people feel pushed from pillar to post?
Did people feel that some one sorted things out?
Did people feel listened to and taken seriously?
Did people feel that progress through the system was smooth?
Did people feel they were thrown out of the system before the problem was resolved?

**Coordination and communication**
Did people feel they repeated information too many times?
Did people feel that services had information about them?
Did people feel that services communicated with each other?

**General**
Did services take people’s personal situations into consideration?
Did the system work well for people on this occasion?
Were people concerned about wasting NHS time?
Did people feel they had to make a lot of effort to get what they wanted?

We are in the process of constructing a questionnaire which will address the above aspects of the system as well as obtain details of the pathways patients take through the system. We intend to test this questionnaire, and further issues
relating to undertaking a survey with users of the system, in order to develop a survey which can be used routinely to monitor the system.

6. References


APPENDIX 1: Topic guide for focus groups

Thinking about the last time you contacted the health service for an unexpected health problem, can you tell me what you liked, what worked well.

[Scenarios introduced in some groups]

What about things you didn’t like, things that didn’t work well

Prompt if they have not discussed
  Accessibility – getting into the system
  - choosing which service to contact
  Availability – awareness of services
  Promptness – how quickly they were seen
  Health professionals – who they saw, level of experience
  Information – did they get the information they needed
  Continuity – did people have the necessary information about them
  Moving from one service to another

What kind of things affect the kind of service you get?

Prompt
  Seriousness of your problem
  Perception of skills of staff
  Time of day/day of week
  Telephone or see someone in person
  Any thing else?

How does the health service work with other services and people offering care and help for unexpected health problems?

Prompt
  Social services
  Voluntary sector
  Looking after yourself

What can be done to improve things?

What comments do you have about the questionnaire you filled out at the beginning?

Prompt
  Would you complete it? Why/why not
  Did it let you tell the story of your last contact with the health service?
  Good/bad points

What is the most important thing you would like to tell us about the health service when you have an unexpected health problem? (Do a Round Robin where each person makes a point).
APPENDIX 2 : Interview schedule for interviews

PART 1
I’d like you to complete this questionnaire. Ask me any questions you need to help you to complete it.

Thank you. I’ll go back to this questionnaire in more detail later in the interview.

PART 2
1. When you completed the questionnaire, did you have a recent contact with a health service without making an appointment more than a day in advance?

   If YES    Tell me about it
   If NO     Tell me about the last time you tried to contact the health service without making an appointment more than a day in advance

(Interviewer – please make sure you know how many days or weeks ago the contact was made, which services were accessed in which order, and whether they were face-to-face or telephone)

2. Why did you decide to contact the [first service] and not another?

3. How easy or difficult was it to access the [first service]?

4. You contacted services in the following order [describe the pathway]. Did you feel this was the best pathway for you?

5. How long did it take you to get through the system of care i.e. from contacting the first service to getting the end point you wanted? What did you think of the time it took?

6. Did the services have the right information about you?

7. What did you think about how information was assed between services?

8. Did you feel that everything worked as one system – were services connected up enough for you?

9. How would you like to see things improved?

PART 3
Can we talk about the questionnaire you completed at the beginning of the interview?

(Interviewer: If it was completed about the event described in the patient story, read through the questionnaire and look for any differences between the story and the questionnaire. If it was completed about a different event, ask why)
1. I noticed you said [X] on the questionnaire but when we were talking you said [Y]. What was going on there?

2. What did you think about the questionnaire?

3. Was it clear enough for you to know what to do?

4. Which bits did you hesitate about and why?

5. Is anything missing that should be on the questionnaire?

**PART 4**

1. We are thinking of posting the first part of the questionnaire to everyone to find people who have recently contacted a service, and then when they send a response back, posting them another questionnaire about the details of the contacts they made. What do you think about that?

2. I have asked you about any event you’ve had in the past four weeks. Can you tell me whether you contacted a service without an appointment made a day in advance….

<table>
<thead>
<tr>
<th>Time Frame</th>
<th>What was it?</th>
</tr>
</thead>
<tbody>
<tr>
<td>in the past week</td>
<td></td>
</tr>
<tr>
<td>in the past 2 weeks</td>
<td></td>
</tr>
<tr>
<td>in the past 4 weeks</td>
<td></td>
</tr>
<tr>
<td>in the past 6 weeks</td>
<td></td>
</tr>
<tr>
<td>in the past 8 weeks/2 months</td>
<td></td>
</tr>
<tr>
<td>in the past 12 weeks/3 months</td>
<td></td>
</tr>
</tbody>
</table>

3. At what point did you struggle to remember
   - when the event occurred
   - the details of the event

4. We want to send the questionnaire to the general population. Can you think of any problems we might face?

5. What should we change to make it easier for different types of people to complete it? *[Interviewer – we are specifically interested in the group they might ‘represent’, e.g. parent of young child, user of mental health services. It may or may not feel appropriate to probe this further]*

**PART 5**

1. Would you like a summary of our findings posted to you in a few months?

☐ yes  ☐ no
If YES, can I take the address you’d like me to send it to.

**PART 6**
We are worried that we are asking people to remember the timing of events and whether it is possible for people to remember accurately. To test this out we would like to read your GP notes for the past 12 weeks ONLY and see if they match with what you said today. This will help us to decide whether we can do the type of study we want to do. Can I have your permission to do this? I have an information sheet and consent form to show you.

**THANK YOU FOR YOUR TIME AND HELP**