

Understanding How the Public Chooses to Use Unscheduled Care Services

Project report

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Cyngorali Cymru Gyfan or Gyfer Ymchwil a Datfygled mewn Iechyd a Gofal Cymdeithasol



All Wales Alliance for Research and Development in Health and Social Care



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Summary

Background and aim

Unscheduled health care is unplanned care, where contact is made directly by the patient or a relative or friend acting on their behalf, which may require prompt action in response to an acute, minor or major injury or illness. Providers of unscheduled care to the public include Accident and Emergency (A&E) Departments, the emergency ambulance service, GPs and GP out of hours (OOH) services, community pharmacists, and NHS Direct.

Currently in Wales:

- demand for unscheduled health care is increasing
- some patients may be contacting services which they do not clinically need.

This study, commissioned from AWARD by the Welsh Assembly Government, aimed to:

- get a picture of current use of unscheduled health care in Wales
- examine factors which influence people's choice of health care provider.

Study methods

1576 people responded to a postal survey (41.7% response rate). 40 of these took part in a follow up telephone interview to discuss their recent use of unscheduled care services in more depth. Four focus groups were held, with: mothers of young children; residents of a Community First area; Muslim men; members of a 50+ forum. Group discussion covered what was appropriate care in various situations, and awareness of unscheduled care services.

Study findings

Among **survey respondents**, awareness of NHS Direct, GP OOH services and A&E was high, at over 85% in each case. Knowledge of how to contact services was generally lower, particularly of Pharmacy OOH services and NHS Direct. Older people were least likely to know how to contact NHS Direct.

Nearly half of survey respondents (n=702) had used unscheduled care services in the past three months. Over half of these (55.1%, n=391) had done so on more than one

occasion. Most respondents made contact for themselves (68.1%, n=466), and the rest for their child or an adult friend or relative.

Almost half of the reported use of unscheduled was by someone with a chronic condition (44.2%, n=289). People with chronic conditions were more likely than others to have used unscheduled care multiple times during the three month period.

A quarter of respondents (n=167) contacted unscheduled care services during 'out of hours' times: between 6.30pm and 8am, at the weekend, or on a bank holiday. Speedier contacts with health care services (the same day or next day) were associated with use of 'out of hours' care. The most common first point of contact was the respondent's own GP, with half (n=274) reporting a visit during open access or emergency surgery. Next most common was the GP Out of Hours service (7.2%, n=39), followed closely by other practice staff, NHS Direct, and A&E. Few reported having their problem resolved with just one contact and the majority were in touch with two or more sources of help about the same incident.

People chose their first point of contact because they thought it was the most appropriate service. Practical issues such as 'nearest to me', 'knew it would be open' and 'shortest waiting time' were reported as reasons of secondary importance. For most people, their choice of first service provider was influenced by multiple factors. More than four out of five people (83.7%, n= 559) said they would choose the same service as their first point of contact again.

Interviews with unscheduled care users revealed:

- The process of accessing unscheduled health care is complex and requires decision-making at three stages: whether care is needed; whether it is needed urgently; what kind of care is needed. Factors influence decision making at each of these stages and can overlap.
- Respondents were anxious to make correct and appropriate use of NHS services, and were fearful of being seen as misusing A&E
- Respondents did not seem to have a complete picture of the range of unscheduled care services. The GP OOH service was rarely mentioned as an option. Even when aware of a service, they made assumptions about function and availability which may not have been correct.

- Respondents' learning and past experience of healthcare encounters influenced future decisions
- Respondents said the media had virtually no influence on health care choices, and friends and family had little influence.
- Perceived need for healthcare is balanced against stoicism and reluctance to bother services
- Respondents were loyal to the NHS, even if they had distressing experiences.

Focus groups revealed:

- A complex decision making process which was specific to the local geographic and personal context of focus group members. Practical issues, expectations, experience and knowledge informed the response to a healthcare need giving the decision making process an apparent logic.
- Awareness of unscheduled care services was varied and consistently highest for A&E services among all four groups. They had a detailed understanding of availability of local services. However, few people knew how OOH pharmacy services were delivered or how to access these.
- There was little consistency in beliefs about what was an appropriate service to provide care for many conditions. Inconsistency was also influenced by context - when, where and why healthcare was needed. But they had strong views about inappropriate use of 'emergency' services.
- Focus group members believed people should take responsibility for their own care and valued their own expertise. Patients with long term conditions, carers and parents were proficient in actively managed the process of giving and seeking care.
- Emotion played a key part in decision making: fear of inappropriate use of services was balanced against fear of the illness and potential outcome.

Discussion points

1. The 'boundaries' of unscheduled care are blurred - both in terms of the range of services included and in terms of how the line is drawn between unscheduled and scheduled.
2. GPs are much the biggest provider of unscheduled care.
3. People follow a personal logic when deciding to access unscheduled care and feel they are acting responsibly in perceived constrained circumstances.
4. People are hugely loyal to the NHS and extend praise to the doctors and nurses who give care, in the most distressing circumstances and even when unsuccessful: in the main, criticism is directed at the system, not at individuals.
5. While most people are not familiar with all unscheduled care options, they tend to know how to access the type of service they want to receive.
6. Experience, based on past use of healthcare services, or care experiences of family members, seems to have a greater influence on choice of services than hearsay or stories in the media.
7. People can access unscheduled care services for most health needs which are not life threatening by many different routes, and by contacting many different providers.
8. People with chronic conditions are significantly greater users of unscheduled care services than the general population.
9. Residents of areas experiencing the highest levels of deprivation in Wales are also more likely to use unscheduled care services.
10. Pharmacists have a significant role in unscheduled care. However, people's awareness and use of out of hours pharmacy services are low and information about accessing the service out of hours is difficult to obtain.
11. Pragmatic factors are a significant influence on when people choose to access unscheduled care and which service they attend.
12. Self care has an ambiguous status amongst study participants – people are willing to choose to self care, and indeed believe that is a responsible course of action, but they may not be happy to be advised to do it by healthcare professionals when they have sought help.

13. People tend to err on the side of caution and risk avoidance when contacting unscheduled services.

1. Introduction

With ever-rising demand across the emergency and unscheduled health care sector, services are under increasing pressure to meet performance targets related to response and waiting times. There is a range of services offering emergency and unscheduled care to the public, without medical referral. The principal providers are Accident and Emergency Departments, other hospital based services such as Minor Injuries Units or Local Accident Centres, the emergency ambulance service, GPs and GP out of hours services, community pharmacists, and NHS Direct.

Many patients call and attend services that they do not clinically need (Department of Health 2005, Snooks et al 2002), although there is considerable disagreement between clinicians, managers and researchers about the definition of appropriate contacts (Shipman and Dale 1999), and there is no agreed gold standard or method to measure the appropriateness of contacts made (Khan et al 1998, Hicks 1994). Unplanned contacts made unnecessarily to health care providers may have consequences for the patient, other patients and the wider NHS: the patient him or herself is put to unnecessary inconvenience, making a journey that could have been avoided, incurring costs and wasting time; other patients, perhaps in more urgent need of care may have to wait longer to be seen; and NHS resources are not used to best effect. Little is known about why individual service users choose to access one part of the unscheduled care system or another (Edwards and Egbunike 2006).

The Welsh Assembly Government has developed a Delivering Emergency Care Strategy (DECS) (WAG 2008) in order to shape the future of emergency and unscheduled care in Wales to provide an integrated, efficient system which is as clinically safe as possible. DECS is in turn a key element of the Designed for Life Strategy. To complement the introduction of DECS, the Welsh Assembly Government commissioned AWARD (the All Wales Alliance for Research and Development in Health and Social Care) to carry out research to examine the factors which influence how and why patients and the public contact different services for urgent and unscheduled care.

2. Context for the research project

For the purposes of this research project, ‘unscheduled care’ is defined in line with the Welsh Assembly Government’s recent strategy document on the DECS strategy as:

‘any episode of care provided for the patient which is unplanned and may require prompt action in response to an acute, minor or major injury or illness’

WAG 2008 p4

‘Emergency care’ is a sub-group of ‘unscheduled care’. Unscheduled care may or may not involve the administration of treatment, and may or may not result in referral to another service provider. In all cases, contact is made directly with a care provider by the patient or a relative or friend acting on their behalf. Unscheduled care does not include any secondary care, or care provided through a referral.

Previous research has given some indication of the complexity of people’s experiences of unscheduled care, for example:

- a study in Neath Port Talbot found that over half of patients do not have their problem resolved at the first point of contact, and will make two or more contacts seeking unscheduled care for the same problem (ORS/WIHSC 2006)
- patients may make complex trade-offs between a range of factors, for example, being willing to accept increased waiting time if they can be seen by a doctor, rather than have contact with some other health professional (Gerard et al 2004)

Previous work in this field has suggested that the following factors may influence people’s decisions about whether to access unscheduled care and, if so, which source of help to access:

- Their level of awareness of what services are available, what their role is, and how to contact them (ORS/WIHSC 2006, O’Cathain et al 2007)
- The nature and perceived severity of the problem (Rajpar et al 2000, ORS/WIHSC 2006)
- The age of the patient (ORS/WIHSC 2006)
- Whether people are primarily seeking advice/information or treatment (ORS/WIHSC 2006)

- Whether person making contact is doing so on their own behalf or on behalf of a child/other relative (ORS/WIHSC 2006)
- The time of day/night
- People's own previous experience of contact with unscheduled care services (ORS/WIHSC 2006, Rajpar et al 2000)
- Hearsay/anecdotes from other users of unscheduled care services (ORS/WIHSC 2006)
- Beliefs about/perceptions of waiting times (Rajpar et al 2000, Morgan et al 2000, Shipman et al 2001)
- Accessibility of services (location/transport availability/caring responsibilities which limit the scope for travel) (Shipman et al 2001, ORS/WIHSC 2006)
- Beliefs about entitlement and appropriateness (O'Cathain et al 2007).

3. Project aim and objectives

The overall aim of the study was to provide an understanding of the factors which influence members of the public when they make emergency or unscheduled contact with health care services.

The study's objectives were to:

1. Describe patterns of health care seeking behaviour across the emergency and unscheduled health care system (who has been where, for what in the past 3 months)
2. Describe the patterns shown by the following subgroups of the population
 - Older people
 - Children
 - Men/women
 - People who live in socio-economically deprived areas
3. Gain an understanding of the factors that influenced the choice of contact made (across the population, by the different subgroups as above, plus the role of ethnicity and rural/urban location)
4. Synthesise findings to provide information to WAG which could feed in to the planning of services and policy to optimise the fit between service configuration and patient priorities

4. Project methods

4.1 *General population survey*

The research team prepared a questionnaire, which drew in part on one previously used successfully in a study of contact with NHS Direct carried out at Sheffield University (Munro et al 2003). It also incorporated the Brief Illness Perception Questionnaire, an eight-scale item designed to rapidly assess cognitive and emotional representations of illness (Broadbent et al 2006), which draws on the theoretical model of Leventhal and colleagues (1984, 1992) on the ways in which individuals respond to health risks or threats and act to reduce those threats in a way which is consistent with their perceptions of them.

The structured questionnaire covered:

- Whether the respondent (or any member of the household) had made any unplanned health contact during the last three months
- Data for the most recent contact on:
 - the nature of the problem
 - the time of day and day of week when the help was sought
 - how long the patient had been aware of the problem before help was sought
 - the source(s) of help or advice with which the respondent made contact, and which of those was the first point of contact
 - whether the respondent was seeking help for themselves or on behalf of a family member or friend
 - reason for choice of first contact
 - whether the respondent would make the same choice of first contact if the same circumstances were to reoccur
 - the respondent's perception of the illness and its impacts.
- Demographics, including information on car and telephone ownership/availability
- Whether the respondent was registered with a GP

- The respondent's level of awareness of a range of emergency/unscheduled health care options
- A consent form for further follow-up

The bulk of the questionnaire had a tick-box format. Limited space was available on the form for free text answers that did not fit neatly into the predefined categories. The questionnaire was produced bilingually, in English and Welsh. The first draft of the questionnaire was piloted on 11 members of the public, and revised in the light of their comments.

Before the first mailout of the questionnaire, a press release was issued, in order to increase awareness of the survey and to encourage people to complete and return it; the press release generated an item in the *Western Mail* (Appendix 1). The questionnaire was mailed out to a sample of 4000 adults drawn from the electoral register. Sampling and mailout of questionnaires were subcontracted to a specialist mailout company. The sample was structured to ensure that it was spread across the 22 local authority areas of Wales in a way which reflected the spread of the population, as shown in Table 1. Within each local authority area, respondents were selected randomly. Respondents selected to be in the sample were sent a postal questionnaire (Appendix 2), with a covering letter from the research team (Appendix 3), and a pre-paid envelope for them to return the form. After six weeks, a reminder letter was sent (Appendix 4) along with a second copy of the questionnaire and freepost envelope. The unusually long period between the first two mailings was because Christmas fell during that time; the research team decided to delay the second mailing until January to try to avoid the questionnaires being ignored in the rush of seasonal activity. A third questionnaire was sent, along with final reminder letter, in February.

The 'tick box' sections of the questionnaires were coded and entered onto an SPSS database for analysis. Free text responses were also entered into the database; responses given in Welsh were first translated into English.

A database of postcodes, matched to questionnaire numbers, was obtained from the mailout company. Each of these postcodes was then matched to one of the 1896 Lower Super Output Areas (LSOAs) used as a basis for categorisation by the Welsh Index of Multiple Deprivation (WIMD) (WAG 2005). The WIMD ranks all LSOAs in Wales according to how deprived they are on combination of measures (income, health status

etc), with 1 being the most deprived and 1896 the least. For analysis purposes, these rankings were then grouped into quintiles.

Local authority area	Population	Number of people sampled in this area
Blaenau Gwent	68,800	93
Bridgend	130,400	176
Caerphilly	170,700	230
Cardiff	316,800	430
Carmarthenshire	177,600	241
Ceredigion	78,100	107
Conwy	111,800	151
Denbighshire	95,600	130
Flintshire	150,100	203
Gwynedd	118,100	160
Merthyr Tydfil	55,100	75
Monmouthshire	87,200	118
Neath Port Talbot	135,800	184
Newport	139,500	189
Pembrokeshire	117,300	159
Powys	130,700	177
Rhondda Cynon Taff	231,800	314
Swansea	225,500	304
Torfaen	90,400	123
Wrexham	130,200	176
Vale of Glamorgan	122,300	166
Ynys Mon (Anglesey)	68,700	94
	2,952,500	4000

Table 1 Distribution of questionnaires by local authority area across Wales

4.2 In-depth telephone interviews

In-depth telephone interviews took place with a sample of the 410 people who had completed the questionnaire survey and consented to follow-up interview. Since the aim of the interviews were to find out more about people's actual experience of using unscheduled care and the decision-making which was involved in that experience, interviewees were selected only from amongst the 236 people who had had some experience of using unscheduled care in the 3-month period prior to completing the form. The sample was stratified, to ensure that there was a good demographic mix, representation from across Wales in terms of regions and areas of low and high deprivation, and contact with people with a range of experiences of using unscheduled care services. Fifty-two people were selected in total; twelve of these either declined to take part in the interview, could not be contacted, or were not available at a suitable time, leaving a total of 40 people taking part in the interviews. Each participant was provided with a Participant Information Sheet (Appendix 5).

Interviews were semi-structured, with an interview schedule (Appendix 6) developed in the light of emerging findings from the quantitative study. Interviews aimed to explore in more depth the factors which influenced previous contacts, beliefs about and attitudes to unscheduled care, and intentions for using unscheduled care, if required, in the future.

Interviews were conducted in English, recorded, and transcribed in full. Data were analysed thematically, with the aid of the Nvivo software package, using the study objectives as a starting point, with the flexibility to allow themes to emerge from the data as the analysis developed.

Feedback on the project findings was provided to interviewees, in the form of a short lay summary (as included in the front of this report).

4.3 Focus groups

Four focus groups took place with members of the public. The four focus groups were selected to reflect a range of patient types: older people, mothers of young children, people of mixed age from an area of relative deprivation (a 'Communities First' area), and men from a Muslim background. Two groups took place in an urban area, one in a rural area, and one in a small town. Each focus group consisted of 6-10 people and took

approximately one and a half hours. Each participant was provided with a Participant Information Sheet (Appendix 7).

The focus groups were used to explore participants' awareness of the various options for unscheduled care, and their beliefs about appropriateness of care in various situations. Participants were presented with four imaginary scenarios (Appendix 8), presented in the third person in order to stimulate discussion. They were also asked to talk about their awareness of, and beliefs about the function of, a range of unscheduled health care services.

Each group was led by a facilitator from the research team, with the support of an observer, who took notes. Each group was recorded and then transcribed in full. Transcripts of the focus groups were analysed thematically.

Focus group members also received feedback on the research project, in the form of the lay summary.

4.4 Public and patient involvement

Contact was made in August 2007 with Involving People/Cynnwys Pobl, the network funded through CRC Cymru to promote the involvement of patients and members of the public in health and social care research. Four members of Involving People volunteered to take part in the research process. Through a series of face to face meetings, they provided feedback on the draft questionnaire, had input into the schedules for the focus groups and telephone interviews, and contributed to the analysis and write up of findings.

In line with guidance from Involving People, the public representatives were paid expenses and an honorarium to acknowledge the time they contributed.

4.5 Ethical considerations

Formal ethical approval was not required, since participants were not contacted via the NHS, no patient records were examined, and data collection consisted only of questionnaires and qualitative methods. However, courtesy letters were sent to all Trusts and LHBs across Wales to inform them of the study. Usual standards of research ethics,

in terms of consent, confidentiality and data security were adhered to throughout the study.

5. Results – quantitative

5.1 Survey response rates

The total number of completed questionnaires received was 1576, out of the 4000 sent out. The number of ‘dead addresses’ (forms returned marked ‘gone away’ or ‘not known at this address’) was 224, resulting in a response rate of 41.7%. Sixty-one questionnaires were completed in Welsh.

Of the respondents, 36.8% were male (n=549) and 63.2% were female (n=944). In terms of age, 37.0% of respondents were 18-49 (n=574), 31.4% were aged 50-64 (n=488), 18.7% were aged 65-74 (n=290) and 12.9% were aged 75 or more (n=201) as the chart below illustrates.

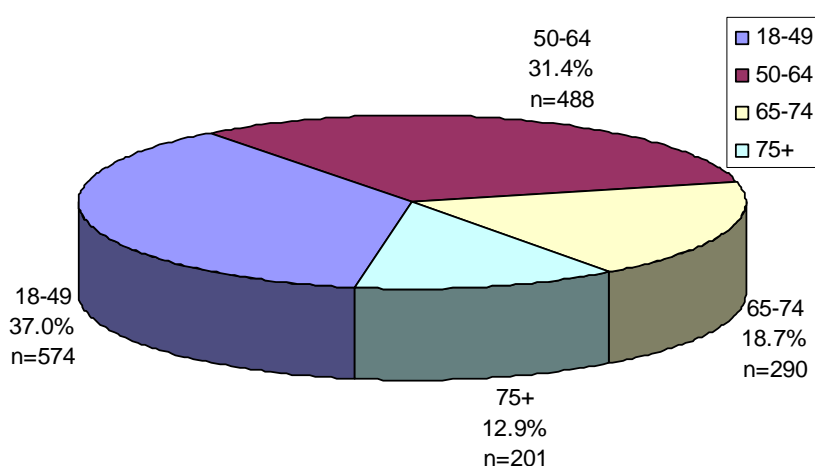


Figure 1: Returned questionnaires by age group

Every postcode to which a questionnaire had been sent was matched to a deprivation score on the Wales Index of Multiple Deprivation (WIMD) (WAG 2005). This ranking was split into five quintiles, with Level 1 being the most deprived, and Level 5 being the least deprived, allowing both respondents and non-respondents to be matched to one of these five deprivation levels. Since the selection of addresses was carried out randomly, respondents were not evenly distributed among the five levels. The numbers of questionnaires posted, the number of responses received, and the response rate from each deprivation level are shown in Table 2 below, which indicates that response rates increased as level of deprivation decreased.

	Number of questionnaires posted	Number of completed questionnaires received	Response rate
Level 1	508	153	30.3%
Level 2	566	214	38.0%
Level 3	793	318	40.0%
Level 4	1137	526	46.2%
Level 5	779	361	46.1%

Note. n=3783: Total number excludes 'dead addresses' and five address which weren't included in the WIMD

Table 2: Posted and returned questionnaires by deprivation level

After the initial mail-out of 4000 questionnaires, a second mail-out of the questionnaire was made to those who had not yet responded, and then a third mail-out was made to try to boost the response rate still further. 51.4% (n=811) responses were received to the first mailing, 35.4% (n=557) to the second, and 13.0% (n=205) to the third.

As indicated in Figure 2, when the responses to the three mail-outs are compared, the data suggests a decrease over time in the proportion of respondents who had used unscheduled care. This implies that the population of non-respondents was likely to have a lower incidence of use of unscheduled care than the respondents.

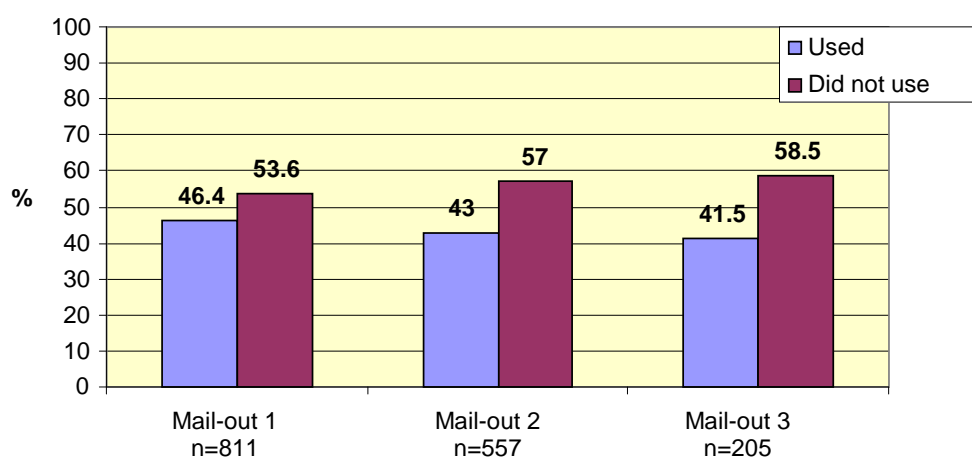


Figure 2: Use of unscheduled care by questionnaire mail-out

5.2 Awareness of services and how to contact them

Respondents were asked to indicate whether they had heard of each of five selected unscheduled care services; their responses are shown in Table 3 below. Participants were also asked to indicate whether they knew how to contact each of these services; the responses to this question are shown in Table 4 below. Figure 3 below brings together data on the proportion of respondents who were aware of and knew how to contact each service. As the tables reveal, the total number of respondents varied across groups and according to the question asked.

	Number of respondents answering this question	Yes	No	Missing data	Proportion of those who answered who said 'yes'
NHS Direct	1497	1279	218	79	86.5%
GP OOH service	1523	1373	150	53	90.2%
A&E	1539	1506	33	37	97.9%
Pharmacy OOH	1483	953	530	93	64.3%
Minor Injuries Unit	1476	639	837	100	43.3%

Table 3: Respondents' awareness of selected unscheduled care services

	Number of respondents answering this question	Yes	No	Missing data	Proportion of those who answered who said 'yes'
NHS Direct	1377	854	523	199	62.0%
GP OOH service	1398	1025	373	178	73.3%
A&E	1408	1268	140	168	90.1%
Pharmacy OOH	1354	491	863	222	36.3%
Minor Injuries Unit	1344	425	919	232	31.6%

Table 4: Respondents' knowledge of how to contact selected unscheduled care services

Awareness of NHS Direct, GP OOH services and A&E was high, at over 85% in each case. However, knowledge of how to contact services was generally lower than awareness, most strikingly so in the case of NHS Direct (a quarter of those who had heard of the service did not know how to contact it) and Pharmacy OOH services (nearly half of those who had heard of the services did not know how to contact them). The relatively low level of awareness of Minor Injuries Units at 43.3% (n=639) is likely to reflect the fact that services are not offered under that name in all parts of Wales.

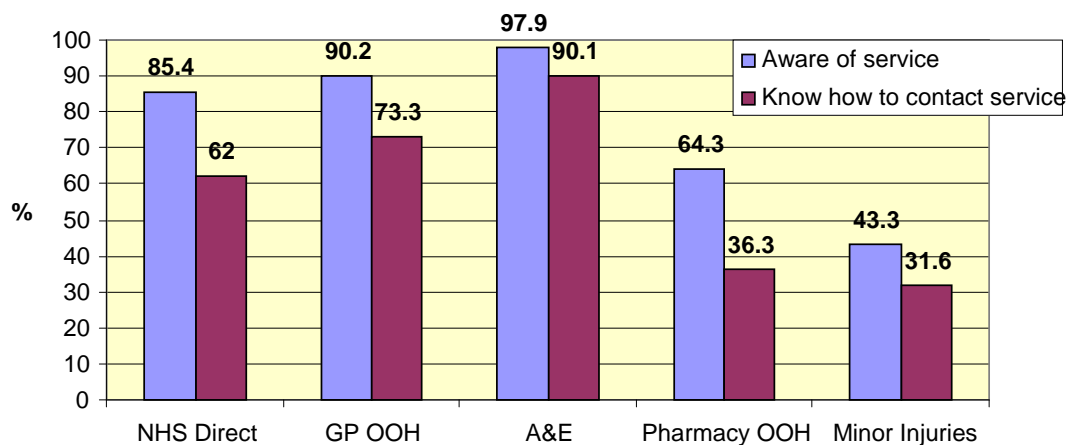


Figure 3: Respondents' awareness of unscheduled services and knowledge of how to contact them

When the knowledge of how to contact services was examined by age group, as shown in Figure 4 below, the most striking trend was in relation to knowledge of NHS Direct, which fell off steadily with age: only 42% of people aged 75+ said that they knew how to contact the service. A χ^2 test confirmed that the association between increasing age and decreasing knowledge of how to contact NHS Direct was statistically significant ($\chi^2=46.74$, $df=4$, $p=.000$).

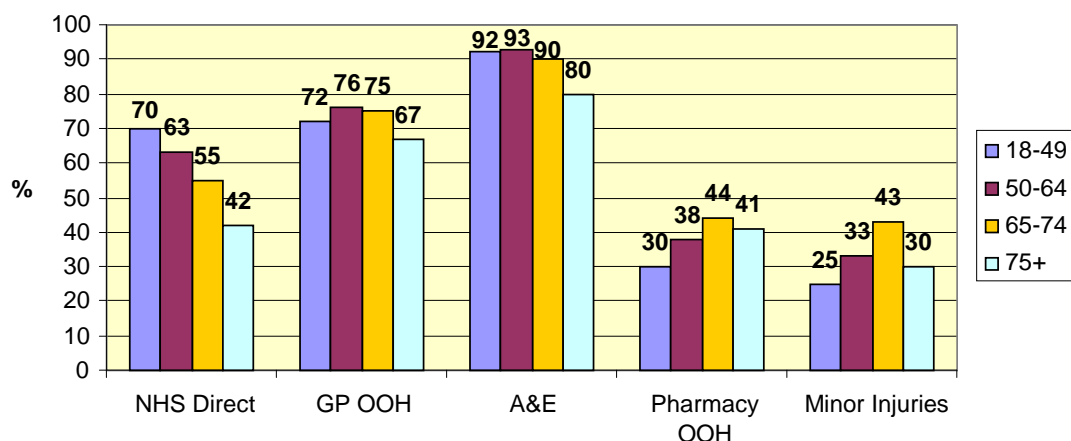


Figure 4: Knowledge of how to contact services by age group

Figure 5 indicates that knowledge of how to contact the five services varied with deprivation level. Although people living in the most deprived areas (i.e. Level 1) tended to have the lowest level of knowledge of how to contact services (with the exception of A&E), a χ^2 test did not show a significant association between deprivation level and knowledge of how to contact individual services.

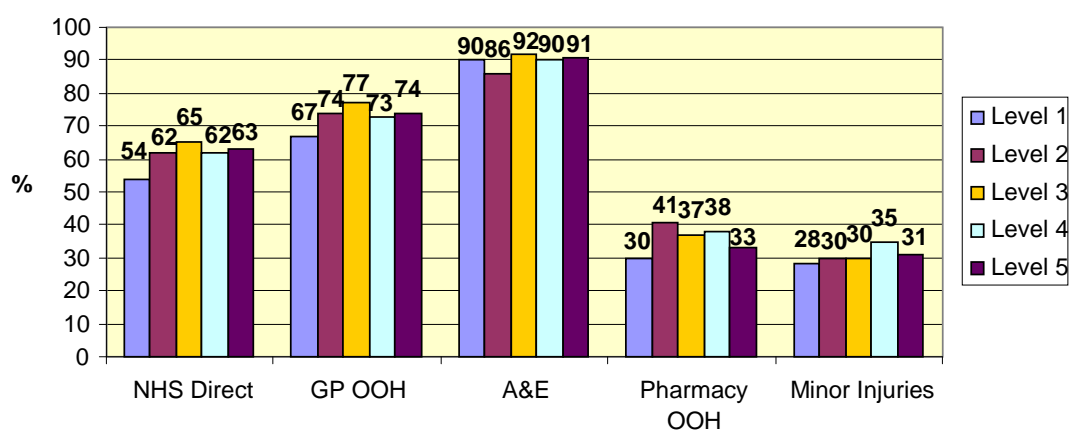


Figure 5: Knowledge of how to contact services by deprivation level

5.3 Use of services

Respondents were asked whether they had recent experience of using unscheduled care. Of the 1576 respondents, 44.5% (n=702) reported using unscheduled care in the last

three months, while 55.5% (n=874) had not. Of those who had used unscheduled care in the last three months, 36.8% (n=211) were male and 63.2% (n=449) female. People aged 18-49 made up the largest age group of unscheduled care users (36.0%, n=274) compared to those aged 50-64 (31.1%, n =214), 65-74 (16.9%, n=116) and 75+ (12.1%, n=83). Table 5 below illustrates the numbers of respondents in each category who had used unscheduled care, as well as the rates of use of unscheduled care depending on age, gender and level of deprivation.

Variables		Total respondents	Respondents who have used unscheduled care	
		No.	No.	%
Age	18-49	572	274	47.9%
	50-64	486	214	44.0%
	65-74	290	116	40.0%
	75+	201	83	41.3%
Gender	Male	548	211	38.5%
	Female	942	449	47.7%
Level of Deprivation	Level 1	154	83	53.9%
	Level 2	215	113	52.6%
	Level 3	318	149	46.9%
	Level 4	526	229	43.5%
	Level 5	359	126	35.1%

Note. Missing data: Age (n=15, 2.1%); Gender (n=42, 6%); Level of deprivation (n=2, 3%); Users of unscheduled care n = 702; Total respondents n = 1572.

Table 5: Use of unscheduled care by age, gender and deprivation level

Pearson chi-square tests were performed to identify possible significant differences in the use of unscheduled care depending on respondents' age, level of deprivation and gender. Results indicated no significant difference in whether individuals used unscheduled care based upon age ($\chi^2 = 5.37$, $df = 3$, $p = .146$). However, there was a significant differences in use of unscheduled care depending on the gender ($\chi^2 = 10.89$, $df = 1$, $p = .001$), with fewer men reporting use of unscheduled care than might be expected, and a greater number of women reporting use of unscheduled care than expected. There was also a statistically significant difference in use of unscheduled care depending on the level of deprivation ($\chi^2 = 24.92$, $df = 4$, $p = .000$), with people in more deprived areas (i.e.

Level 1) reporting greater use unscheduled care than expected, and people in least deprived areas using less unscheduled care than expected.

Table 6 below indicates the responses to a series of questions about facilities available to respondents, their household structure, and whether or not they were registered with a GP. It gives figures for all respondents, and then for those respondents who reported having had use of unscheduled care services in the previous three months.

Variables	Total respondents			Respondents who have used unscheduled care		
	Yes	No	Missing	Yes	No	Missing
Access to a car	1307 83.7%	255 16.3%	14 .9%	574 82.7%	120 17.3%	8 6.2%
Access to a telephone	1475 94.4%	88 5.6%	13 .8%	651 94.1%	41 5.9%	10 5.8%
Access to a mobile	1368 87.9%	189 12.1%	19 1.2%	610 88.3%	81 11.7%	11 8.5%
Live with other adults	1210 76.8%	366 23.2%	0 0%	541 77.1%	161 22.9%	0 0%
Live with children	370 23.5%	1206 76.5%	0 0%	202 28.8%	500 71.2%	0 0%
Registered with a GP	1562 99.7%	4 .2%	8 .5%	696 99.9%	0 0%	5 3.6%

Note. n=1576

Table 6: Use of unscheduled care according to access to telephone, car, household structure, and registration with GP

Pearson chi-square tests were performed to identify possible significant differences in the use of unscheduled care depending on the variables shown in the table above. There was a statistically significant association between respondents' use of unscheduled care and whether they lived with children. The results indicated that respondents who lived with children used unscheduled care more than expected, while participants who did not live with children, used unscheduled care less than expected. ($\chi^2 = 19.25$, $df = 1$, $p = .000$).

The following variables were found not to have a significant association with use of unscheduled care: access to a car ($\chi^2 = 1.76$, $df = 2$, $p = .415$), access to a telephone ($\chi^2 = 5.77$, $df = 2$, $p = .052$) or access to a mobile phone ($\chi^2 = 1.59$, $df = 2$, $p = .452$). In addition, using the continuity correction values for chi-square, there was no significant difference in use of unscheduled care according to whether respondents lived with another adult ($X^2 = .034$, $df = 1$, $p = .854$). It was inappropriate to assess differences depending on registration with a GP due to minimum cell expectancy.

5.4 Multiple contacts with services during the three month period

The next analyses focused on the number of times unscheduled health care services were contacted within the three month period leading up to the survey. As shown in Table 7, over half of the respondents who reported contacting unscheduled care services had done so on more than one occasion during the previous three months.

Number of times unscheduled care services were used in the past three months	Number of respondents	Proportion of respondents
1	310	44.9%
2	229	33.2%
3-5	124	18.0%
6-10	24	3.55%
10+	2	0.3%
Missing data	12	-
Total	701	100%

Table 7: Number of times respondents contacted unscheduled care services in previous three months

In total, 44.2% (n=289) of respondents who reported using unscheduled care also reported that the person needing care had one or more chronic conditions. As shown in Table 8 and Figure 6, the percentage of patients with a chronic condition increased as the number of unscheduled care visits also increased. Based on Pearson's chi-square, there was a significant difference in the use of unscheduled care based upon whether individuals had a chronic condition ($\chi^2 = 29.56$, $df = 4$, $p = .000$), with people with chronic conditions more likely to be heavier users of unscheduled care services.

	Times unscheduled care used during the last three months				
	1	2	3-5	6-10	10+
Total number of unscheduled care users	312	228	124	24	2
Number of unscheduled care users with a chronic condition	104	93	65	18	2
Missing data	23	11	11	1	-
Proportion of unscheduled care users with a chronic condition (valid percentage)	33.3%	40.8%	52.4%	75.0%	100.0%

Table 8: Multiple use of unscheduled care by chronic condition

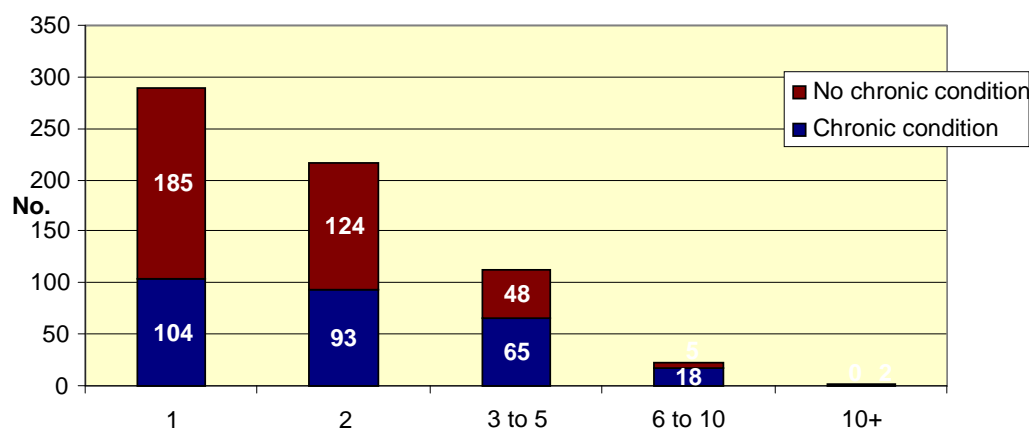
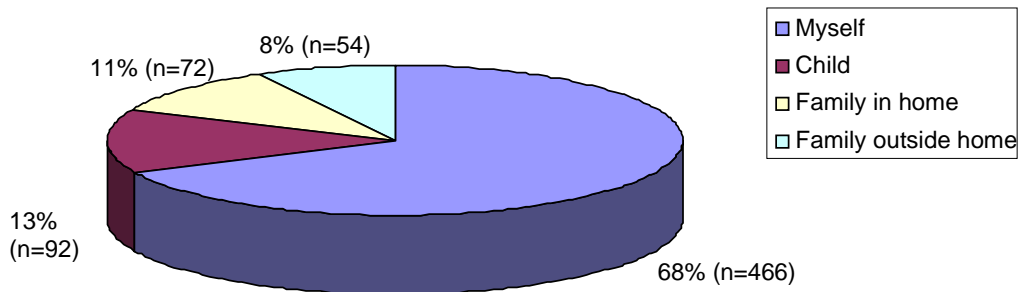


Figure 6: Levels of unscheduled care use by patients with and without chronic conditions

5.5 Who was the patient?

Of the participants reporting contact with unscheduled care services, the majority (68.1%, n=466) reported making contact for themselves rather than any other person. Figure 7 shows that 13.5% (n=92) sought help for their child; 20 of those children were reported as having a chronic health condition of some sort. 10.5% (n=72) sought help

for an adult family member or friend living in a different home, and 13.5% (n=92) for an adult family member or friend with whom they shared a home.



Note. Total n= 684

Figure 7: Person for whom unscheduled care was sought

Figure 8 indicates the age groups for the people for whom care was sought, that is, the patient. Figure 7 indicates, in nearly one third of cases, the patient was someone other than the respondent. Table 9 below combines the figures on the number of patients in each age group with the number of respondents. It indicates that a high proportion of respondents in the youngest age group sought help on behalf of someone else (such as their child), and also that many people in the oldest age group had used unscheduled care services after someone else made contact on their behalf.

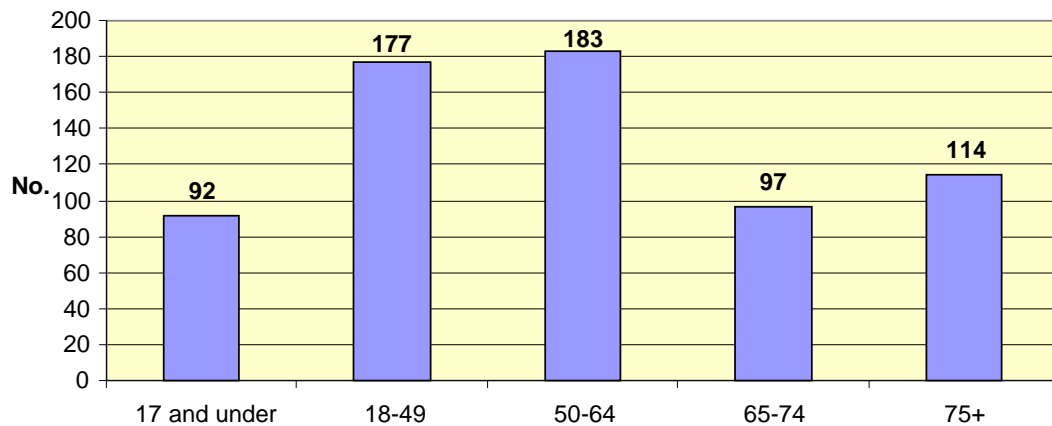


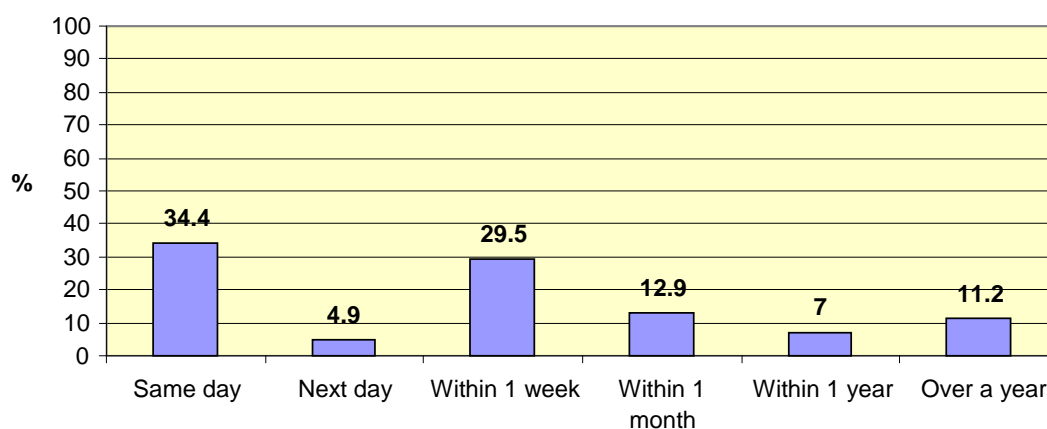
Figure 8: Age of person for who help was sought

Age group	17 and under	18-49	50-64	65-74	75+	Total
Number of respondents	n/a	274	214	116	83	687
Number of patients	92	177	183	97	83	663

Table 9: Number and ages of people seeking unscheduled care services

5.6 Making contact with care services

Respondents were asked how long they had been experiencing the problem before they sought unscheduled care. Their responses are given in Figure 9 below, which indicates that just over 40% of respondents sought help within one day of the problem appearing, but that almost 60% experienced problems for a longer period before they sought help. However, these responses should be treated with care, since it is possible that different respondents may have interpreted the question in different ways, particularly in relation to long-term or recurrent conditions. Where a problem was identified as being in existence for ‘more than a year’, it may simply mean that a patient was first diagnosed with a condition at that time, and the need for treatment may simply relate to a flare-up in symptoms or increase in pain which took place over a shorter period of time.



Note. n=596

Figure 9: Time waited before respondents contacted an unscheduled care service

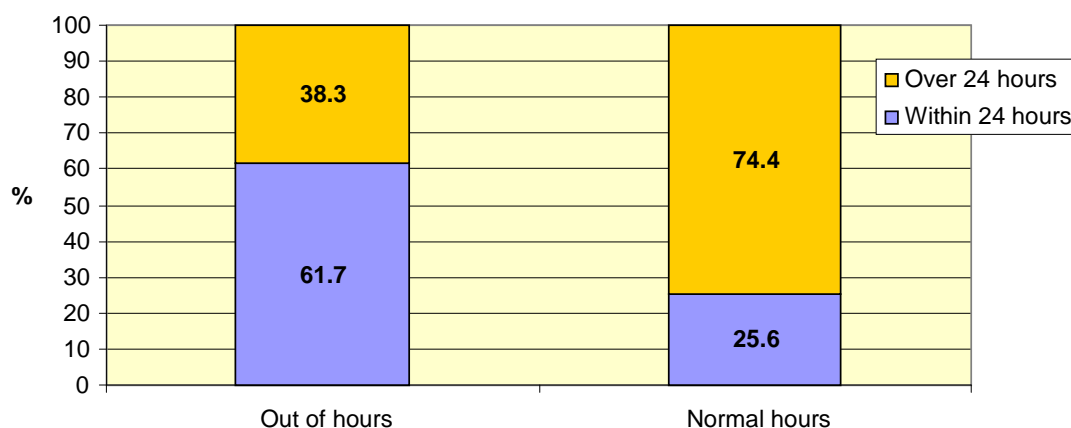
Table 10 below shows when respondents made contact with unscheduled health care services.

		Number of users	Proportion of users
Day	Weekday	597	87.7%
	Weekend	84	12.3%
	Missing		-
Time	Between 8am and 630pm	567	84.1%
	Between 630pm and midnight	91	13.5%
	Between midnight and 8am	16	2.4%
	Missing	28	-
Bank holiday	Bank holiday	11	1.9%
	Not a bank holiday	583	98.1%
	Missing	108	-

Note. n=702

Table 10: Time and day when respondents contacted unscheduled care

A total of 167 respondents (24.6%) had contacted unscheduled care services during what would be regarded as ‘out of hours’ times: between 6.30pm and 8am, at the weekend, or on a bank holiday. Speedier contacts with health care services (the same day or next day) were associated with use of ‘out of hours’ care (see Figure 10.). This association was statistically significant ($\chi^2 = 60.07$, $df = 1$, $p = .000$).



Note. Out of Hours care n= 141, Normal hours care n=441.

Figure 10: Time waited to seek help and when help sought

5.7 Services used

Respondents were asked to indicate, from a list of options, the names of all the types of unscheduled care service with which they had contacted during the episode of care described on the form. They were also asked to indicate which one was the first source of help that they went to. As shown in Table 11 below, much the most common first point of contact was the respondent’s own GP, with half of respondents reporting a visit during open access or emergency surgery. The next most common first point of contact was the GP Out of Hours service (7.1%), followed closely by other practice staff, NHS Direct, and A&E.

Service	Frequency	Valid percent
Family doctor (GP)	274	50.0
Out of hours doctors (GP) service	39	7.1
Someone else at practice	35	6.4
NHS Direct	33	6.0
Hospital A&E	30	5.5
Chemist (treatment or advice)	25	4.6
Dentist	23	4.2
Family & friends	22	4.0
Someone else	18	3.3
999 ambulance	18	3.3
Chemist (collect prescription)	12	2.2
Hospital clinic or day ward	7	1.3
Minor injury unit	6	1.1
Another telephone hotline (not NHS Direct)	2	.4
Complimentary or alternative therapy	2	.4
Admitted to hospital 1+days	1	.2
Physiotherapist	1	.2
Total	548	100%

Table 11: First service contacted by users of unscheduled care

As indicated in Table 12 below, few respondents reported having their problem resolved with just one contact, and the majority (95.2%) contacted two or more sources of help about the same incident. The most common pattern was simply seeing the GP, then going to the pharmacist to pick up medication, but many other complex stories emerged. One respondent even reported having contact with seven different sources of help in relation to the same problem. Respondents could write in other sources of help they had

used if these were not already on the form: one reported his first point of contact being a vet who happened to be visiting to treat a cow.

Number of services used for same problem		
	%	No.
1 service	4.0	28
2 services	60.3	423
3 services	16.7	117
4 services	2.0	14
5 services	.4	3
6 services	0	0
7 services	.1	1
Missing	16.5	116

Note: n=702

Table 12: Number of unscheduled services contacted for reported health problem

As seen in Figure 11, once all contacts (initial and contacts and referrals on) with unscheduled care services were plotted, GPs retained their dominance of the picture, but other services such as pharmacists and A&E start to look a little more significant.

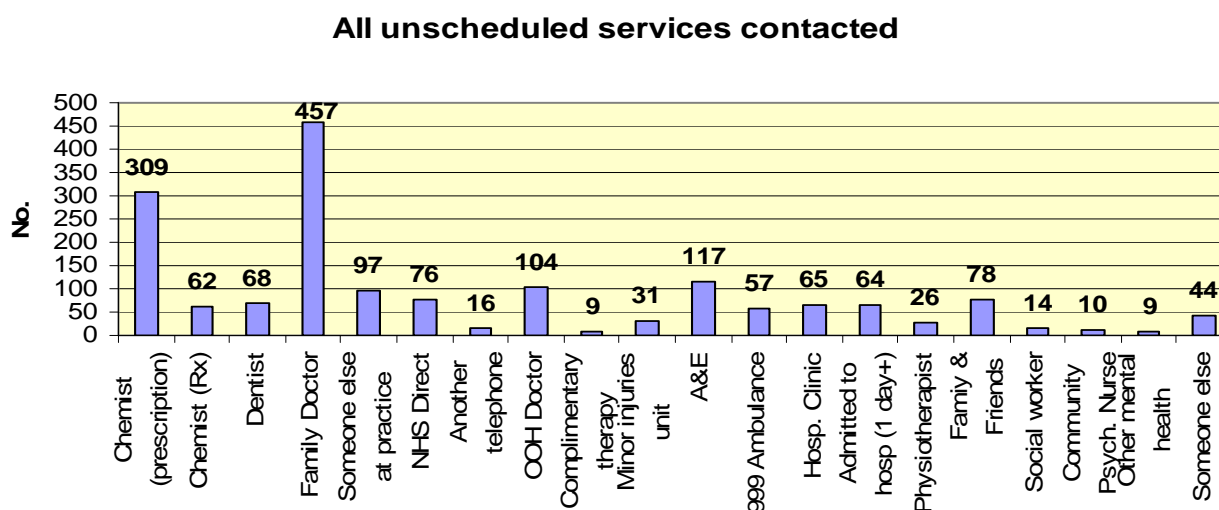


Figure 11: All contacts with unscheduled care services

5.8 Stated reasons for choice of first contact

Respondents were presented with a list of nine possible reasons which may have influenced their choice of health care service for first contact. They were asked to indicate, for each reason, whether this was a very important influence on their choice, quite important, or something which they thought was unimportant or had not considered at all. Responses are shown in Table 13 and Figure 12.

Reason	Very important	Quite important	Not important/ not considered	Total
Most appropriate	408 (81.4%)	80 (16.0%)	13 (2.6%)	501 (100%)
First to come to mind	295 (71.8%)	80 (19.5%)	36 (8.8%)	411 (100%)
Used before	275 (67.4%)	78 (19.1%)	55 (13.5%)	408 (100%)
Know and trust service	201 (51.5%)	79 (20.3%)	110 (28.2%)	390 (100%)
Nearest to me	196 (49.2%)	93 (23.4%)	109 (27.5%)	398 (100%)
Knew would be open	133 (37.0%)	97 (27.0%)	129 (35.9%)	359 (100%)
Shortest waiting time	132 (38.6%)	78 (22.8%)	132 (38.6%)	342 (100%)
Didn't know where else to go	94 (28.1%)	64 (19.1%)	177 (52.8%)	335 (100%)
Recommended	25 (7.9%)	51 (16.0%)	242 (76.1%)	318 (100%)

Table 13: Reason for contacting first service

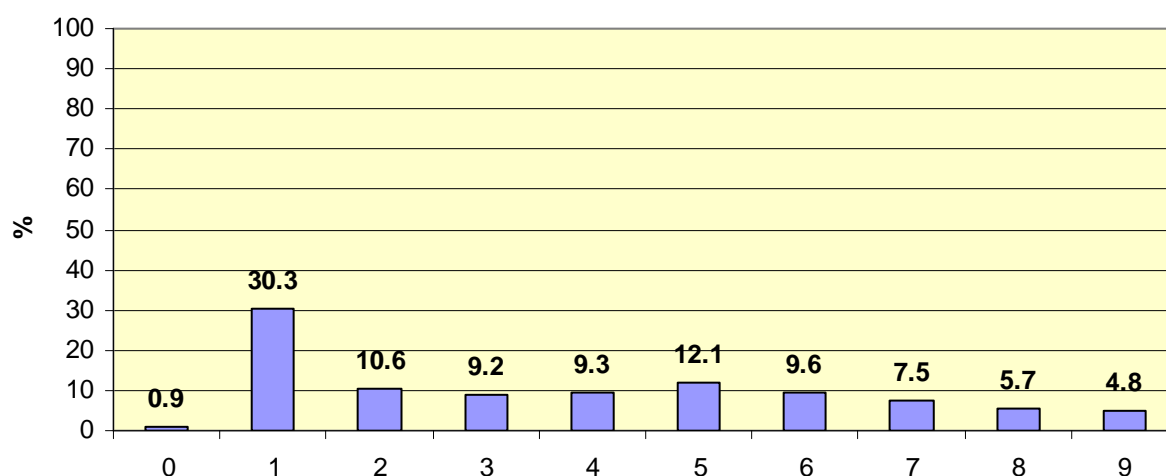


Note. n=702

Figure 12: Reason for contacting first unscheduled care service

As might be expected, the reason which was most cited was simply that people thought it was the most appropriate service. Practical issues such as ‘nearest to me’, ‘knew it would be open’ and ‘shortest waiting time’ feature as reasons of secondary importance, with relatively high proportions of respondents stating they were ‘quite important’ reasons. Fewer than half of respondents stated that their choice was influenced by not knowing where else to go. The reason ‘someone said I should use it’ scored remarkably low, suggesting that advice from friends and family was not a significant influence on most people’s choice. As Figure 13 shows below, the choice for first service provider was influenced by multiple factors, with over two thirds citing two or more reasons.

Number of reasons given for contacting first health service



Note: n=644; Missing n=58.

Figure 13: Number of reasons cited for choosing first health service contact

5.9 Health needs for which unscheduled care was sought

The questionnaire included a free text box where respondents were asked to describe the health care problem which led to their contact with unscheduled care services. Responses were grouped into categories which were developed during the analysis, as shown in Table 14 below. Of the eight, two categories ('long-term condition or follow-up treatment' and 'information, advice or routine test or results') might be expected to lend themselves more to scheduled care than unscheduled care. 'Pain in back/limb/joints' and 'dentistry' were two categories of complaint which might be acute or chronic, and it was not always clear from the respondents' description which was the case. The next three categories were unambiguously acute problems. The first, 'acute infections', made up of symptoms such as sore throat or diarrhoea and vomiting, were generally familiar and common place. 'Other symptoms of concern' brought together a range of problems, from unexpected rashes to 'a lump where no lump should be', which weren't matched by the respondent to a diagnosis. The next category, 'accidents/emergency/morning after pill' covered health problems which were clearly of sudden onset or needed urgent intervention. Health problems which were unclear from the respondent's description, or where information was withheld, were placed in 'Other/Unknown'.

	Proportion of respondents	Number of respondents
Long-term/follow-up treatment	11.9%	82
Info/Advice/ Routine tests	3.6%	25
Pain in back/Limbs/Joints	11.3%	78
Dentistry	3.5%	24
Acute infections	21%	145
Other symptoms of concern	27.5%	190
Accident/Emergency/ Morning-after pill	13.6%	94
Other/Unknown	7.7%	53
Missing	1.6%	11

Note. n=702

Table 14: Health problem which led to contact with unscheduled care services

A Kruskal-Wallis Chi-square test was performed to assess any association between the type of health care needed and the number of different services that were accessed. The test suggested a significant difference in the number of services used according to the type of medical problem for which help was sought ($\chi^2=20.28$, $df=7$, $p<.005$). The results, presented in Table 15, suggest that individuals with reported ‘accident, emergency and/or a need for the morning after pill’ concerns reported using a higher number of services compared to individuals with other medical problems. People in need of dental assistance tended to be in contact with the smallest number of medical services.

Medical Problem	Ranking
Accident/Emergency/Morning after pill	325.65
Other symptoms of concern	302.93
Pain in back/limbs/joints	300.93
Long-term/follow-up treatment	280.92
Acute infection (cold, flu)	277.41
Other/Unknown	242.86
Info/Advice/Routine tests and results	239.12
Dentistry	228.43

Note. Higher mean rank indicates greater use of services for problem, n = 579.

Table 15: exploring association between health need and number of services contacted

5.10 Willingness to use the same service again

Respondents were asked, should the same situation arise again, whether would they choose the same course of action. Out of the 668 unscheduled care users who responded, more than four out of five people (83.7%, n= 559) stated they would choose the same service as their first point of contact again, while 11.2% (n=75) responded 'No' and 5.1% (n=34) responded 'Don't know'.

Reasons given for choosing a different service next time fell broadly into three categories, as listed below, with the biggest group of responses falling into the first category:

- the patient had not been treated by the first care provider contacted, but had been referred on to another service – in many cases, respondents expressed frustration at the delays involved
- after the incident described on the form, the patient felt more knowledgeable and confident about 'reading' their symptoms and working out an appropriate response for future occasions
- the patient had discovered the limits on the range of medication available directly from pharmacists.

5.11 Health beliefs

In the section of the questionnaire based on the Brief Illness Questionnaire (Broadbent et al 2006), respondents were asked to give their response to the following eight questions on Likert scales from 0 to 10:

- **Consequences:** How much did the problem affect your life (or the life of the person you sought help for)? (0=no effect at all, 10=severely affects my/their life)
- **Timeline:** How long did you think the problem would continue? (0=a very short time, 10=forever)
- **Personal control:** How much control did you think that you/the person had over the problem? (0=absolutely no control, 10=extreme amount of control)
- **Treatment control:** How much did you think that treatment could help the problem? (0=not at all, 10=extremely helpful)
- **Identity:** How much did you/the person experience symptoms from the problem? (0=no symptoms at all, 10=many severe symptoms)
- **Concern:** How concerned were you about the problem? (0=not at all concerned, 10=extremely concerned)
- **Understanding:** How well did you feel that you understood the problem? (0=didn't understand at all, 10=understood very clearly)
- **Emotional response:** How much did the problem affect you emotionally? (e.g. did it make you angry, scared, upset or depressed?) (0=not at all affected emotionally, 10=extremely affected emotionally)

Responses to all these questions are shown in Table 16 below. Responses to all questions were generally skewed towards the more extreme scores, and this was most striking in the case of two questions. When asked how much they thought treatment could help the problem, 41.7% (n=267) answered with a score of 10, that is, they thought treatment would be extremely helpful. When asked how concerned they were about the problem, 39.7% (n=263) of respondents answered with a score of 10, that is, they were extremely concerned.

Health belief question	Score on Likert scale												
	0	1	2	3	4	5	6	7	8	9	10	Mean	Standard deviation
1.Consequences (n = 659)	26 3.9%	24 3.6%	17 2.6%	28 4.2%	34 5.2%	70 10.6%	54 8.2%	78 11.8%	118 17.9%	55 8.3%	115 23.5%	6.81	2.854
2.Timeline (n = 623)	30 4.3%	34 4.9%	29 4.2%	53 7.7%	64 9.3%	96 13.9%	61 8.8%	50 7.2%	54 7.8%	26 3.8%	126 18.3%	5.83	3.032
3.Personal control (n = 652)	168 25.8%	61 9.4%	47 7.2%	72 11.0%	42 6.4%	57 8.7%	41 6.3%	38 5.8%	49 7.5%	18 2.8%	59 9.0%	3.80	3.37
4.Treatment control (n = 641)	12 1.7%	15 2.1%	12 1.9%	20 2.9%	15 2.1%	60 8.7%	28 4.0%	56 8.1%	95 13.6%	61 8.9%	267 41.7%	7.80	2.647
5.Identity (n = 643)	22 3.4%	16 2.5%	19 3.0%	19 3.0%	27 4.2%	60 9.3%	57 8.9%	87 13.5%	125 19.4%	65 10.1%	146 22.7%	7.02	2.698
6.Concern (n = 662)	11 1.7%	10 1.5%	11 1.7%	18 2.7%	19 2.9%	45 6.8%	51 7.7%	61 9.2%	93 14.0%	80 11.6%	263 39.7%	7.88	2.501
7.Understanding (n = 654)	35 5.4%	12 1.8%	22 3.4%	21 3.2%	19 2.9%	54 8.3%	46 7.0%	47 7.2%	112 17.1%	57 8.7%	229 35.0%	7.29	2.983
8.Emotional response (n = 660)	69 10.5%	35 5.3%	23 2.5%	36 5.5%	26 3.9%	65 9.8%	49 7.4%	71 10.8%	90 13.6%	54 8.25%	142 21.5%	6.12	3.345

Note: figures indicate the number of respondents who gave the score indicated in response to each question.

Table 16: Responses to health belief questions – all respondents

In order to explore whether there was any association between these health beliefs and multiple use of unscheduled health care services, data on how many times respondents had contacted unscheduled health services in the previous three months was first grouped into three categories: once (n=312), twice (n=228) and three or more times (n=150). A series of χ^2 tests found that health beliefs about the following factors to have a statistically significant association with more frequent use of unscheduled care:

- Consequences (linear by linear association 11.826, df=1, p=.001) – people who believed the problem severely affected their life were more likely have high use of unscheduled care services
- Timeline (linear by linear association 10.741, df=1, p=.001) - people who believed the problem would continue for a long period of time were more likely have high use of unscheduled care services
- Identity (linear by linear association 8.320, df=1, p=.004) - people who were experiencing many severe symptoms were more likely have high use of unscheduled care services
- Concern (linear by linear association 18.131, df=1, p=.000) people who were extremely concerned about the problem were more likely have high use of unscheduled care services
- Emotional response (linear by linear association 27.897, df=1, p=.000) people who extremely affected emotionally were more likely have high use of unscheduled care services

Beliefs about the following factors did not show a statistically significant association with more frequent use of unscheduled care:

- Personal control (linear by linear association 1.805, df=1, p=.179)
- Treatment control (linear by linear association .322, df=1, p=.570)
- Understanding (linear by linear association 2.531, df=1, p=.112)

A series of χ^2 tests were also carried out to find out if there was any statistically significant relationship between the health belief scores and whether or not people contacted unscheduled care services within 24 hours of the onset of the problem. The only health belief to show such an association was timeline): people who thought that

their problem would be of short duration were more likely to seek help within 24 hours, whereas people who thought that their problem would be of long duration were more likely to wait 24 hours or more before seeking help (linear by linear association = 17.350, df = 1, p=.000).

A final series of χ^2 tests were carried out to see if there was any statistically significant relationship between health belief scores and the type of health care provider selected for first contact. No such statistically significant relationship was found in relation to any of the health beliefs.

5.12 Summary of key points

- The survey response rate was 41.7% (n=1576). The response rate was higher in more affluent areas.
- Awareness of NHS Direct, GP OOH and A&E is generally high, but knowledge of how to actually make contact with services tends to be lower, particularly for NHS Direct and Pharmacy OOH services.
- Over forty per cent (n=702) of survey respondents had used unscheduled care services in the past three months. Higher rates of use were found among women, among people living in relatively deprived areas, and among people with children in the household.
- Over half of respondents had used unscheduled care services on more than one occasion in a three month period.
- Almost half of respondents who reported using unscheduled care also reported that the person needing the care had a chronic condition. People with chronic conditions were more likely to be multiple users of unscheduled care (more than once in the three month period).
- A quarter of contacts (n=167) were 'out of hours': between 6.30pm and 8am, at the weekend or on a bank holiday. 'Out of hours' contacts tended to be made within 24 hours of the problem first developing.
- Just over 40% of contacts were made within 24 hours of the problem developing.
- Roughly two-thirds of respondents (n=466) had sought unscheduled care for themselves, and the rest had made contact on behalf of family or friends.

- Half of respondents (n=274) made first contact with their GP during open access or emergency surgery. GP OOH was next most common (7.2%) followed closely by NHS Direct and A&E. Most people were in touch with two or more services about the same incident.
- The three most commonly cited reasons for the choice of first service to contact were ‘most appropriate’, ‘first which came to mind’ and ‘used before’.
- More than four out of five users (n=559) would use the same provider again.
- High levels of use of unscheduled care services were associated with certain health beliefs – that the health problem severely affected the respondent’s life, that it would go on for a long time, they were experiencing many severe symptoms, that they were concerned about the problem, and that they were affected emotionally.

6. Comparison with routine data

The 1576 adult respondents represented one in 1421 of the adult population of Wales, based on the 2001 census which reported that there were 2,240,306 people in Wales aged 19 or over.

116 of the respondents reported that they had unscheduled contact with A&E in the previous three months, seeking treatment either for themselves or for a family member or friend. If this pattern was repeated across Wales, this would suggest that there would be 164,836 contacts in a 3 month period, and 659,344 in a 12-month period. Actual data for the 12 month period ending in December 2007 show that there were 740,326 new contacts with A& E departments across Wales.

76 of the respondents reported that they had unscheduled contact with NHS Direct in the previous three months, seeking treatment either for themselves or for a family member or friend. If this pattern was repeated across Wales, this would suggest that there would be 107,996 contacts in a 3 month period, and 431,984 in a 12-month period. Actual data for the 12 month period ending in December 2007 show that there were 360,000 contacts with NHS Direct across Wales.

In the case of both A&E services and NHS Direct, the similarity of the figures to the figures derived from the survey suggests that we can have confidence in the accuracy of the survey findings.

No routine data are available for unscheduled contact with GP practices. However, extrapolating the 467 contacts reported in the survey, on the same basis as above, suggests that there would have been some 2.65 million unscheduled visits to GPs across Wales during 2007.

7. Results – in-depth interviews

7.1 Introduction

This section of the report presents some key themes which emerged from the in-depth qualitative interviews. The interviews examined in more depth the recent experience of unscheduled care which respondents had described in the form.

Where verbatim quotations are given, those from qualitative interviews are identified by the respondent’s unique four digit ID number which was allocated during the original questionnaire mail-out.

While we have identified themes which appeared to be important issues for most of the 40 people we talked to, it is important to remember that there was a diversity of perspectives and experience among the respondents, as there will be in the population as a whole. Even individual respondents were, on occasion, capable of expressing inconsistencies.

7.2 Participants

The 40 participants in the interviews comprised 22 men and 18 women. The make-up of the group in terms of age and the deprivation level of the area where they lived are shown in the two tables below.

18-49	50-64	65-74	75+
12	13	8	7

Table 17: Participants in the qualitative interviews by age

Level 1	Level2	Level 3	Level 4	Level 5
7	9	6	10	8

Table 18: Participants in the qualitative interviews by level of deprivation of area where they lived

7.3 *Key themes*

7.3.1 **The complexity and variety of respondents' experiences**

Most 'stories' of contact with unscheduled care were not clear-cut narratives of problem-diagnosis-treatment-recovery. There may have been considerable delay between the onset of symptoms and patients seeking help. One provider of care might have referred the patient on to another, either immediately, or by appointment, or by advising on what the patient should do if symptoms persisted or recurred after a period of time. This might have led them to, for example, go to A&E some days after their original contact with their GP, but still acting on the GP's advice.

In a few cases, respondents were still unclear, at the end of their contact, about what the problem was. Some recovered without treatment, in some cases being given medication but choosing not to take it. Some received treatment which didn't work.

Table 19 below shows some examples of the experiences of ten of the respondents who took part in the qualitative interviews. In order to provide a cross-section of respondents, rather than a purposive sample, those reported here are simply the first ten, in numerical order of their ID numbers. In each case, the contact highlighted in bold is the incident that they described in their questionnaire form, and which provided the starting point for the interview. Where the respondent had a chronic health condition, this has been shown. These miniature case studies provide an indication of the range of types of health need, the range of times people took to make the first contact, and the range of outcomes, all of which are reflected in the full dataset.

Interviews with patients revealed how the process of accessing unscheduled health care is complex and requires decision-making at three stages:

- deciding **whether** care is needed
- deciding that care is needed **now**
- deciding **what kind** of care is needed.

The following sections present a discussion of the factors which may influence decision-making at each of those stages. The stages provide a framework for discussion, but there are inevitably some themes which overlap more than one stage: emotion, for example, can influence whether or not a person seeks help and also what type of help they look for.

1105	Vomiting	6 hours	called GP OOH	an hour	home visit, medication	an hour	recovery	
1287	Abscess on thigh	a few days	visited GP	medication	a few days	visited GP, medication	two weeks	recovery
1306	Groin pain	a week	visited GP	two weeks	visited another GP, referred to specialist			
1384	Sore throat	three days	visited GP, medication	two days	recovery			
			Asthma					
1413	Shortness of breath		visited GP, change to medication	one day	recovery			
			Asthma, heart disease					
1576	Pain in knee	six weeks	visited GP, change to medication		improvement			
			Chronic knee and back trouble					
1736	Chest pain	eight hours	called OOH	paramedics arrived, declined to go to hospital	GP appt, referred for chest x-ray			
1919	Inflamed toe	one week	visited GP	referred to practice nurse, dressing changed	many weeks	inflammation continued		
			Chronic rheumatoid arthritis, hammer toe					
2156	Cough, fever	8 days	visited GP, prescribed antibiotics	two weeks	recovery			
			Chronic high blood pressure					
2378	Rash	next day	visited GP, prescribed antihistamine	one week	recovery			

Table 19: Summaries of contacts with unscheduled care for 10 sample respondents

7.3.2 Deciding whether care is needed

The first step in accessing unscheduled health care is deciding that the health need is beyond what the patient, or the household, can deal with from their own resources, and that some form of help from outside is required. Respondents described the various ways in which they, as patients, had expertise on health, illness and usual response to problems or treatment which fed into their decision that the threshold for seeking help had been reached.

There were two groups of respondents who talked particularly clearly about how finely tuned they were to detecting when variations in health went beyond the ordinary to something which needed help: these were parents of young children and people with chronic conditions. For example, respondent 2424 had diabetes, and described how he monitored his condition for ups and downs which may be of concern:

“I know the signs and symptoms. I know what happens.” – 2424

Not all cases provided illustration of patients as reliable experts on their own bodies. Respondents may have been unclear about what is the matter, or making assumptions about their diagnosis which were wrong. Even in cases where patients with chronic conditions were being encouraged to manage their own day to day care, there may have been a perceived need for intervention which was more to do with emotion than with symptoms. For example, 1576 experienced chronic pain through arthritis, and although she had long term medication, did not feel comfortable or confident in managing her medication alone, contacting her GP as much for support as for professional expertise:

“I know it’s a bit stupid suffering when I can take eight Cocodamol a day. It’s me being stubborn but sometimes it gets that bad that I think I need reassurance.” - 1576

Some respondents described a subtle balance between their own judgement and their need for advice, looking to unscheduled care services to reassurance or endorsement for their own judgement. One mother, for example, described how she would call NHS Direct ‘as a backup’:

“I think it’s brilliant to have someone on call to phone up and say that something’s not right and to get their point of view on what you should be doing because your instinct might be that they need to go to the hospital but it’s nice to just have a backup.” – 4899

Perceived need for health care would be weighed up, in many cases, against a reluctance to trouble services and a sense of stoicism, which often increases with age. In some cases this was challenged by friends and family, who emerged as a factor influencing people to seek, over-riding the patient's own stoicism or fear of contacting medical services:

"[My partner] wanted me to go to the GP in actual fact. I'm a man so I wouldn't have gone at all." - 4330

"My friend rang me again that night and I thought, 'Well maybe I ought to ring them' and that's what made me ring them basically. Otherwise I'd have left it a couple of weeks." – 1220

Other emotional factors also had an influence on decision-making. Fear of the illness and its potential consequences was identified as a factor for precipitating the call for unscheduled care, and also for delaying some people's decision to seek help or turning instead to a family member or friend for assistance. Respondents described how fear could have a bigger part to play in the middle of the night, especially for people who lived alone. 1413, for example, contacted his GP after suffering shortness of breath:

"I think it's purely because I got a little bit frightened. It was every time I lay down, and of course at that time I lived on my own, I was miles from the nearest person." - 1413

"I was panicking and I was on my own, so I think it's handy to know that you've got that little bit of reassurance [NHS Direct] instantly on the phone if you need it." - 2391 whose young daughter had recurrent chest problems.

While fear may commonly encourage people to seek help, 3712 provided an example of how it can work in the opposite way, inhibiting someone from contacting 'higher order' sources of help. When respondent 3712 developed persistent nosebleeds, the first place he sought help was the chemists. Asked why he didn't go to see his GP, he said:

"I don't know; probably fear because I have a heart condition.'" - 3712

In the end, his visit to the chemist then led to him going to the GP and eventually to hospitalisation.

7.3.3 Deciding that care is needed now

Making the decision that care is needed now is effectively making the decision to seek unscheduled healthcare, rather than making an appointment for scheduled care.

However, deciding that help is needed now was not always simply a direct response to symptoms appearing or suddenly getting worse. This was illustrated by 1287's "...little boil" which "...all of a sudden came up big". In many cases, the trigger for seeking help could not always be immediately understandable to the researchers. Some people reported taking an analytical approach, deciding that *because* their symptoms had continued for a week they must be serious. For others, it was simply a case of being unable to stand the pain any more.

Also feeding into the decision about whether to seek care immediately was the pragmatic process of weighing up the likelihood of a making a fairly quick recovery without intervention against the anticipated time it would take to make a routine appointment, that is, to remain within the scheduled care system:

"You could wait for a couple of weeks. That's the problem with the doctor's surgery really. You could have a cold and by the time you make an appointment and get to see them, you've probably recovered." –1384

One respondent provided a particularly clear illustration of the way in which 'emergency' health care can be defined by organisational issues rather than any absolute of need:

"Somebody I knew worked on reception and I told them it feels like my hip joint. And he told me that one of the GPs in the surgery is a hip specialist, so I asked when I could see him and he said 'If you book in as an emergency you can see him tonight' so I booked in to see him as an emergency" – 3286

In the case of people with chronic conditions, the time required to get a routine appointment and the possibility of developing a serious health crisis may have had an influence on how they time their contact with a health service. These patients used their experience to judge the balance between the speed at which their condition could deteriorate and the need for treatment. 1384, for example, had asthma that made her particularly worried when she got any kind of throat infection:

"I used to just leave it but when it got to the point where I was coughing green phlegm, I go to the doctor now and they treat it with antibiotics or sometimes steroids depending on how bad it is. I've now decided that I should go sooner rather than later which is a help." – 1384

7.3.4 Deciding what kind of help is needed

The comments of many respondents suggested that they did not have a complete picture of the range of unscheduled care services available. For example, when asked why it was that she chose to make an unscheduled visit to the GP practice, 4847 replied:

“Because I don’t know other sources of healthcare. I only know the doctors.” – 4847

If a comparison was made explicitly, it was generally between two possible options, rather than the full range of unscheduled care providers. For example, when asked what influenced her choice of healthcare service, 4899 reported:

“Time, really, because if my GP was open, I would have phoned the GP but because obviously it was out-of-hours. That’s when I normally phone NHS Direct.” – 4899

Particularly striking was how rarely the GP OOH service was mentioned as a possible option for health care, in terms of people evaluating it as one possible option or suggesting that they might use it in the future.

Even when respondents had heard of services, their beliefs about the role, function, availability or appropriateness of those services did not necessarily conform with what service managers might believe. For example, one respondent suggested NHS Direct was a good option for help in circumstances where the patient was not well enough to get to the surgery. Another saw NHS Direct as a way of avoiding disturbing the GP or the hospital. A number of respondents mentioned A&E as a possible first point of call for out of hours care. However, this group were outweighed by the respondents who appeared to look on A&E as a service of last resort:

“I’d only go to A&E if my leg was hanging off.” – 4330

Virtually all the respondents who had had experience of A&E appeared to be very much aware that this was a service for which eligibility were rigidly enforced, and that anyone trying to use it should be very confident of their need for it if they didn’t want to be made to “feel like idiots”, as 2391 put it.

For 4899, anxiety about the barriers presented to her use of A&E was alleviated by the fact that she had made contact with NHS Direct initially, which functioned in her mind as a means to confirm the legitimacy of her child’s need for the A&E service.

“When we went to hospital they looked at us as if to say, ‘What’s he doing here?’ and it was like my backup then because I could say that we did phone NHS Direct and they did tell me to come here if he was sick twice. Sometimes you’ve got that-

they're looking at you as if you're panicking, so if I'm unsure I would rather phone NHS Direct to get that backing." – 4899

Such anxieties about correct or appropriate use of NHS services were not just limited to A&E. One respondent reported a similar sense of needing authorisation for care in relation to the GP: 3552's husband had a chronic cough, which eventually led to hospitalisation, but their first contact for help was a pharmacist. After repeated visits, it got to the stage where:

"We went to Tesco [pharmacy counter] one day and were told 'well, sorry but you can't have any more cough medicine, you've got to see a doctor now' so from then you felt as though you had a bit of backup. You felt as though you had a bit more weight to your argument." - 3552

Respondents were asked directly whether the media – either news media or TV drama – had any influence on their use of unscheduled care services, and the virtually unanimous response was that they did not. 3286 suggested that there was already plenty of media attention given to problems of inappropriate use of ambulances, but:

"On the flip side they don't really advertise the places you can phone up first, there seems to be an imbalance in the media" - 3286

What did come through strongly in the interviews is that respondents based their decisions in part on their own learning and experience over many years. Decisions about use of unscheduled healthcare were not generally made in isolation, in relation to single experiences. Instead, they tended to build on previous healthcare encounters, whether these were positive or negative. This might work either to encourage or discourage a particular course of action. Many respondents talked about how they would choose to go to their own GP because of their positive experience of care built up over years of encounters:

"Well my doctor is my friend as well and I've been with him for so many years.....He doesn't have to look at my notes or anything because he knows me so well." - 1919

As with the decision about whether or not to seek care, the decision about which provider to turn to could also be based on expertise at judging health status – in the following example, a mother making a judgement about a child with chronic health problems:

“Well, depending on how well we think he is, if he is okay but feeling under the weather, we take him to the GP. But there have been times when he has gone down pretty badly so we take him straight to A&E.” – 4882

When asked directly about the reason for their choice of provider, a few respondents made very straightforward, pragmatic responses. 4984, for example, visited his local GP surgery:

“Because it’s local and convenient.” – 4984

For others, the process of decision-making was more clearly based on weighing up all the information they had about service options and availability, with multiple factors together feeding into a decision about the use of unscheduled care. 4217’s description of the decision-making process she went through before going to A&E with chest pains (leading to hospital admission and surgery) provides a case study. The story started with a consultation at her GP surgery about suspected angina, where she was advised what to do if the pains recurred and continued:

“They said if it lasts any longer than fifteen minutes to go, don’t wait for an ambulance if you can, to get yourself to hospital.” - 4217

This situation arose while 4217 was out shopping:

“As it happened, it was on the weekend, and because I was in such a lot of pain and frightened I suppose, we didn’t know what was going on, we thought the best place to go was A&E. And on a weekend you wouldn’t get a doctor out or anything.” - 4217

Her husband took the decision to seek immediate healthcare:

“He got me back into the car and he just drove straight to hospital because he said if he’d asked me I would probably have said to take me home and it would pass.” - 4217

In her description of this one incident, 4217 articulates four different factors feeding into the decision to attend A&E:

- **advice previously received from her GP**
- **the influence of her husband** whose care for her over-rode her own stoicism, and who provided his practical support as a driver
- **fear and pain** which influenced her to seek a ‘higher order’ health care provider

- **beliefs about the appropriateness and availability of services at the time she needed them**, even though these were not necessarily entirely accurate.

While 4217 described how a number of factors accumulated to point her in the direction of A&E, other respondents were more explicit about how they weighed up the relative importance of factors which might have contradictory influences, and deciding to make trade-offs between possible pros and cons. Participant 4857, for example, spent some hours debating whether to go to A&E following a road traffic accident. Eventually deciding that “following the right procedure” might help any subsequent insurance claim, he attended A&E at what he thought would be a time of low demand, since:

“The reason I decided not to go there in the first place was because of the waiting times. You could be there for three or four hours. I thought because the injury wasn’t that bad, I couldn’t be bothered to hang-around up there. If it happened again I would do the same thing.” – 4857

7.4 A group of ‘satisfied customers’ –with some reservations

One of the most striking aspects of interview respondents’ descriptions of unscheduled healthcare was how positive the majority of them were about the experience. They used expressions such as:

“You’ve got a satisfied customer here.” - 4859

Many of the positive comments focussed on professionals, particularly GPs. This was indicated by 1384, who stated she trusted her doctor’s judgement “200% -*he is brilliant.*”

When people had reservations, they were generally about practical issues –waiting times, distance to travel, bureaucracy and regulations and so on – and directed at ‘the system’ rather than at any individual. Some comments about NHS Direct were positive:

“On this particular occasion, I think the government have actually managed to make it a better system” - 4984

However, a familiar complaint about NHS Direct did crop up regularly:

“The only downside is the actually repeating yourself numerous times, it drives you mad. You phone up saying ‘he’s got stomach pains’ and they ask ‘is he blue?’ etc. and he’s breathing fine. He’s just got stomach pains, know what I mean? ...When you’re a bit anxious the last thing you want is questions that are not relevant.” - 4899

Other frustrations were expressed in relation to rules, regulations and opening hours. 4399 was frustrated with the triage arrangements at the new 'super practice' where his GP worked:

"The doctor I was under originally was in the surgery when I went down on that Wednesday night but I couldn't see him. Because the system said I couldn't see him."
- 4339

However, on the whole, respondents expressed great loyalty to the NHS, even those who had very distressing personal experiences. Many rationalised bad aspects of their experiences, making allowances for the strains and constraints on the service. As one respondent put it:

"I love our National Health Service" - 2574

7.5 Summary of key points

Interviews with patients revealed how the process of accessing unscheduled health care is complex and requires decision-making at three stages: whether care is needed; when it is needed; what kind of care is needed.

Factors influence decision making at each of these stages and can overlap.

- Patients seek unscheduled care for reassurance or to endorse their own judgement
- Perceived need for healthcare is balanced against stoicism and reluctance to bother services
- Patients are anxious about correct and appropriate use of NHS services, especially A&E
- Fear of illness can delay or precipitate a call, especially at night
- Deciding when to seek help is logical to patients, although not always apparent so to an outsider
- Duration of symptoms, potential for quick deterioration and likelihood of speedier improvement if accessing unscheduled treatment, are factors in seeking help

- Interview respondents did not seem to have a complete picture of the range of unscheduled care services. The GP OOH service was rarely mentioned as an option. Even when aware of a service, they make assumptions about role, function, availability or appropriateness
- Patients' learning and past experience of healthcare encounters influences future decisions
- Patients are loyal about the NHS, even after distressing experiences. Any criticism is directed at the system, such as rules, regulations and opening times

8. Results – focus groups

8.1 Introduction

This chapter presents findings from the four focus groups, which were designed to gather data on awareness of different parts of the unscheduled health care system, and on attitudes and beliefs about the purpose and function of the various services which make up the system. As might be expected, discussion also ranged widely over participants' actual experiences.

Vignettes (see Table 20) describing four imaginary scenarios for which unscheduled care might be required were presented to the focus groups and participants were asked to describe what they thought would be an appropriate course of action in each case, with follow-on prompt questions designed to expand the discussion (shown in full in Appendix 8). Two experts (a GP and an A&E consultant) were asked for their opinion on what would be the appropriate course of action in each case: their responses are noted on Table 20, but were not shared with respondents during the focus groups. The vignettes were presented in the first part of the focus group, to ensure that respondents' discussion was not influenced by the names of any services being mentioned by the researchers.

The second part of the focus group consisted of a series of direct questions about respondents' awareness of, and belief about the appropriateness of, four services – GP Out of Hours, Accident and Emergency departments, NHS Direct, and Out of Hours Pharmacists. In the area where a Minor Injuries Unit existed, respondents were also asked about this.

As with the telephone interviews, we have identified themes which seemed to be consistently important across groups, but this should not be taken as implying consensus on all topics. The themes draw on discussion in both the first and second parts of the focus groups. In the write up which follows, quotations from members of focus groups are identified by focus group and an ID number for the participant. Quotations have been selected to highlight a majority view, except where noted.

<p>Scenario 1</p> <p>Amanda is the mother of two children, Jack aged four and Chris aged two. Jack has a very bad cold, is coughing and his nose is blocked. At about 11pm, she is aware that Jack is awake and sounds distressed. She goes into his bedroom and finds he has a high temperature (2 degrees above normal) and his cough has become wheezy. Her husband is working away that week.</p> <p>What should she do?</p>	<p>Scenario 2</p> <p>Gwyn Davies, 56, is sawing wood one Saturday morning, when the saw slips and he cuts his hand. The cut is not deep but is bleeding quite a lot. His wife is in the house. Both of the Davies' have driving licences, and they have a car. The Davies' live five miles from the nearest town with a doctor's surgery and 25 miles from the district hospital with an A&E department.</p> <p>What should he do?</p>
<p>Expert 1: In most cases, self-care. If the child has other/recurrent problems, contact GP. If child becomes floppy/croupy/widespread rash, phone 999.</p> <p>Expert 2: Ring GP OOH service for advice.</p>	<p>Expert 1: Self care. If wound won't stop bleeding, A&E. Contact GP or NHSD for advice on tetanus.</p> <p>Expert 2: Self care. If stitches required, contact GP.</p>
<p>Scenario 3</p> <p>Mrs Lloyd has a heart condition which is managed by medication. Although she is in her 70s, she generally leads a full and normal life. On a routine visit to the doctor, her medication is changed. The next day, a Thursday, she experiences bouts of nausea and goes to bed. By early evening she has been sick and feels weak. She is a widow with children living in London and the Midlands. Mrs Lloyd has a part-time carer who visits every morning and evening.</p> <p>What should she do?</p>	<p>Scenario 4</p> <p>John Jones, 41, of Cardiff, is shaving one Tuesday morning. Looking in the mirror, he notices that his left eye has developed a bright red patch on the white part. The eye is not painful or itchy. Mr Jones was not aware of having injured his eye.</p> <p>What should he do?</p>
<p>Expert 1: Self care. If she thinks that nausea results from medication change, contact GP.</p> <p>Expert 2: Self care. Stop taking medication. Wait until GP open, then contact for advice on medication.</p>	<p>Expert 1: Self care.</p> <p>Expert 2: Make appointment with GP.</p>

Table 20: Scenarios discussed in focus groups, with expert opinion on appropriate action

8.2 *Participants*

The four focus groups were selected to cover a wide range of experiences. Participants were not meant to be representative of wider groups, but simply to be a mix of people, with whom common themes and diversity could be explored.

The four groups were:

- Six mothers of young children, identified through ‘snowballing’. This group met in the home of one of the mothers, over a buffet lunch. Members were in their thirties and forties and lived in a rural area.
- Eight members of a community organisation in a ‘Communities First’ area, five of whom were female and three male. This group met in a community centre, with tea and cake. Members’ ages ranged from thirties to seventies, and they lived in a small town.
- Nine Muslim men, who all attended the same mosque. This group met in a meeting room at the University, over a buffet lunch. Members’ ages ranged from twenties to fifties. The men had come to the UK from abroad; many of them maintained close links with their home country and anticipated returning within a few years. They lived in an urban area.
- Seven older people who were members of a 50+ Forum. This group met in a meeting room at the University, with tea and cake. Three were women and four were men. Their ages ranged from sixties upwards, and they lived in an urban area.

Although each of the four groups had some common factors, there was also diversity within the groups, and some cross-cutting factors relevant to more one group. For example, many of the Muslim men were also parents of young children. The older people varied in terms of socio-economic status of the areas they lived in, household structure, and family support.

In the case of all groups, participants were not specifically selected to be people known to have recent use of unscheduled care, and the researchers did not know the extent of participants’ use of unscheduled health care before the focus groups took place. In each group, some members knew each other well, some slightly, and some met for the first time at the group.

8.3 *Key themes*

8.3.1 Awareness of services and knowledge of how to contact them

The table below summarises the level of awareness in each group of four key unscheduled care services. It also indicates the level of knowledge of group members in terms of how to access each service. Respondents provided vivid information based usually on personal experience to illustrate not just their awareness of what healthcare services were available but also their perception about the roles, functions, and appropriate usage of those services.

	NHS Direct	GP OOH	A&E	OOH Pharmacies
Young mothers	High awareness and high knowledge of how service works and how to contact	High awareness and high knowledge of how to contact and how it operates	High awareness and knowledge of the service	Aware of service but very little knowledge of how to access or how to find information on accessing
Communities First area	Low awareness and low knowledge of how to contact – had only been used by 1/8	High awareness of service and high knowledge of how to contact and how it operates	High awareness and knowledge, including details of the level of service available at two local hospitals	High awareness but little knowledge of how service provided and how to access
Muslim men	Mixed levels of awareness and knowledge of how to contact	Mixed levels of awareness and knowledge	High awareness and knowledge of service. However, may think of it just as 'the hospital' without fully understanding A&E function	Mixed level of awareness – some had not heard of service, some had high knowledge of how to access service
Older people	High levels of awareness and knowledge of how to contact, with all but one knowing the number	High awareness but only moderate knowledge of how to contact and role of the service	High awareness and knowledge of the service, including details of local provision	High awareness but low knowledge of how service delivered or how to access information on it

Table 21: Awareness and knowledge of selected unscheduled care services amongst focus group members

The service with universally highest awareness was A&E, with generally high levels of knowledge of the role of the service and how it was delivered. This knowledge was in

some cases derived from personal experience, and in others from the experience of friends or family members. The Communities First group in particular showed a very detailed understanding of the availability of local A&E services and services at a local Minor Injuries Unit (MIU), clearly spelling out the difference between the A&E services 15 miles away and the MIU three miles away, including opening times, types of services, how to contact at different times of the day and night. By contrast, the group of Muslim men had the least clear understanding of the role of A&E, which may in part be explained by the fact that hospitals are providers of primary care in the home countries of many group members.

Awareness and knowledge of how to contact NHS Direct and GP Out of Hours services was more mixed, with the Communities First group reporting particularly low awareness of NHS Direct. Awareness was highest among young parents, with many recounting their own experiences of the service. Muslim focus group participants recalled information they received on arrival into the UK that stated NHS Direct was the first point of contact. While some respondents had a clear understanding of NHS Direct as the point of entry into the unscheduled care system as a 'triage service' to other services, many were less clear. Confusion related to the service provided by NHS Direct, waiting times and the experience level of the staff. Many people described NHS Direct as only for 'out of hours' problems or as a second option for a course of action already chosen. This confusion appeared in turn to be reflected the way people reported using the service.

Although awareness and knowledge of the GP out-of-hours service was not particularly high in the Muslim men focus group, some other group members demonstrated an intricate knowledge of local out of hours healthcare services:

8: "You can go down. The out-of-hours doctor is there. He's there until ten o'clock at night and its there that they direct it to. You can go down there then to whatever doctor is on duty then. But you won't know which doctor is on duty until you get there."

6: "If you make the phone call a sister or a receptionist will speak to you and ask you your problems and then she gets an appointment for you or asks if you've got transport to come down."

8: "But they will come out. But you don't know what time they're going to come out because that GP out-of-hours doctor might be the other end of the county." -

Respondents 6 and 8, Communities First focus group

While members of all focus groups were aware, in principle, that pharmacy services were available out of hours, there was strikingly low awareness across all groups of how to actually access such services and consequently out of hours use was infrequent. Most respondents did not even know where to start to find information on them, though some had tried and failed to get information from NHS Direct. One respondent in the 50+ group suggested, without any apparent irony, that the best way to get information on out of hours pharmacies would be to ask a recovering drug addict.

Discussion of service availability ranged across more services than the four shown in the table, covering in particular use of 999 ambulances, ‘same day’ visits to the GP, and use of pharmacists within normal hours. Awareness among the Muslim men focus group of the 999 phone number was low, but other groups discussed how they identified the 999 ambulance service with very serious situations where medical intervention would be needed *en route* to hospital. In relation to ‘same day’ visits to the GP, respondents tended to show high levels of detailed knowledge of opening hours and practice rules. The pharmacist was spontaneously suggested as a source of help by some respondents, who praised the service for their accessibility and approachability:

“ I must admit, I ask more advice from my pharmacist than my doctor. The regular people I go to, they are generally pretty forthcoming with sensible advice that I can understand. The terror – not the terror, that’s too dramatic – of going to the doctor, you know, but the pharmacists are great.”

Respondent 7, 50+ Focus Group

8.3.2 Beliefs about appropriate use of services

The table below summarises the responses of focus group members to the four scenarios. These responses demonstrate that there was diversity of response within groups, and diversity of response between groups. Responses to a single scenario ranged from self-care to calling the air ambulance. In most cases, group members were more likely to seek professional help than were the experts who had commented on the scenarios, and were more inclined to go for a ‘higher order’ service. When responding to the scenarios, some respondents made a clear choice immediately, whereas others probed, asking supplementary questions (for example, ‘does the child have asthma?’) which served to emphasise the complexity of the decision-making process in real-life situations.

	Scenario 1 Sick child	Scenario 2 Cut hand	Scenario 3 Nausea	Scenario 4 Bloodshot eye
Young mothers	GP OOH service Self-care	A&E GP (if weekday)	GP OOH service 999 ambulance	GP NHS Direct Pharmacist
Communities First area	GP Self care Minor Injuries Unit 999	A&E 999	GP Pharmacist Advice from family	GP Optician Self-care Advice from friends
Muslim men	NHS Direct Self care Advice from family A&E GP OOH service	A&E Self care 999 ambulance Air ambulance	Carer 999 ambulance GP NHS Direct	GP Watch and wait GP OOH service
Older people	NHS Direct Advice from friend A&E Pharmacist Self-care	Local first aider Pharmacy 999 (if pumping blood)	999 ambulance Pharmacist GP	Optician Watch and wait Pharmacist A&E GP

Note: Responses listed in descending order of frequency within each box. 'GP' means a visit to the patient's usual GP by appointment.

Table 22: beliefs about appropriate use of services among focus group members responding to scenarios

There was much ambivalence in people's beliefs about appropriate use of services; they could advise two diverse actions for the same incident or hold apparently contradictory opinions about when to use a service. This was illustrated by the comments of a mother in the Young Mothers focus group:

"If you've got a child and you think there's something semi-serious which you really want to get checked out and it's in that funny time zone [out of hours], you'd just go down to your local A&E, wouldn't you? Even if it was twenty-five miles you'd just drive there just for the peace of mind." – Respondent 3, Young Parents focus group

Then, when asked later in the same focus group about what she saw as appropriate role for A&E:

“I think when you get there you’re actually expecting somebody to do something for you like put plaster on a broken arm or...something that you can’t do yourself. Or it’s more than just a phone call for a bit of advice. You’re actually wanting something to happen.” – Respondent 3, Young Parents focus group

For her, the decision was nuanced according to a range of factors and circumstances in each situation. So, time, individual health status, emotions, assumptions and expectations fed, in different degrees, into two different decisions to attend A&E. Deciding on unscheduled care was a logical process but followed a logic which related specifically to the context, according to focus group members. However, there is a tension between the ideal choice of service and the reality which is influenced by factors such as emotions, accessibility, knowledge and expectations.

Respondents were also very loyal to the NHS, anxious that services should be properly used and defending A&E against inappropriate users. One member of the 50+ group was concerned that his local A&E was:

“Clogged up by people involved in nefarious actions and social occasions, drunks and goodness knows what....There’s got to be a way of determining the severity and needs of the people, rather than the ones who just want it because they want rather than, because they couldn’t manage on their own.” Respondent 7, 50+ Focus Group.

Many respondents described a hierarchy of urgency when selecting a service and they felt responsible for not misusing services themselves, in some cases citing anecdotes about tragic results of ambulances being unavailable when needed.

8.3.3 The patient as expert

They emphasised the role of the patient or carer as expert in terms of being finely tuned to health status and symptoms, which enabled them to decide when intervention was needed.

“But then I think the more time you spend with your children the more likely you are to be laid-back about it because you know your child, you know if something.... You’ve got a better feel for if their behaviour is out of the norm.” – Respondent 2, Young Parents focus group

They also described how this expertise extended to matching health concerns to home remedies. Many respondents expressed pride in self-treatment through traditional remedies, knowledge passed down through generations or within a peer group. Treatment available at home might be ‘off the shelf’ medication from the chemist, but in the case of a number of members of the Muslim men focus group, they also included herbal remedies and antibiotics imported without prescription by friends or relatives.

“With time and experience, we become our self-doctors. Sometimes now, from last year, with my babies, for my kids, I don’t go to the doctors, we have built our foundations, we have become self-doctors, we are treating our kids, we try to stop with Calpol or something. If something is an emergency, we go back home.” – Respondent 7, Muslim Men focus group

Many respondents believed people had a responsibility to self-treat before seeking medical help in most situations. One respondent in the Muslim men focus group gave a very articulate explanation of his beliefs about self-care and the role of health services:

“I think there is a tendency for people to think that whatever happens, straight away then think they need to see a doctor. I think people should come away from that, I think they should assess how serious the situation really is. If they can address it themselves then so be it, it’s always better to try and sort the problem out yourself without having to go to the doctor. People need to appreciate that there’s massive pressure on the National Health Service and people should accept their part of the responsibility not to expect doctors to be available like 24 hours a day, seven days a week to answer any queries that they might have. So they need to make a decision and ask “Is this really serious? Do we need to speak to the doctor about this or can we do this on our own?” – Respondent 5, Muslim men focus group

In some cases, self-treatment was described more in terms of being a more trouble-free option compared to negotiating the system to seek help.

“To be honest, I do think people do a lot of self-medication because of the hassle of getting to a doctor and the hassle of getting an appointment is far greater than trying to medicate your self first.” - Respondent 1, Communities First focus group

On occasions, there could be conflict where patients’ diagnoses or requests for treatment were not immediately acknowledged by health professionals.

“When I call NHS Direct, they say ‘Is it serious?’ Well yes, I think it is serious.” - Respondent 2, Muslim focus group

People with long-term and chronic conditions, carers, and parents were three groups who had built up expertise over the time they were responsible for managing their own or other's health and could usually judge speed of deterioration. This knowledge was another ingredient in the complex reasoning process which respondents undertook when considering the need for healthcare. The threshold for 'emergencies' was determined by various issues and not always triggered by a specific health need. Respondents actively managed the process, as this mother explained:

"I think one of the issues is when one of the children isn't very well on a Friday afternoon. You have the debate of whether you should hold on or do you ring the surgery and take the kids down. Then you go down and their chest is rattling, they don't really need antibiotics but they give you a script and say if he gets any worse go and get it. That might be quite wasteful but then I just don't want to be in that scenario of having to down to [town] on a Sunday afternoon." – Respondent 2, Young Parents focus group

Self-diagnosis was not risk free, however. One Muslim focus group members explained that he bought a 'Home Doctor' book but no longer uses it after 'diagnosing' himself with every disease in it.

In the comments of many focus group members, it was possible to discern a certain sense of resentment at being advised to self-care. It seemed that once people had made the decision that professional intervention was needed, they felt 'fobbed off' with advice to treat with Calpol or Panadol. This situation was described repeatedly, particularly in relation to NHS Direct. One focus group member with a young grand-daughter described a sense of frustration with NHS Direct which she had picked up on at playground:

"It's easy to be judgemental but being sent away with 'it's OK, take Calpol,' and returning several times, and it's a waste of time. That is the perception of some of the parents." – Respondent 4, 50+ Focus Group

8.3.4 Practical factors in decision-making - the everyday and the unavoidable

Respondents talked at length about the practical and pragmatic issues involved in making choices about use of unscheduled care, both in terms of constraints on the patient and limitations on the service. Respondents described making trade-offs between their health needs and practical considerations.

Convenience and proximity were mentioned by a number of respondents in relation to choosing GP services and many chose to make an emergency or same-day appointment for healthcare. Individual circumstances meant that people did not respond to practical issues in the same way but found a solution which suited them at the time. This was illustrated in discussion of the scenario about the sick child:

“I wouldn’t want to have to leave the house because obviously if you’re on your own with two children it’s then a pain if you’ve got to go and see the out of hours doctor, because you’ve then got to wake up a sleeping child who was actually quite happy.”- Respondent 2, Young mothers focus group

“Well if she went to a GP drop in centre, or an out of hours drop in centre, then obviously she would have two children that she would have to get ready and take along. Whereas maybe she could ring NHS direct where they can talk her through other symptoms that the child might be displaying and actually all she may need is a bit of reassurance and to give the child some Calpol, keep him cool, or keep an eye on him and see how he is in the morning” – Respondent 2, 50+ focus group

The Young Mothers focus group, who were based in a rural area, described how the decision to call 999 would be influenced by what they knew of ambulance response times in rural areas. For a child with a more minor health need, the decision to seek face-to-face advice or call NHS Direct could depend on whether they were a five minute to 25 minute drive from the GP surgery.

YP4: “In terms of seeing a GP, it usually means you have to travel to [town].”

YP2: “From here it’s a forty mile round trip.”

YP3: “You only do it if you really have to.”

Respondents in Young Parents focus group

Transport issues were raised more widely than in the rural group. One member of the 50+ Focus Group expressed his frustration that the out of hours care system was largely based on the assumption that all patients had access to private transport. When he phoned NHS Direct with concerns about his wife:

“this lady answered the phone and ...said ‘Pop along in the car to the hospital’, I thought, ‘thank you very much’ and put the phone down. They naturally assume that everybody’s got a car, everyone lives in middle class world or middle England world,

cars to pick them up here there and everywhere and it's not the case." – Respondent 3, 50+ Focus Group

8.3.5 Frustration with 'the system'

An area of concern that emerged across the diverse focus groups was a sense of frustration with what were seen as bureaucratic aspects of the health care system: the rules, regulations and practice which control access to health care. Respondents struggled when the 'system' came into conflict with practical reasons related to the time of the need (i.e. time of day, day of week), family responsibilities such as employment commitments or the need for child care, access to a telephone, as well as the travel time from the healthcare service/assistance. As one respondent said:

"Life gets in the way of what you're supposed to do. If you're supposed to be at work at eight o'clock, you're at work at 8 o'clock, not you're –'Oh I'll be there at half past nine because I have to phone the doctors and wait in a queue'.....If the choice is you pay your bills or go to the doctor, you're going to go the doctor later on in the day.' – Respondent 2, Communities First focus group

Though there were positive reports of NHS Direct, there was also a recurrent theme of disappointment with the way in which the NHS Direct service is provided, particularly concerning the number of people a caller is referred to and how long the process takes.

"This passing of a person to another person and so on and so forth, till you get sometimes eventually... I eventually got a doctor to come out, but it was well over an hour. ...They may be all busy, fine, ok, that can't be helped, but that's the system (calling own GP) I would like to see. Not this ringing NHS Direct and being passed from pillar to post when things can get really nasty." –Respondent 5, 50+ focus group

"I find it annoying because there's so much red tape; so many things they've got to ask you. I find that after you've talked to them for fifteen to twenty minutes they might get a nurse to phone you back. Then the nurse will talk to you and then they'll say that a doctor needs to phone you back, whereas if you phoned your out-of-hours you only get the doctor phoning you back." –Respondent 1, Young Parents focus group

"You need to call [NHS Direct] but you need to be patient." – Male respondent, Muslim focus group

Specifically, a number of members from the Muslim focus group found it difficult to access unscheduled healthcare, despite following advice received. One respondent said that the mobile phone for the emergency dentist was switched off while some other member indicated that they were refused care until contact was made through NHS Direct. Members of this group were the most critical of all focus group members for the way they experienced the system hindering, as they perceived it, their access to health care.

"One time [my daughter] has asthma as well and she became wheezy so we drove down to emergency and at the front of the emergency they said, 'we're not going to let you in, call NHS Direct before you come....So I stayed in the car and called NHS Direct on the mobile phone and they said, 'where are you?'. I said, 'I'm just in front of the hospital, I'm in the car park actually'. And then after that, half an hour later I was allowed in. I stayed in the cold for half an hour in the car.' - Participant 2, Muslim men focus group

8.3.6 Emotion as an influence on use of unscheduled care

Emotion was a powerful factor within decision making. Fear, of the illness and its potential consequences was identified as a factor: sometimes for precipitating the call for unscheduled care; at other times for delaying people's decision to seek help or turning instead to a family member or friend. This fear ran alongside the fear of calling the wrong service. The responsibility of making a decision also generated emotion whether it was for yourself, especially if alone, or for someone else. Fear could be a driver encouraging people to contact health care:

"It's down to severity and how frightened you are- whether you would get in the car and do that or phone the ambulance." –Respondent 3, Young Parents focus group

7: "You're not allowed to be ill during the night."

3: "And of course everything's worse during the dark."

-Respondents 7 & 3, 50+ focus group

Focus group members talked about older people in stereotypical terms as a group who might be inhibited in their use of health care services, because they take pride in self-reliance and “worry about wasting people’s time” (Respondent 4, 50+ Focus Group).

Stoicism was balanced against the potential severity of a condition according to younger people who cited the behaviour of elderly relatives.

“The older people in my family wouldn’t call an ambulance. They’d just suffer. Unless they were feeling really poorly, if you happened to ring them then they would mention it.” – Respondent 5, Young Parents focus group

This fear of being thought a timewaster could be a source of potential embarrassment, but it would not necessarily stop people accessing services, as one older woman described:

“My feeling is my eyesight is very precious and I’d rather risk humiliation if I thought it genuinely required some attention.” Respondent 4, 50+ focus group

Respondents valued being cared for and praised the treatment they had received. At a time of heightened emotions, people emphasised their wish for high quality and personal care. Individuals claimed that face-to-face communications, especially by a familiar GP, was preferred and prized because it equated with real care and not ‘pseudo’ treatment. Subsequently, many respondents selected the GP out of preference for the relationship and knowledge of case history which, they indicated, led to higher quality care. Old fashion courtesy and respect characterised people’s attitudes to GPs. Indeed, some respondents chose to make emergency GP appointments because they perceived it as a ‘natural thing’ or as an impolite gesture not to consult their doctor. Older focus group members especially expressed regret for the changed patient-GP relationship which was believed to reduce care quality. Treatment which appeared to lack personal care, such as a doctor focused on a computer, was strongly criticised. Once again, NHS Direct came in for criticism as it was contrasted with respondents’ vision of a traditional GP service:

“...these other pseudo medical services are in place. To almost act, I sometimes think, as a placebo. It makes you feel better that they’re there. In my case, I never use them, thank goodness. Doctors and people, they’ve got all your records there. They should know what you are like and what’s wrong with you. Those are the people that I’ve got confidence in. Besides, my doctor is a good rugby man... [NHS Direct] is trying to give the impression that they’re able to give you the confidence that you would have if you were dealing with your GP or surgery.” – Respondent 7, 50+ focus group

"I'm not a lover of call centres and I class NHS Direct as a call centre...it's not local...I thought it was just me and my age group, but my children have said the same. There's loads and loads of money being put into the NHS but if you actually speak to anyone about their satisfaction with it, they'd like to step back to as it was years ago where you went and you had your own GP. They knew when your children were born. They saw your children growing up and there was sort of continuity whereas now you don't have that." - Respondent 4, Communities First focus group

8.4 *Summary of key points*

Focus group respondents described a complex decision making process which was specific to their local geographic and personal context. Thus, practical issues, expectations, experience and knowledge informed the response to a healthcare need giving the decision making process an apparent logic.

Local variations did not appear to be a concern to people when they understood their local system and personal accounts illustrated a good enough understanding to satisfactorily resolve the health needs that focus group members had experienced.

Awareness of unscheduled care services was varied and consistently highest for A&E services among all four groups. They had a detailed understanding of availability of local services. However, few people knew how OOH pharmacy services were delivered or how to access these.

There was little consistency about what respondents believed was an appropriate service to provide care for many conditions. Inconsistency was also influenced by context - when, where and why healthcare was needed.

Respondents had strong views about inappropriate use of 'emergency' services.

They believed people should take responsibility for their own care and valued their own expertise. Patients with long term conditions, carers and parents were proficient in actively managed the process of giving and seeking care.

Emotion played a key part in decision making: fear of inappropriate use of services was balanced against fear of the illness and potential outcome.

8. Conclusions

8.1 Key findings from the study

Use of unscheduled care services

- Awareness of NHS Direct, GP OOH and A&E is generally high, but knowledge of how to actually make contact with services tends to be lower, particularly for NHS Direct and Pharmacy OOH services.
- Over forty per cent of survey respondents had used unscheduled care services in the past three months. Over half of these had done so on more than one occasion.
- Almost half of respondents who reported using unscheduled care also reported that the person needing the care had a chronic condition. People with chronic conditions were more likely to be high users of unscheduled care.
- A quarter of contacts were 'out of hours': between 6.30pm and 8am, at the weekend or on a bank holiday. 'Out of hours' contacts tended to be made within 24 hours of the problem first developing.
- Half of respondents made first contact with their GP during open access or emergency surgery. GP OOH was next most common (7.2%) followed closely by NHS Direct and A&E. Most people were in touch with two or more services about the same incident.

Factors influencing the choice of unscheduled care service

- On the whole, people are confident in their belief that their first choice of unscheduled care provider for their first contact is the most appropriate one.
- Deciding when and what care is needed is a complex process specific to local and personal factors including: practical issues; expectations; experience; knowledge.
- Deciding when to seek help is logical to patients but not always apparently so an outsider.
- Patients may seek unscheduled care for reassurance or to endorse their own judgement. However, if they are hoping for an intervention, they may be unhappy with being advised to self-care.
- Duration of symptoms, potential for quick deterioration and likelihood of speedier improvement if accessing unscheduled treatment are factors in a decision.

- Fear of making inappropriate use of services is balanced against fear of the illness and potential outcome.
- People are anxious to make correct and appropriate use of NHS services, especially A&E.

8.2 Study limitations

This study achieved a response rate of 41.7%. Although this is a high response rate for a general population survey, it is still possible that other experiences and views relating to accessing unscheduled care have not been captured by this survey. There was a lower response rate from residents of areas listed as the most deprived within Wales, so the experience of unscheduled care users from these areas may be under-represented in the data. However, the comparison of survey-derived data with actual usage data (see Section 6) suggest that we can have reasonable confidence in the findings on usage.

Interviews were undertaken with 40 questionnaire respondents. While the sample was selected from a larger number who consented, it is possible that this was a group of 'satisfied customers' and their willingness to participate stemmed from a positive care experience.

The four focus groups included 30 members of the public from four distinct but sometimes overlapping groups. They revealed a wide diversity of views; it is possible that further focus groups would present further diversity of opinions, experience and attitudes. Nevertheless, the group discussions did access opinions from people of varied ages, different economic experience, cultural background and geographic residence, and common themes were found across all four groups.

8.3 Discussion points

- 1. The 'boundaries' of unscheduled care are blurred - both in terms of the range of services included and in terms of how the line is drawn between unscheduled and scheduled.**
- 2. GPs are much the biggest provider of unscheduled care.**

Unscheduled visits to the patients' own GP practice are a very important part of the picture. However, availability of 'same day' consultations varies greatly between practices; in turn, this may have an impact on demand for other unscheduled health care services.

3. People follow a personal logic when deciding to access unscheduled care and feel they are acting responsibly in perceived constrained circumstances.

Information to people about using unscheduled care should avoid any suggestion that people act wrongly or irresponsibly and advice should appear a realistic option for them, if public education seeks to change or reinforce people's behaviour. People's sense of moral responsibility can, with care, work to the advantage of those seeking to improve delivery of unscheduled care.

4. People are hugely loyal to the NHS and extend praise to the doctors and nurses who give care, in the most distressing circumstances and even when unsuccessful: in the main, criticism is directed at the system, not at individuals.

This loyalty is a great resource for anyone managing health care services. But changes which are perceived to impact negatively on staff, reduce contact with health care professionals and threaten the quality of care may be difficult for policy makers and managers to push through.

5. While most people are not familiar with all unscheduled care options, they tend to know how to access the type of service they want to receive. Local variations, and differently named services (such as Minor Injuries Unit, Casualty, Emergency Department, Accident Centre) don't appear to be an issue for patients; they seem to know how to access the service they choose.

This suggests the quality of care and experience of accessing it is more relevant to individuals than what a service is called. Patients' priorities should be considered when prioritising actions in any future strategy.

6. Experience, based on past use of healthcare services, or care experiences of family members, seems to have a greater influence on choice of services than hearsay or stories in the media.

Any media campaigns aimed at behaviour change may have limited scope for influence.

7. People can access unscheduled care services for most health needs which are not life threatening by many different routes, and by contacting many different providers.

From the patient's point of view, there does not seem to be any single perfect route to care, in most cases. It could mean that more appropriate treatment may be accessed more quickly if one choice rather than another were made. But it also means that people often have more than one route to accessing care and are likely to obtain the help they need somehow. It is not necessarily appropriate to have a policy aim of trying to promote one ideal treatment option for each health care need.

8. People with chronic conditions are significantly greater users of unscheduled care services than the general population.

Management of chronic conditions is a priority for the Welsh Assembly Government and Local Health Boards are focused on care systems and interventions to reduce occurrence and improve care. There should be good and ongoing communication between policymakers and service managers responsible for unscheduled care services and those involved with chronic conditions programmes.

9. Residents of areas experiencing the highest levels of deprivation in Wales are also more likely to use unscheduled care services.

Links between those responsible for unscheduled care services and statutory and community based schemes in these areas (for example, Communities First, Surestart) should also be explored.

10. Pharmacists have a significant role in unscheduled care. However, people's awareness and use of out of hours pharmacy services are low and information about accessing the service out of hours is difficult to obtain.

There is scope for increasing the role of the community pharmacist by providing a regular service with clear information about its role and how to access it.

11. Pragmatic factors are a significant influence on when people choose to access unscheduled care and which service they attend.

This fact must be taken into account when considering future service provision since little can be done to change personal and practical issues such as: not having a car or cash for a taxi, or caring by oneself for several young children.

12. Self care has an ambiguous status amongst study participants – people are willing to choose to self care, and indeed believe that is a responsible course of action, but they may not be happy to be advised to do it by healthcare professionals when they have sought help.

Care should be taken not to alienate patients or discourage them from seeking help when assistance is really needed. Service providers and policy makers should be sensitive to people's sense of pride about self-care.

13. People tend to err on the side of caution and risk avoidance when contacting unscheduled services.

This presents a tension for healthcare professionals and managers. Avoiding risk is embedded in service provision through, for example, preventative care and providing treatment at an early stage to avoid deterioration. But it can also increase the likelihood that people seek healthcare, including out of hours if they perceive that advice or treatment will minimise their contact with the NHS in the longer term.

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Appendix 1 - project press coverage

10 **Western Mail** 

Thursday, 29 November 2007

Researchers to question 4,000 over emergency care

A major survey will be carried out this week into how people are using emergency health services in Wales.

A team of university-based researchers will question 4,000 people in an attempt to help the Welsh Assembly Government plan emergency care.

Dr Alison Porter, an All Wales Alliance for Research and Development (Award) research officer, based at Swansea

University's School of Medicine, said, "Our research will examine the factors that influence how and why patients and the public across Wales contact different services for urgent and unscheduled care. The findings will help the NHS to improve access to health services, especially when people need help in an emergency."

The findings will be presented to the Assembly Government next year.

Appendix 2 - questionnaire



CONFIDENTIAL



Survey about using health services in Wales

This survey is being carried out to help improve NHS services in Wales. It asks you about recent health problems.

The information you provide will be very valuable in helping to plan the future health services, even if you feel that the survey doesn't apply to you.

Completing the survey will probably take about 15 minutes. All responses will be confidential and will only be seen by the research team.

An envelope has been provided for your reply. No stamp is required.

Please enter today's date/...../.....(e.g. 12/9/07)

1. There are many different services providing health care in an emergency or outside normal hours. Please put ticks in the boxes below to tell us whether you have heard of these, and whether you would know how to get in touch with them if you needed them.

	Have heard of		Would know how to contact	
	Yes	No	Yes	No
NHS Direct	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GP out of hours service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospital A&E department	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Out of hours pharmacy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Minor injuries unit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. In the past 3 months, have you sought treatment or advice for any health problem, however minor, either for yourself or on behalf of somebody else?

Include any problems for which you consulted a doctor, telephone helpline, dentist, nurse, chemist, phoned for an ambulance, visited hospital, or consulted anyone else.

Yes If yes, please go to question 3

No If no, please go to question 14

3. We are particularly interested in the times when you contacted someone for health treatment or advice without arranging it at least a day beforehand. So we are not interested in times when you had an appointment to see someone; only in the times when you wanted to see or talk to someone straight away.

How many times during the last three months have you sought treatment or advice for any health problem, for yourself or on behalf of someone else, without arranging it at least a day beforehand?

- None *If you ticked 'none', please go to question 14.*
- 1
- 2
- 3-5
- 6-10
- More than ten

If you ticked '1' or more, please think about **just the most recent occasion when contact 'wasn't arranged more than a day before'**, and answer Questions 4 to 13

4. What sort of problem was it for which you needed help or advice?

For example, sore throat, accident, back pain etc.

.....

5. When did you seek treatment or advice:

(a) Was it A weekday (Mon to Fri) or Weekend (Sat or Sun)

(b) Was it a bank holiday? Yes No

(c) What time was it? Between 8am and 6.30pm

Between 6.30pm and midnight

Between midnight and 8am

6. On this occasion, how long had there been a problem before you sought help? Please tell us how long it was from the time you first became aware of symptoms, or (if it's a long term problem) things seemed to get worse than usual.

.....

7. Please tell us some more about the person you were seeking help for.

(a) I was seeking help for:

Myself

My child

Another family member or friend who lives with me

Another family member or friend who lives in a different home from me

(b) The age of the person I was seeking help for is:

- 17 or under
- 18-49
- 50-64
- 65-74
- 75+

8. Does the person you were seeking help for have a chronic medical condition (e.g. diabetes, asthma, arthritis, heart condition)?

Yes No

9. Thinking just about this particular occasion, please tick below to show all the people or services from who you sought help or advice.

Please tick all those which apply to the problem you described in answer to question 4. Include all the people and services which you contacted, even if you did not actually get any help from them in the end.

- A chemist (to collect a prescription)
- A chemist (for treatment or advice)
- A dentist
- A family doctor (GP) from my usual practice
- Someone else at my usual practice, but not a doctor
- NHS Direct
- Another telephone helpline (not NHS Direct)
- An Out of Hours doctor service
- A complementary or alternative therapist
- A minor injury unit
- A hospital Accident and Emergency department
- A 999 ambulance
- A hospital clinic or day ward
- Admission to hospital for one or more nights
- A physiotherapist
- Family or friends
- A social worker
- A community psychiatric nurse
- Other mental health services
- Someone else (please say who).....

Now please put a star beside the one that you contacted first.

10. Thinking about the person or service that you contacted first, please can you tell us why you chose to contact that service.

For each of the possible reasons below, please circle a number to show whether you thought that was a very important reason for you choosing the service, whether it was quite important, or whether it was not something that was important/not something you thought about.

	Very important	Quite important	Not important/ not considered
It was the nearest to me	1	2	3
First source of help which came to mind	1	2	3
I thought it was the most appropriate	1	2	3
I'd used them before	1	2	3
Only service I knew would be open	1	2	3
I know and trust this person	1	2	3
Someone said I should use it	1	2	3
I didn't know who else to contact/where else to go	1	2	3
I thought that this service would have the shortest waiting time	1	2	3
Other (please write in)	1	2	3

11. After you contacted the service, please can you describe what happened?

For example, the problem was solved within 30 minutes; I was advised to wait until morning to see my GP etc.

.....

12. If the same situation were to arise again (same condition, same time of day or night), would you choose the same service again as the first one to contact?

- Yes
- No
- Don't know

If you answered 'no', which different service do you think you would choose first on a future occasion?

.....
 Why would you choose to use a different service?

.....

13. For the following questions, please circle the number that best corresponds to your views about the medical problem for which you sought help. We are interested in how you felt at the time when you decided you needed to get some help or advice.

<p>How much did the problem affect your life (or the life of the person you sought help for)?</p> <p>0 1 2 3 4 5 6 7 8 9 10</p> <p>No effect at all Severely affects my/their life</p>
<p>How long did you think the problem would continue?</p> <p>0 1 2 3 4 5 6 7 8 9 10</p> <p>A very short time Forever</p>
<p>How much control did you think that you/the person had over the problem?</p> <p>0 1 2 3 4 5 6 7 8 9 10</p> <p>Absolutely no control Extreme amount of control</p>
<p>How much did you think that treatment could help the problem?</p> <p>0 1 2 3 4 5 6 7 8 9 10</p> <p>Not at all Extremely helpful</p>
<p>How much did you/the person experience symptoms from the problem?</p> <p>0 1 2 3 4 5 6 7 8 9 10</p> <p>No symptoms at all Many severe symptoms</p>
<p>How concerned were you about the problem?</p> <p>0 1 2 3 4 5 6 7 8 9 10</p> <p>Not at all concerned Extremely concerned</p>
<p>How well did you feel you understood the problem?</p> <p>0 1 2 3 4 5 6 7 8 9 10</p> <p>Didn't understand at all Understood very clearly</p>
<p>How much did the problem affect you emotionally? (e.g. did it make you angry, scared, upset or depressed?)</p> <p>0 1 2 3 4 5 6 7 8 9 10</p> <p>Not at all affected emotionally Extremely affected emotionally</p>

Now, please can you tell us a bit about yourself:

14. At home, do you have use of a car?

Yes No

15. At home, do you have the use of a telephone (landline)?

Yes No

16. Do you have the use of a mobile phone?

Yes No

17. Are you registered with a GP?

Yes No Don't know

18. Apart from you, how many people live in your household? Include everyone who shares a kitchen with you, and put the number in the box.

Adults

Children aged 17 or under

19. What age group do you belong to?

18-49 50-64 65-74 75+

20. Are you

Male Female

We would like to invite some people who completed this survey to take part in follow-up interviews on the telephone, to talk more about accessing emergency and unscheduled health care. If you would be willing to take part in a follow-up interview (about half an hour), please give us your details below. Your contact details will only be used by the research team for this project.

Name.....

Address.....

Phone number.....

You do not have to give your name and address if you are not interested in taking part in a follow-up interview.

If you have any other comments, please write them below

Thank you very much for your help

When you have completed the questionnaire, please use the envelope provided, which does not need a stamp, and return it to:

School of Medicine, Swansea University, FREEPOST SWC4951, Swansea SA2 8PP

Appendix 3 - covering letter for first mailout of questionnaire

School of Medicine

Swansea University

Swansea SA2 8PP

24th November 2007

Dear

Survey about using health services in Wales

I am writing to ask for your help with a survey about how health services are used in Wales. Please would you complete and return the enclosed survey form, which should take about 15 minutes. We hope that the findings of this survey will help the NHS to improve access to health services, especially when people need help in an emergency.

We selected your name at random from the electoral roll. You are one of 4000 people across Wales who are being invited to take part in the survey. We hope that some of the people will also take part in telephone interviews afterwards.

We hope you will decide to complete and return the survey form, and we have supplied a Freepost envelope for you to send it back. You can complete the form in English or in Welsh.

The survey is being carried out by the AWARD team at Swansea University and is funded by the Welsh Assembly Government. All the information you give us for the survey will be kept confidential to the research team. No-one else will know that you have taken part in the survey, or what you have said on the form.

If there is anything you would like to ask about the survey, please contact me on 01792 513422 or email me on a.m.porter@swansea.ac.uk.

Thank you very much for your help. We look forward to receiving your completed survey form, if you decide to take part.

Yours sincerely



Dr Alison Porter

Appendix 4 - covering letter for reminder mailout of questionnaire

School of Medicine

Swansea University

Swansea SA2 8PP

11th January 2008

Dear

Survey about using health services in Wales

I recently wrote to you to ask for your help with a survey about how health services are used in Wales. I am now getting in touch with everyone who I haven't yet heard from yet, to encourage you to complete and return the form. Please do take a few minutes to look at the survey. We hope that the information gathered will help to improve the way in which emergency health care is provided, and it is important that we get as many views as possible from the people of Wales.

Just to remind you, the survey is being carried out by the AWARD team at Swansea University and is funded by the Welsh Assembly Government. All the information you give us for the survey will be kept confidential to the research team. No-one else will know that you have taken part in the survey, or what you have said on the form.

If there is anything you would like to ask about the survey, please contact me on 01792 513422 or email me on a.m.porter@swansea.ac.uk.

Thank you very much for your help. We hope you decide to take part and we look forward to receiving your completed survey form.

If you have sent back the form within the last few days, thank you and please accept my apologies for contacting you again.

Yours sincerely



Dr Alison Porter

Appendix 5 - participant information sheet for telephone interviews

Understanding how the public chooses to use unscheduled care services

March 2008

Participant information sheet

This information sheet explains:

- why the study is being conducted
- the nature of your contribution
- the benefits/consequences of your participation.

If there is anything which is not clear, please ask and we will be happy to discuss it with you.

It is entirely your choice as to whether or not you contribute to the study by taking part in an interview.

Background

Unscheduled health care means any contact people might have with a health care professional which isn't arranged in advance. So, for example, it might be phoning NHS Direct, having a visit from the Out of Hours doctor, or going to A and E. Visits to the GP when you have an appointment, and treatment which you're booked in for in hospital don't count as unscheduled health care.

Why is this study being undertaken?

It's important that people have access to the right health care at the right time. If people aren't finding their way to the right form of health care when they need it, it's possible that they could be putting their health at risk. Also, it's important that services which are aimed at dealing with serious problems aren't kept busy with minor problems, just because people don't know where else to go.

This study aims to find out more about how people make choices about which type of unscheduled health care to use. It should help the Welsh Assembly Government to develop their policy on providing unscheduled health care.

The study has a number of different parts, including a questionnaire survey, telephone interviews and focus groups.

Who is conducting the research?

The research is being undertaken by a team from the School of Medicine, Swansea University. It is funded by the Welsh Assembly Government.

Why have I been asked to take part in this interview?

Over a thousand people from across Wales completed our questionnaire asking about their experience of unscheduled health care. We have selected 40 of those people at random to take part in a more in-depth telephone interview, to help us to understand more about the decisions people make about unscheduled care.

What we are asking you to do?

To take part in telephone interview about unscheduled health care services, with a researcher from Swansea University. The interview will be recorded in order to assist with the analysis. Afterwards, we will make a transcript of the recording, but it will only be read by people in the research team. No names, or any identifying details of individuals, will be used in the transcripts of the interviews or in the final report.

Do I have to take part?

No, it is your choice whether or not you take part. If you decide to take part you may withdraw at any time without the need to give an explanation.

Who will see the information and results about this study?

No-one other than the researchers will see/hear the unprocessed information gathered during the interview. There will be a report and journal publications following from this study but they will not identify any individual contributor.

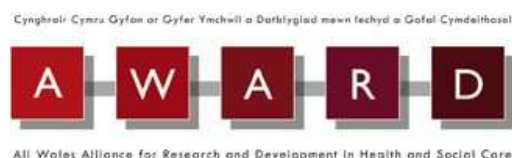
The data collected during the interviews will be securely stored and analysed on computers based at the Swansea University. Your name will not be used in the study or disclosed by the researcher/research team. The analysis will not be presented in ways which allow any individual to be recognised.

Who do I contact if I would like more information about the study?

Alison Porter, Research Officer, School of Medicine, Swansea University SA2 8PP

01792 513422

a.m.porter@swansea.ac.uk



Appendix 6 - interview schedule for telephone interviews

Understanding how the Public Chooses to Use Unscheduled Care Services

Telephone interview schedule.

Telephone interviews will take place with people who have completed a questionnaire they received in the post. The interviewer will have read the respondent's questionnaire, so can tailor questions to the information already received.

I can see from your questionnaire that X happened to you (describe the incident reported in the questionnaire).

Question 1

a) The first service you contacted was X. In your questionnaire, you said the most important reason for going to this service was (answer given).

Can you tell me more about that reason

Can you tell me more about the other reasons why you chose this service first (prompt from answers given)

b) Did you talk through what to do with anyone else?

Prompts: family
friends
neighbours
anyone else

Question 2 (asked only if the respondent contacted more than one service before the problem was resolved.)

a) You were in touch with several services about your problem. Can you tell me more about what happened when you tried to get help?

Respondent is encouraged to talk through their story of seeking help

b) How did you feel when you were referred to another service or had to go elsewhere?

Prompts: surprised
annoyed
upset
reassured
anything else

Question 3

a) Can you tell me a bit more about what happened before you got in touch with [first service they made contact with]. How long had you been feeling bad/since you noticed there was something wrong?

b) What made you decide at that time that you needed help?

Prompts: pain got worse
Started to feel scared
I knew the surgery was about to open

Question 4

When you made contact with [first service] were you clear in your own mind about what was wrong?

Question 5a (asked if the respondent said they would follow the same action again in the future)

On your questionnaire, you said you would contact the same service again for help if the same thing happened again.

Why would you choose to use (X service) again?

Prompts: nice people
Familiar people
Sorted out the problem quickly
Gave me reassurance/stopped me worrying

Question 5b (asked if the respondent said they would contact a different service in the future)

On your questionnaire, you said you would contact a different service (give name) for help if the same thing happened again.

Why do you think contacting (X service) would be a better way to resolve a problem like this?

Prompts: What is good about X service?
What was wrong with the service you went to first?
Didn't solve problem
Didn't like the way they treated me
Didn't like the way they treated family/carers
Waited too long

Question 6

Some people have told us that their decision to use, or not to use, a particular service was influenced by the experience of family or friends.

a) Did you think about other people's experiences when you were seeking help?

b) Did anything else influence your decision?

Prompts: news
TV programmes
Films
Anything else

Question 7

What advice would you give to someone else needing help in the same situation as you were in?

Question 8

Overall, what did you think about your contact with the health service on this occasion? What were the good aspects? What were the bad aspects?

Appendix 7 - information sheet for participants in focus groups

Understanding how the public chooses to use unscheduled care services

February 2008

Participant information sheet

This information sheet explains:

- why the study is being conducted
- the nature of your contribution
- the benefits/consequences of your participation.

If there is anything which is not clear, please ask and we will be happy to discuss it with you.

It is entirely your choice as to whether or not you contribute to the study by taking part in a group discussion.

If you are willing to help, you will be asked to sign a consent form stating that you have voluntarily chosen to do so and will be given a copy to keep.

Background

Unscheduled health care means any contact people might have with a health care professional which isn't arranged in advance. So, for example, it might be phoning NHS Direct, having a visit from the Out of Hours doctor, or going to A and E. Visits to the GP when you have an appointment, and treatment which you're booked in for in hospital don't count as unscheduled health care.

Why is this study being undertaken?

It's important that people have access to the right health care at the right time. If people aren't finding their way to the right form of health care when they need it, it's possible that they could be putting their health at risk. Also, it's important that services which are aimed at dealing with serious problems aren't kept busy with minor problems, just because people don't know where else to go.

This study aims to find out more about how people make choices about which type of unscheduled health care to use. It should help the Welsh Assembly Government to develop their policy on providing unscheduled health care.

The study has a number of different parts, including a questionnaire survey, telephone interviews and focus groups.

Who is conducting the research?

The research is being undertaken by a team from the School of Medicine, Swansea University. It is funded by the Welsh Assembly Government.

PTO

Why have I been asked to take part in this focus group?

We are talking to people in four different focus groups across Wales. We are trying to get a mix of people of different ages and backgrounds and who live in different places. We are interested in the views of members of the public, whether or not you have experience of using unscheduled health care services.

What we are asking you to do?

To take part in a group discussion about unscheduled health care services, chaired by a researcher. The discussions will be recorded in order to assist with the analysis. Afterwards, we will make a transcript of the recording, but it will only be read by people in the research team. No names, or any identifying details of individuals, will be used in the transcripts of the group discussion or in the final report. Details which may identify the group (such as where the meeting took place) will not be used in the transcript or the final report.

It is important to note that those participating are asked to keep confidential the details of what was said, and the identity of the other people attending. This is necessary so that participants feel able to express their views openly knowing that what is said will not be passed on.

Do I have to take part?

No, it is your choice whether or not you take part. If you decide to take part you may withdraw at any time without the need to give an explanation.

Who will see the information and results about this study?

No-one other than the researchers will see/hear the unprocessed information gathered during the group discussions. There will be a report and journal publications following from this study but they will not identify any individual contributor.

The data collected at group interviews will be securely stored and analysed on computers based at the Swansea University. Your name will not be used in the study or disclosed by the researcher/research team. The analysis will not be presented in ways which allow any individual to be recognised.

Who do I contact if I would like more information about the study?

Alison Porter, Research Officer, School of Medicine, Swansea University SA2 8PP

01792 513422

a.m.porter@swansea.ac.uk



Appendix 8 - scenarios and topic guide for focus groups

Understanding how the Public Chooses to Use Unscheduled Care Services

1: Scenarios

The focus group is given a number of scenarios. For each scenario, the group is asked the following questions:

- In this situation, what do you think (name of person) should do? Why?
- If a circumstance changed (example given by researcher), would that make any difference to what they should do? Why?

Scenario 1

Amanda is the mother of two children, Jack aged four and Chris aged two. Jack has a very bad cold, is coughing and his nose is blocked. At about 11pm, she is aware that Jack is awake and sounds distressed. She goes into his bedroom and finds he has a high temperature (2 degrees above normal) and his cough has become wheezy. Her husband is working away that week.

What should she do?

Changed circumstances:

- Amanda's husband James is also at home.
- Instead of it being 11pm when Amanda finds Jack has a temperature, it is 11 am (Jack's been kept home from school)

Scenario 2

Gwyn Davies, 56, is sawing wood one Saturday morning, when the saw slips and he cuts his hand. The cut is not deep but is bleeding quite a lot. His wife is in the house. Both of the Davies' have driving licences, and they have a car. The Davies' live five miles from the nearest town with a doctor's surgery and 25 miles from the district hospital with an A&E department.

What should he do?

Changed circumstances:

- The Davies' car is in for repair.

Scenario 3

Mrs Lloyd has a heart condition which is managed by medication. Although she is in her 70s, she generally leads a full and normal life. On a routine visit to the doctor, her medication is changed. The next day, a Thursday, she experiences bouts of nausea and goes to bed. By early evening she has been sick and feels weak. She is a widow with children living in London and the Midlands. Mrs Lloyd has a part-time carer who visits every morning and evening.

What should she do?

Changed circumstances:

- Mrs Lloyd has no carer, but she has a panic alarm button which was arranged through Social Services.

Scenario 4

John Jones, 41, of Cardiff, is shaving one Tuesday morning. Looking in the mirror, he notices that his left eye has developed a bright red patch on the white part. The eye is not painful or itchy. Mr Jones was not aware of having injured his eye.

What should he do?

Changed circumstances:

- It is a Sunday morning

2: Questions about emergency/unscheduled care services

The focus group is shown five cards. On each card is the name of an emergency or unscheduled service as follows:

- NHS Direct
- GP out of hours service
- Hospital A&E department
- Out of hours pharmacy
- Minor injuries unit [*only if one exists in the study area*]

For each card, the group is asked the following questions:

a) Before you came here today, had you heard of this service (show card and count numbers who have and have not)

b) Can you tell me about this service?

What does it provide?

How do you access the service?

c) How do you know about this service?

Have you personal experience of this service?

Have you heard from someone else (if so, please explain who)?

