

Sense-making strategies and help-seeking behaviours associated with urgent care services: a mixed-methods study

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Disclaimer: This report contains transcripts of interviews conducted in the course of the research and contains language that may offend some readers.

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Scientific summary

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Scientific summary

Background

English NHS policy has focused on the ways in which urgent care service provision can reduce emergency department (ED) attendances and better support self-care. The proliferation of different services has created a complex urgent care landscape for people to navigate, and previous research largely predates this expansion in services offered.

Objectives

Our study aimed to identify sense-making strategies and help-seeking behaviours that explain the utilisation of urgent care services. We set the following objectives:

- to describe how patients, the public, service providers and commissioners define and make sense of the urgent care landscape
- to explain how sense-making influences help-seeking strategies and patients' choices in accessing and navigating available urgent (and emergency) care services
- to analyse the 'work' (activities and effort) for patients involved in understanding, navigating and choosing to utilise urgent care
- to explain urgent care utilisation and identify potentially modifiable factors in urgent care patient decision-making.

Methods

The study had a mixed-methods sequential design consisting of three integrated work packages (WPs). The first WP comprised a literature review and four citizens' panels with service users and health-care professionals. The second WP used serial qualitative interviews to examine the role of sense-making in patient help-seeking strategies for accessing and navigating available urgent (and emergency) care services and to identify and describe the 'work' involved for people navigating and using urgent care. In WP3 we integrated our analyses of these data to construct a conceptual model of urgent care help-seeking behaviour that explains urgent care utilisation and identifies potentially modifiable factors that affect urgent care patient decision-making.

A structured review of the published literature from 1990 was undertaken with the primary aim of generating meanings and definitions of urgent care from multiple perspectives. Documentary research methods were used to identify and compare policy and service provider literature conveying definitions of urgent and unscheduled care. The search terms incorporated patient decision-making, knowledge, beliefs, attitudes, expectations and experiences related to conceptualisations of urgent and emergency care, and we included urgent care (e.g. general practice out-of-hours, NHS Direct, walk-in centres, minor injuries units, NHS 111) and emergency care where the focus was about the use of EDs or ambulance services for 'non-urgent' or 'primary care' reasons. Key information about the content of the papers was summarised in tables, and included papers were critically appraised against the questions in the Critical Appraisal Skills Programme checklists. Relevant literature was synthesised using a narrative, theme-based approach.

Four citizens' panels were convened to deliberate on urgent and emergency care and to develop agreed definitions of urgent care. Our 'citizens' were drawn from (1) the Polish community, (2) a wider general population, (3) health professionals and (4) members of Clinical Commissioning Groups. We purposively

sampled to represent a range of different perspectives and to include public, provider and policy-maker perspectives. In total, 41 participants took part in the panels. The commissioner's panel consisted of three participants and the other panels had between 12 and 14 participants. Public panel members ranged in age from 18 years to ≥ 75 years. Panels entailed face-to-face deliberation over 4–6 hours in a single day. The research team prepared a set of activities to facilitate discussion. Two members of the research team attended each panel to facilitate the discussion. Data included contemporaneous notes and audio recordings, as well as written material generated in the panels. All notes and transcripts were digitised and anonymised.

Semistructured qualitative interviews were used to examine sense-making and how the participants accessed and navigated services, and to identify and describe the 'work' entailed in navigating and using urgent care. Three purposively selected groups of service users and public were chosen to reflect a diversity and range of experiences of urgent care need and service use. Participants were sampled from a geographical area served by a single NHS 111 provider, covering four counties (Oxfordshire, Berkshire, Hampshire and Buckinghamshire) that are diverse in their geographic and demographic characteristics. Two groups were chosen to reflect populations with a known high use of emergency care (people aged ≥ 75 years and those aged 18–26 years) and a third group, people from the East and Central European community, was chosen as a group that was growing in the local context and could be vulnerable because of a lack of familiarity with the NHS. A first interview examined attitudes and beliefs about urgent care and services, and a second interview was conducted between 6 and 12 months after this to examine interviewees' experiences of using urgent care services in the intervening months (if at all). The topic guide for the first interview was informed by the literature review and the citizens' panels analysis, and the second interview topic guide was informed by the analyses of interview 1.

Data analysis began alongside data collection. We undertook initial thematic analysis following the stages described by Braun and Clarke (Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol* 2006;**3**:77–101), familiarising ourselves with the data, generating initial codes and categories and then identifying themes. To facilitate analysis and discussion among the team, grids and matrices were used to chart and compare the data, and we used 'data clinics' to share and interpret data collectively, building narrative and interpretive summaries. We drew on the framework analysis approach looking across cases and exploring similarities and differences (paying attention to contradictory cases). These analyses were informed by conceptual ideas drawn from previous research and theorising. We synthesised the findings from the literature review, citizens' panels and qualitative interviews to develop a conceptual model.

Research findings

The literature review suggests that there is some consensus between policy and provider perspectives regarding the physiological factors that feature in conceptualisations of urgent care. However, the terms 'urgent' and 'emergency' are far from clear in the policy literature, lacking specificity or consistency in meaning and messages across documents and, as a result, people are confused about which services to use. Urgency is often defined in relational terms: in relation to emergency care. Service users' conceptualisations of different services are shaped by perceptions of availability, accessibility and acceptability.

Our exploration of sense-making about urgent and emergency care confirmed that the boundaries between urgent and emergency care are ill-defined and there is considerable confusion about the appropriate use of the many different services on offer. The general public, health-care professionals and service commissioners share this confusion. The term 'urgent' care is often used interchangeably with 'emergency' care. People found it difficult to articulate the differences between urgent and emergency care, but they had strong moral views on what deserves 'emergency' care and they made fewer moral judgements about the 'misuse' of urgent care services.

We constructed a typology that distinguishes three related, but distinct, types of work that takes place at both the individual level and at the social network level in relation to urgent care sense-making and help-seeking. *Illness work* involves interpretation and decision making about the meaning and the severity of symptoms, the management of physical symptoms and psychological states and the assessment and management of possible risks. Two key prompts to urgent care help-seeking are 'pain' and 'anxiety' and together these drive decisions about help-seeking. In addition, reassurance – 'making sure nothing is wrong' – was a reason for urgent care help-seeking. Illness work was often carried out across social networks and there were some differences between groups in relation to how they used weak and strong ties within these networks. Help-seeking was guided by *moral work*: the legitimisation and sanctioning work done by service users. Service users were keen to portray themselves as responsible users of services, and here, too, social networks played a key role in influencing decision-making. *Navigation work* concerned choosing and accessing of services and relied on prior knowledge and experience of what was available, accessible and acceptable. Convenience was a key reason why people chose the ED rather than other services.

From these empirical data, we developed a model of urgent care sense-making and help-seeking behaviour to help us understand urgent care service use. This emphasises that work informs the interaction between what we think and feel about illness and the need to seek care (sense-making) and action: the decisions we take and how we use urgent care (help-seeking). Deciding to act involves balancing different types of work, and while there may be strong motivation to be a 'legitimate' user of a particular service, this can be 'traded off' against what is most accessible or convenient at a particular time or in a specific context.

Conclusions

This understanding of the work entailed in urgent care help-seeking alerts us to factors that could potentially be modified to alter sense-making and help-seeking. A clearer acknowledgement of the importance of pain as a reason for seeking urgent (and emergency) care, and better advice about managing pain symptoms, could help service users understand when to seek help. Much of the policy surrounding urgent and emergency care is predicated on the notion that 'urgent' sits neatly between emergency and routine; however, service users in particular struggle to distinguish it from emergency or routine care in this way. Clarity in what different urgent care services 'are for' would help service users, but relational definitions of urgent care (that contrast it with emergency care) are less helpful. Service users legitimise their own use of particular services, and people's moral reasoning is unlikely to be modifiable. Different population groups have different experiences and knowledge and so may require different support to navigate access to services. That said, more standardisation of what services offer and of opening times could help all service users know what is available and when. Rather than focusing solely on individual sense-making, future policy and provision could attend to the social and temporal contexts that have an impact on help-seeking, such as why people find it more difficult to manage pain at night, and how different social networks and the ties within them shape service use.

Future research

Further co-design work could be undertaken with patients and the public to develop and test definitions of urgent care. Our proposed model requires further testing, notably to quantify relationships between sense-making and help-seeking and to identify and predict causal relationships. A whole-systems approach to considering integration across a wider network of services will also be key to explaining the complex relationships between demand, access and the provision of urgent health care.

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