

The role of first aid education to support people attending urgent care services

Research report for the British Red Cross

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Contents

| | |
|---|----|
| Foreword..... | 4 |
| Acknowledgements | 5 |
| Executive summary | 6 |
| Introduction | 7 |
| Aim of the study | 7 |
| Methods..... | 7 |
| Findings..... | 8 |
| Conclusions..... | 8 |
| Recommendations | 8 |
| 1. Policy context | 9 |
| 2. First aid education..... | 11 |
| 3. The study: aims, methods and limitations..... | 12 |
| 3.1 Study aims | 12 |
| 3.2 Study methods..... | 13 |
| 3.3 Study limitations | 14 |
| 4. Findings | 15 |
| 4.1 Document analysis | 15 |
| 4.2 Who uses urgent care services and why? | 18 |
| 4.3 First aid education to support people using urgent care services | 38 |
| 5. Conclusions | 46 |
| 6. Recommendations..... | 47 |
| 6.1 Explore the opportunities for first aid education | 47 |
| 6.2 Target first aid education to the needs of specific groups | 47 |
| 6.3 Help the public understand when and where to seek urgent health advice and care.. | 47 |
| 6.4 Promote self-care, resilience and prevention..... | 47 |
| 7. References | 48 |
| Appendix 1: Methodology | 50 |
| Document analysis..... | 50 |
| Survey of people using urgent care services..... | 54 |
| Interviews with people using urgent care services | 61 |
| Focus groups..... | 64 |
| Interviews with healthcare professionals..... | 66 |
| Appendix 2: Survey form | 69 |

List of Tables

| | |
|---|----|
| Table 1: Sources used in the document analysis | 51 |
| Table 2: Sources of data from survey study, by setting and category of analysis | 55 |
| Table 3: Sex of survey respondents | 58 |
| Table 4: Ethnicity of survey respondents | 59 |
| Table 5: Respondents reporting having a long-term condition | 61 |
| Table 6: Characteristics of participants completing telephone interviews | 64 |
| Table 7: Participants by job title and occupational setting | 67 |

List of Figures

| | |
|---|----|
| Figure 1: Examples of sources in each of the four domains | 15 |
| Figure 2: What problem brought you here today? | 19 |
| Figure 3: What made you seek help today? | 20 |
| Figure 4: What did you want to happen? | 21 |
| Figure 5: Did you seek advice before coming here today? | 22 |
| Figure 6: Age distribution of all survey respondents | 56 |
| Figure 7: Age category of adult patient respondents to survey | 58 |
| Figure 8: Topic guide for interviews with people using urgent care | 63 |
| Figure 9: Topic guide used for focus groups | 65 |
| Figure 10: Topic guide for interviews with healthcare professionals | 68 |

Foreword

In 2016 a review commissioned by the British Red Cross¹, confirmed that there was increased pressure on urgent and emergency services and that this pressure reflected more complex, system-wide issues within the wider health and social care system than simply increased public demand. Nevertheless the impact of these pressures affects those presenting at A&E; people who are experiencing a crisis for which they are seeking urgent care.

The Red Cross has a goal to ensure that “for those with an increased risk of experiencing a crisis ... our education offer will ensure all those reached are better equipped to understand, cope and take action.” (British Red Cross 2014, p4). As such we are keen to explore ways in which we can reduce the prevalence of crisis and/or increase the resilience of those who are experiencing it. To that end we commissioned the University of the West of England in conjunction with the University of Bristol to examine the potential role of first aid education to support people accessing urgent care services.

We are delighted to present the research report alongside recommendations for first aid education providers, public health partners and policy-makers.

The research identified seven key groups who were felt could benefit from specific aspects of first aid learning. For the most part, these groups are people the Red Cross already interacts with, be that through providing a service, such as supporting people discharged from hospital, or through our existing first aid education offer. However, there is also an opportunity to explore whether there is more that we can do to meet their needs. You can find more about how we’ve already taken on board the findings in our summary report at www.redcross.org.uk/urgentcare.

As a first aid provider, we are hugely encouraged that the research found that at their time of crisis, first aid could help support those who may attend A&E and, by supporting them, may also help take some of the strain off busy A&E departments.



Norman McKinley,
Executive Director of UK Operations,
British Red Cross

¹ Henwood, M (2016) A&E demands and opportunities for change: Literature review and analysis for the British Red Cross. Melanie Henwood Associates

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Contributions

The British Red Cross commissioned and funded this study but had no involvement in the design or undertaking of the research. The research team at the University of the West of England, Bristol, and the University of Bristol designed and conducted the research and were the authors of this research report. The Red Cross provided chapter 2 of this report (First aid education), and worked jointly with the authors to develop the recommendations for the research (chapter 6). In addition the Red Cross provided editorial support for the final report

Executive summary

Introduction

The pressures affecting the UK National Health Service (NHS), urgent and emergency healthcare services particularly, have been described prominently in recent media. The reasons behind these pressures are complex, not least because of the confusing array of urgent and emergency care services available. It is thought that the *way* people use healthcare, urgent and emergency care in particular, is changing, but it is unclear whether these changes contribute to the pressures on services.

The British Red Cross currently provides first aid education through a range of formats and resources, including face-to-face first aid courses as well as web-based content and mobile apps. The aim is to support people so they feel more confident and willing to give first aid in the event of an emergency (British Red Cross, 2015).

In December 2015, the Red Cross commissioned the University of the West of England, Bristol, and the University of Bristol to undertake a study to explore how, when and why people use urgent and emergency care services, and whether any groups could be supported in their decision to attend accident and emergency (A&E) departments through first aid education.

Aim of the study

The aim of the study was to explore the potential of developing a first aid education intervention for the people who are most likely to attend urgent care services. This required:

- an understanding of the reasons why people attend urgent care services
- exploration of views on whether a first aid intervention might support the people who are likely to use urgent care services
- insight into the routes taken by service users into urgent care, to identify potential first aid learners and how to reach them.

Methods

The study combined a range of qualitative and quantitative methods to address the research questions. We completed a document analysis of 61 publicly available documents and resources to understand the factors influencing the delivery of urgent care services and the decisions people make about using these services. We sought the views of people who use urgent care services, through three methods: a) survey of 176 people waiting for treatment in four urgent care settings; b) telephone interviews with 11 recent users of urgent care services; and c) two focus groups with potential users of urgent care services. We also interviewed 23 healthcare staff from different professional groups to gather their views on the types of people using urgent care services frequently and whether first aid education could support them.

Findings

The document analysis showed that advice on how and when the public should use urgent care services is inconsistent. Our findings suggested that factors relating to the organisation of services are just as likely to contribute to the pressures on urgent care services as the health-seeking behaviours of service users.

The survey of people using urgent care services showed that falls, pain and other types of accident were the most common reasons in the sample for attending, although the reasons varied by the type of user; for example, with children, the management of fever was another common reason for seeking help. The most frequent explanation for attending (34.1 per cent) was that they were 'worried and didn't know what to do'. Many (58.5 per cent) had sought advice before attending A&E, mostly from their general practitioner (GP) surgery (18.2 per cent) or from friends and relatives (11.9 per cent). Many adult patients (79 per cent) had not attended with the current problem previously. The interviews and focus groups highlighted the difficulty people have when deciding whether a health problem is severe enough to require urgent care. Knowing what options are available for advice and care and how to access them appeared to be equal challenges.

Some healthcare professionals working in A&E felt that first aid was a 'lost skill'. The interviews with healthcare professionals identified seven groups of patients who use urgent care services frequently and were thought to have the potential to benefit from first aid education interventions, whether directly or via carers:

- patients with long-term conditions, including mental illness
- children, particularly young children
- older people, especially those who are frail or have multiple health needs
- people who use substances
- people referred to A&E by their employer or a first-aider at work
- people receiving health or social care at home or in community settings
- the general public experiencing self-limiting infections and minor injuries.

Conclusions

First aid education has a role to play in supporting people using urgent care services, particularly around issues such as making judgements about when a condition is 'minor' or 'serious', and at what point a symptom indicates that urgent care is required. First aid education could support the public with greater knowledge and confidence to use over-the-counter medicines and provide self-care, and to successfully navigate the complex range of urgent care services available. For some audiences, the first aid education would need to be targeted to the specific requirements of the group.

Recommendations

Four areas of recommendation have emerged from the research:

1. Explore the opportunities for first aid education
2. Target first aid education to the needs of specific groups
3. Help the public understand when and where to seek urgent health advice and care.
4. Promote self-care, resilience and prevention

1. Policy context

There is a general consensus that urgent and emergency healthcare services across the United Kingdom have been put under increasing pressure over recent years. The reasons behind the growing pressure appear to be complex. While data indicate an overall trend towards increasing numbers of people attending accident and emergency departments (A&E) and other types of urgent care facility over the past few years, there has also been an increase (although less substantial) in the number of people being formally admitted to hospital (NHS England, 2016). Ambulance services have also experienced an incremental rise in the number of calls over the past decade (Department of Health, 2009). Data from primary care show that general practitioner (GP) services are also seeing significant year-on-year increases in and demand for consultations (RCGP, 2013). There are various potential interpretations of these trends. The national public health data do not support the idea that the 'population is getting sicker', which implies that the *way* people are using healthcare – urgent and emergency care in particular – is changing.

One of the challenges of interpreting the national data on A&E outcomes rests in determining what defines an 'unnecessary' or 'avoidable' attendance at a particular service. While it is true that a notable proportion of patients are discharged from A&E without needing treatment or with advice alone, this does not equate in a straightforward manner to those patients who do not need to be there in the first place (The Kings Fund, 2016a). Much media attention has been given to so-called 'inappropriate' attenders, or those choosing A&E because they cannot get an appointment with their GP. Some recent studies have suggested that – while access issues certainly do contribute – the extent to which GP access accounts for the pressures on A&E departments is relatively marginal and is not supported by patient survey data (RCGP, 2013; The Kings Fund, 2016a). It is also clear that a significant factor contributing to pressures in emergency care 'front door' services is the complexity surrounding the flow of patients through the hospital, particularly discharge back into the community, where there are also substantial pressures on social care services (The Kings Fund, 2016a).

Despite this, finding alternative ways of managing the demand for A&E services has been a priority for policy-makers and local health services alike. In recent years, the number of Type 3 Units (see Box 1 below) has increased substantially, with much more regard given to strategic positioning within communities. Current trials are seeking to determine whether it is helpful to co-locate Type 3 with Type 1 units. The use of advice services, such as NHS 111, community pharmacies and online support (e.g. NHS Choices) has also been encouraged (NHS England, 2013), although some evaluations suggest these may be accessed disproportionately by certain demographic groups. In addition, with continued financial pressures on community pharmacy services, the capacity to deliver to the maximum potential may be limited (PSNC, 2016).

Box 1: Types of urgent care services

Type 1 Unit: Major A&E unit, providing a 24-hour service led by a consultant, with full resuscitation facilities and on-site access to specialist care.

Type 2 Unit: Single speciality A&E unit, such as a dental, eye, etc. May not be available 24 hours.

Type 3 Unit: Urgent care centre, minor injuries unit, walk-in centre or similar service providing treatment for less serious injuries and illnesses. May not be available 24 hours.

The complexity of the current urgent and emergency care infrastructure has received political and public criticism, with research indicating that the array of services and their associated in-routes can be confusing for patients and carers, and difficult to navigate. Indeed, the Urgent and Emergency Care Review has itself noted that: "starting from scratch, nobody would design the current array of alternatives and their configuration" (NHS England, 2013, p.17). NHS England has undertaken a full review of the urgent and emergency care infrastructure and, on the back of the *NHS Five Year Forward View*, has commissioned a number of 'vanguard' sites around the country to trial novel approaches to delivering urgent and emergency care services (NHS England, 2014). In addition, many of England's NHS Sustainability and Transformation Plans include close collaboration with a wider range of community partners (including the voluntary sector) as part of a 'place-based planning' strategy for urgent and emergency care services (The Kings Fund, 2016b). However, these initiatives all rely on having a sound understanding of *how* and *why* people make decisions about how to access care, how people assess and define 'urgent' and 'emergency' situations, and what information people require to help them make the right decisions. Box 2 provides a definition of urgent and emergency care services, as used in this report.

Box 2: Definition of urgent and emergency care services

NHS England defines **emergency care** as that provided in an emergency department (also known as A&E or casualty), a hospital facility specialising in acute care for patients who present without prior appointment, either by their own means or by ambulance (NHS England, 2013).

Urgent care is defined as ambulatory care in a facility dedicated to the delivery of medical care outside of the hospital emergency department.

In this report, we use 'urgent care services' to include the full range of urgent and emergency care services that are available to people who need medical advice, diagnosis and/or treatment quickly and unexpectedly, including emergency departments, urgent care centres, minor injuries units and walk-in centres.

2. First aid education

The British Red Cross offers a variety of first aid training and resources, including high-quality face-to-face education and free online resources for students and teachers in primary and secondary education. It also puts life-saving tools into people's pockets via its free first aid mobile phone apps. The aim is to support people so they feel more confident and willing to give first aid in the event of an emergency (British Red Cross, 2015).

The Red Cross has developed an everyday first aid approach in line with current good educational practice. The training and resources are tailored according to the needs of the group and can include how to apply first aid in the following emergencies:

- bleeding heavily
- stroke
- heart attack
- broken bone
- head injury
- choking
- unresponsive and breathing
- unresponsive and not breathing
- unresponsive and not breathing when an automated external defibrillator is available
- seizures/epilepsy
- diabetic emergency
- asthma attack
- poisoning
- distress
- sprains and strains
- hypothermia
- meningitis
- allergies/anaphylaxis
- burns.

Face-to-face courses are also tailored to people in specific circumstances; for example, a course designed for parents may cover a range of childhood emergency situations, from choking and unresponsiveness, to fever and meningitis. Online and app-based learning, meanwhile, is self-navigated.

3. The study: aims, methods and limitations

3.1 Study aims

Within the context of increasingly limited public funds and rising health and social care needs in the population, preventative programmes that enhance wellbeing and resilience, and reduce the burden on vital health services, are becoming more worth investigating. The Red Cross is exploring the ways in which it supports people who are in crisis and is interested in looking at the potential of developing tailored first aid interventions for those at risk of attending urgent care services, and their families/carers.

In 2015, the Red Cross Research, Evaluation and Impact team commissioned a literature review to better understand the operational and policy contexts for any changes in A&E attendance in recent years. Following this, the team commissioned this primary research study to gain further insight into how the Red Cross might support people attending A&E.

The aim of the study was to explore the potential to develop a first aid education intervention for the people who are most likely to attend urgent care services (see research questions in Box 3). This required:

- an understanding of the reasons why people attend urgent care services
- exploration of views on whether first aid education might support people likely to use urgent care services
- insight into service users' routes into urgent care, to identify first aid learners and how to reach them.

Box 3: Research questions

1. Who attends urgent care services and why?

- a. Who is attending urgent care? What are their reasons for emergency attendance? What was the trigger for their decision to attend?
- b. Do some groups use urgent care services more frequently than others? What are the causes of their frequent attendance?
- c. Which ailments or injuries are perceived to be appropriate for first aid intervention without urgent care attendance?
- d. What can we say about any potential audiences for first aid education services?

2. How can first aid education reach the people who are considered most likely to attend urgent care services?

- a. What are the pathways into and out of urgent care services?
- b. Where are the best entry points to access the people most likely to attend urgent care services?

3.2 Study methods

The study combined qualitative and quantitative methods to gather the information required to answer the research questions. The study was based in Bristol in southwest England and involved four urgent care service providers. We obtained approvals from the West Midlands NHS Research Ethics Service and the Health Research Authority prior to starting the research.

3.2.1 Analysis of documents

To understand the factors influencing the delivery of urgent care services and people's decisions about using them, we studied a range of publicly available information using document analysis (Bowen, 2009). This included printed and electronic materials that might otherwise not be examined routinely; for example, patient literature, public documents, publicity material, internal health organisational policies and electronic/social media. Between January and October 2016, we identified 61 documents from four types of sources or 'domains'. We identified common themes, which we then explored across other documents. The four domains were:

- public messages about using urgent care
- clinical guidelines and policies for healthcare professionals delivering urgent care
- service delivery policies relating to the organisation of urgent care services
- social media/media.

3.2.2 Interviews with healthcare staff providing or referring patients to urgent care services

To understand the views of healthcare professionals about who is using urgent care services and why, and whether any of these users could benefit from first aid education, we interviewed healthcare staff working in urgent care settings (e.g. A&E and urgent care centres). We also interviewed healthcare staff who refer patients to urgent care services (e.g. GPs, community nurses and paramedics). In recognition of the pressures placed upon healthcare professionals during their working day and the consequent limitation on their ability to contribute to research, we used an interview method described as a 'conversation with a purpose' (Burgess, 1998). This involved a short interview around a focused set of questions to explore the role of the interviewee, their views about who is using urgent care frequently and why, and the potential role of first aid education. We interviewed 23 healthcare professionals and these conversations were audio-recorded, transcribed and analysed thematically.

3.2.3 Understanding the views of people using urgent care services

We used three different methods to help us understand the views of people using urgent care services: a) a survey of people sitting in urgent care waiting rooms; b) follow-up interviews with people who had completed the survey; and c) focus groups with people who had not visited urgent care services recently, but with past experience of attendance who may attend in the future.

Survey of people using urgent care services

We asked people who were using urgent care services at four different sites if they would complete a short paper questionnaire that explored their reasons for attending that day and their expectations of what might happen during their visit. This was a convenience sample of people who were approached after they had been seen by the triage nurse and while they were waiting for investigation or treatment, or before they went home. Each site was visited on three occasions at different times and on different days. A total of 176 patients, carers and parents of children under 16 years completed the survey (26.9 per cent of all

patients booked in by reception staff at urgent care centres during the time the researcher was in the department). Data from the survey were entered in a database and analysed descriptively.

Interviews with people using urgent care services

To better understand the decisions taken by people using urgent care services, we asked people completing the survey if they would consider taking part in a longer discussion regarding their visit. Patients who agreed were invited to take part in a telephone interview lasting up to 30 minutes. We used an interview guide to explore three areas: a) the context in which they used urgent care services; b) 'typical' health events that might result in attendance at an urgent care service; and c) information that might support their decisions on using urgent care services in the future. Interviews were audio-recorded, transcribed anonymously and analysed thematically using a coding framework. Of 176 patients completing the survey, 23 agreed to be contacted and 11 patients or carers subsequently took part in interviews.

Focus groups with people using urgent care services

To help identify the patient groups that could be supported by first aid education, we conducted two focus groups with members of the public who had not recently visited urgent care services but who may have attended in the past. This part of the study helped us to check the emerging findings to ensure they were valid to a wider group of potential service users. The focus groups were chosen to reflect the potential beneficiaries identified in the previous activities. We used established networks to identify groups who meet regularly and who know each other and are therefore more likely to be comfortable when expressing their views in front of the others. The focus groups were held in the setting where the group normally meet and were audio-recorded, transcribed and analysed thematically. Two focus groups were conducted, one with a group of young mothers and one with a group of older patients and carers.

3.3 Study limitations

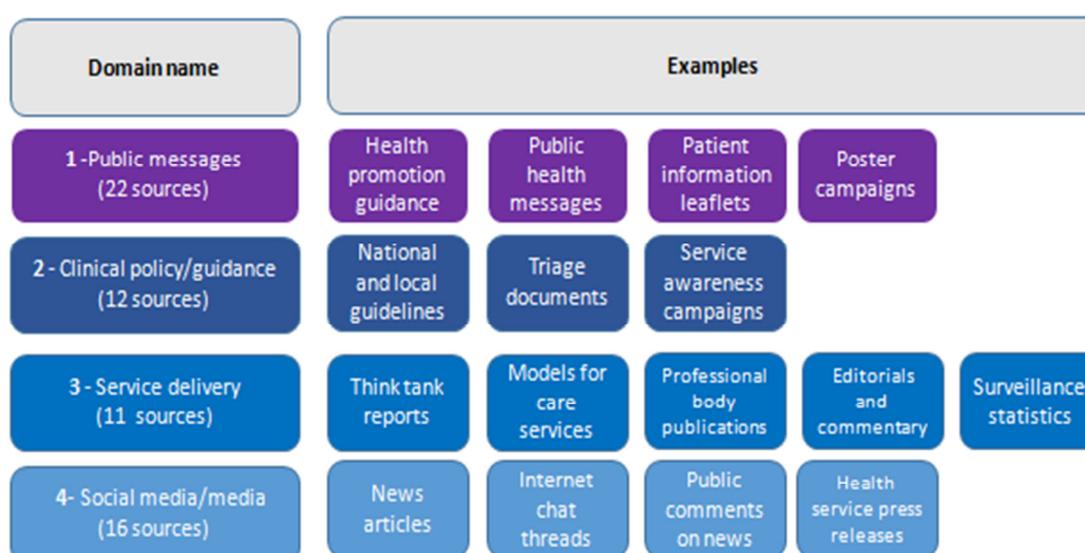
The study reflects the opinions of the participants recruited. It cannot be assumed to reflect the views of everyone who uses urgent care services or to be representative of all staff who provide urgent care services. The survey of patients in the waiting rooms reflects those who were willing and able to take part, and is likely to under-represent those waiting for care on trolleys or who were too unwell to participate, although these patients may have conditions less amenable to first aid education. The survey was not designed to be representative of the local, regional or national population who may use urgent care services.

4. Findings

4.1 Document analysis

We explored 61 documents, guidelines, policies, public messages and social media/media records using document analysis methods. The sources of information were categorised using a framework (Figure 1). A list of the sources used in this analysis is included in Table 1 in Appendix 1.

Figure 1: Examples of sources in each of the four domains



4.1.1 Public messages

Messages for the public emphasised people's responsibility to use urgent care services appropriately. The messages explained that A&E is for serious conditions, while other types of services (e.g. pharmacies, walk-in centres and minor injuries units) can provide advice and care for minor health problems (e.g. colds, sore throats and mild skin complaints). These messages implied that choosing the wrong place to seek care may result in attendance being judged inappropriate and could result in other patients not getting the best care by overstretching limited resources. The messages appealed directly to the public's social conscience, implying they could cause harm to others by misusing resources.

However, these messages assume that people are able to confidently and correctly assess their own medical needs and the severity of their condition. The use of language such as 'serious bleeding' or a 'minor head injury' may be unhelpful when these descriptions are not explained. Patients may feel confused if they are not told when bleeding should be considered minor or when it becomes serious. Different members of the public are likely to have different views about when a condition has reached the threshold of becoming serious. In addition, messages may not specify where and when to attend to receive care. This confusion may leave patients unsure about which service is appropriate for which conditions and how their own health need fits this continuum.

Some public messages focused on a specific and potentially life-threatening condition (such as meningitis) and stressed the importance of seeking help immediately if people think they may be affected. Many public messages ended with a phrase such as: if you are worried, or if symptoms persist, seek medical attention. This phrasing may perpetuate the view that A&E is the place to get reassurance when people are unsure if their condition needs to be seen quickly.

4.1.2 Clinical policies and guidance

The guidelines, protocols and policies for healthcare professionals we reviewed showed the delicate balancing act made every day by health staff. On one hand, staff are reminded of their responsibility to keep patients safe and that they should always assess and investigate if they believe there may be a serious condition underlying the patient's symptoms. Particularly for healthcare staff working in the community, where access to investigations is more limited, this may mean they have to refer to A&E to obtain the assessment or test results they need, especially if the patient has presented outside normal working hours.

On the other hand, healthcare staff are encouraged to avoid unnecessary hospital attendance and admission due to the current pressures on services and limited bed availability. This means that community-based staff (e.g. GPs, community nurses or paramedics) need to decide whether they feel comfortable managing the risk that there may be a serious underlying condition, or whether they believe the risk is too great to observe and investigate from a community setting and the patient should attend an urgent care service. Exercising such clinical judgement depends on their experience and personal views on managing patient risk.

4.1.3 Models of service delivery

We reviewed several documents describing how health services are organised or being developed, and how this may affect urgent care services. Health and care services, including urgent care, have undergone significant changes in recent years. The Health and Social Care Act (2012) led to a greater role for primary care in the commissioning of health services, including local urgent care. Changes in the delivery and funding of social care services have resulted in a reduced ability of community-based care services to support patients on discharge from hospital. Performance targets have been introduced in an attempt to reduce waiting times in A&E. New service models for urgent care (e.g. walk-in centres and minor injuries units) have also been introduced to provide capacity for patients with minor illnesses and injuries, and there is a drive towards the provision of a '24/7' NHS.

Over the same period, the population in England has grown. Improvements in healthcare mean that people are living longer, with many older age groups having complex, long-term conditions (The Kings Fund, 2016a). These groups are more likely to need urgent care services. In response to the introduction of new types of services, increasing numbers of people are using walk-in centres, minor injuries units and urgent care centres. The reasons for this increase are complex and relate to the increased provision of services and the increased need for their use (Nuffield Trust, 2014). Some patients seen in these settings are subsequently referred to A&E for further assessment or treatment.

These changes in the delivery of services and the growing numbers of people who need to use urgent care services combine to produce the current pressures.

4.1.4 Social media and general media messages

Reports from social media sources and online comments posted by the public following news items about the urgent care system reveal that A&E is seen as reliable, safe and the

place to go for expert care; and a place where patients will not be turned away. There appears to be greater faith in urgent care services (especially A&E) compared with community-based services, leading to greater attendance at A&E. Urgent care services appear to be valued highly by the public, who express anxiety at the reporting and experience of A&E under pressure.

The media conversations we explored showed that service factors (such as those described in section 4.1.3) are sometimes reported although often understated. More often the sources 'blame' patients for using services inappropriately. The public (often those not experiencing an immediate health need) are critical of perceived service misuse by others, but less critical of their own previous attendance habits, which are often justified and defended. The sources suggest that the public find it difficult to assess their own or others' health conditions and struggle to decide where they should go for care. They do not want to be considered to be using services inappropriately.

4.2 Who uses urgent care services and why?

4.2.1 Survey results

We asked 176 people waiting in urgent care settings for investigation or treatment to complete a short questionnaire. Details about the people responding to the questionnaire can be found in Appendix 1.

What problem brought you here today?

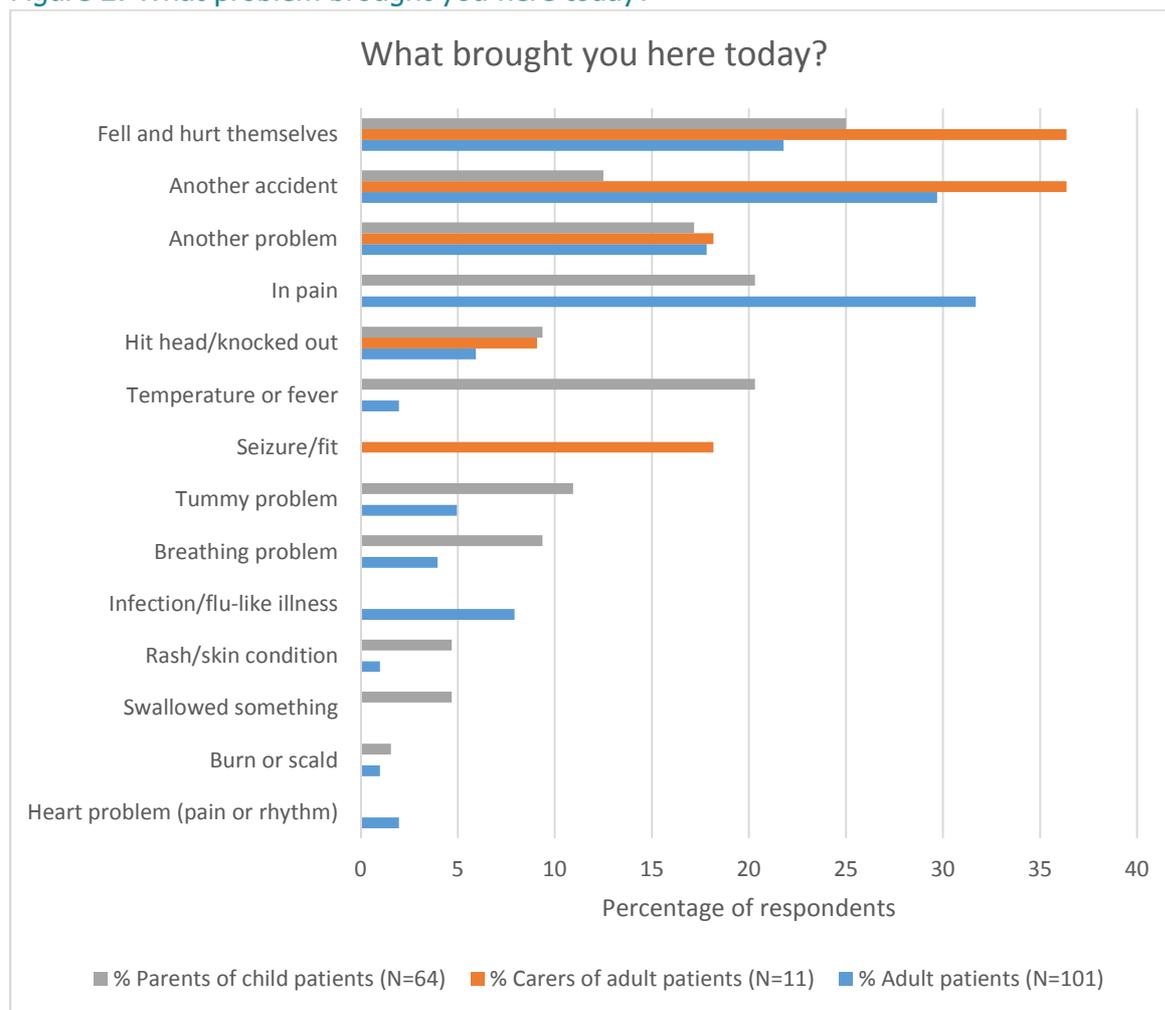
Participants were asked about the problem that led them to attend the urgent care setting that day. Respondents were presented with a list of options and could tick as many answers as they wished. The most common reason for attending was being 'in pain' (42/176, 25.6 per cent), followed by 'fell and hurt myself' (42/176, 23.9 per cent) and 'another accident' (42/176, 23.9 per cent). The responses (see Figure 2) vary by category, with parents bringing their children reporting a higher incidence of attendance for fever and stomach problems than other categories. The small numbers mean that some responses should not be over-interpreted (e.g. the 18.2 per cent of patients having a seizure or fit represents just 2/11 patients attending with carers). The responses suggest that minor injuries and their consequences were a common reason for attendance.

For children, falls, fever and pain were the three most common reasons for attendance. Combining all trauma and poisoning (falls, bang to head, burns and scalds, swallowed something and 'other' accidents) accounted for 34/64 (53 per cent) of child attendances.

For adult patients, injuries were the most common reasons for attendance, including being 'in pain' (32/101, 31.7 per cent) and 'fell and hurt myself' (22/101, 21.8 per cent). Respondents answered 'other accident' on 30 (29.7 per cent) questionnaires, with these injuries including possible broken bone or problem with previously diagnosed fracture (n=10), cuts and wounds (lacerations n=4, nosebleed n=1), soft tissue injuries (n=9) and vehicle accidents (bike accident n=2, car accident n=4).

Trauma was the main reason given by patients attending with carers. Four of the 11 had fallen (36.4 per cent) and a further four had an accident including 'broken leg', 'cut to tongue', 'reopened wound following a fall' and 'swollen hand'.

Figure 2: What problem brought you here today?



'Another accident' included a range of responses, including but not limited to: painful joints, repeat injuries, whiplash and road traffic injuries.

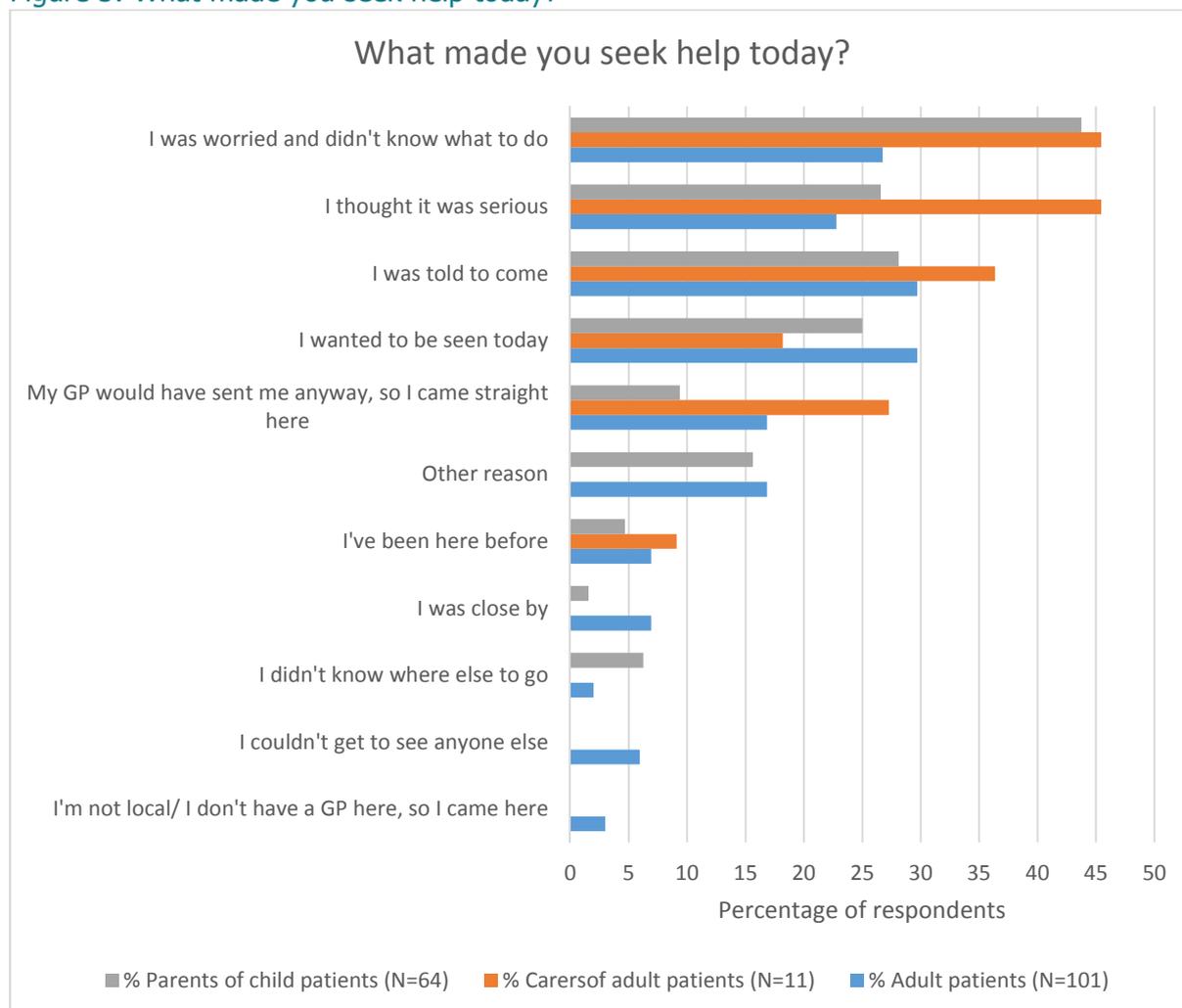
'Another problem' included a range of responses, including but not limited to: infections, nosebleeds and problems with wound dressings.

What made you seek help today?

Respondents were asked why they went to that urgent care setting on that day and they were free to tick as many options as they wished from a list. The results by category of respondent are shown in

Figure 3. The most common reason across all categories was 'I was worried and didn't know what to do' (60/176, 34.1 per cent), followed by 'I was told to come' (52/176, 29.5 per cent), 'I wanted to be seen today' (48/176, 27.3 per cent) and 'I thought it was serious' (45/176, 25.6 per cent). These four responses were ranked highest for all three categories of respondents.

Figure 3: What made you seek help today?

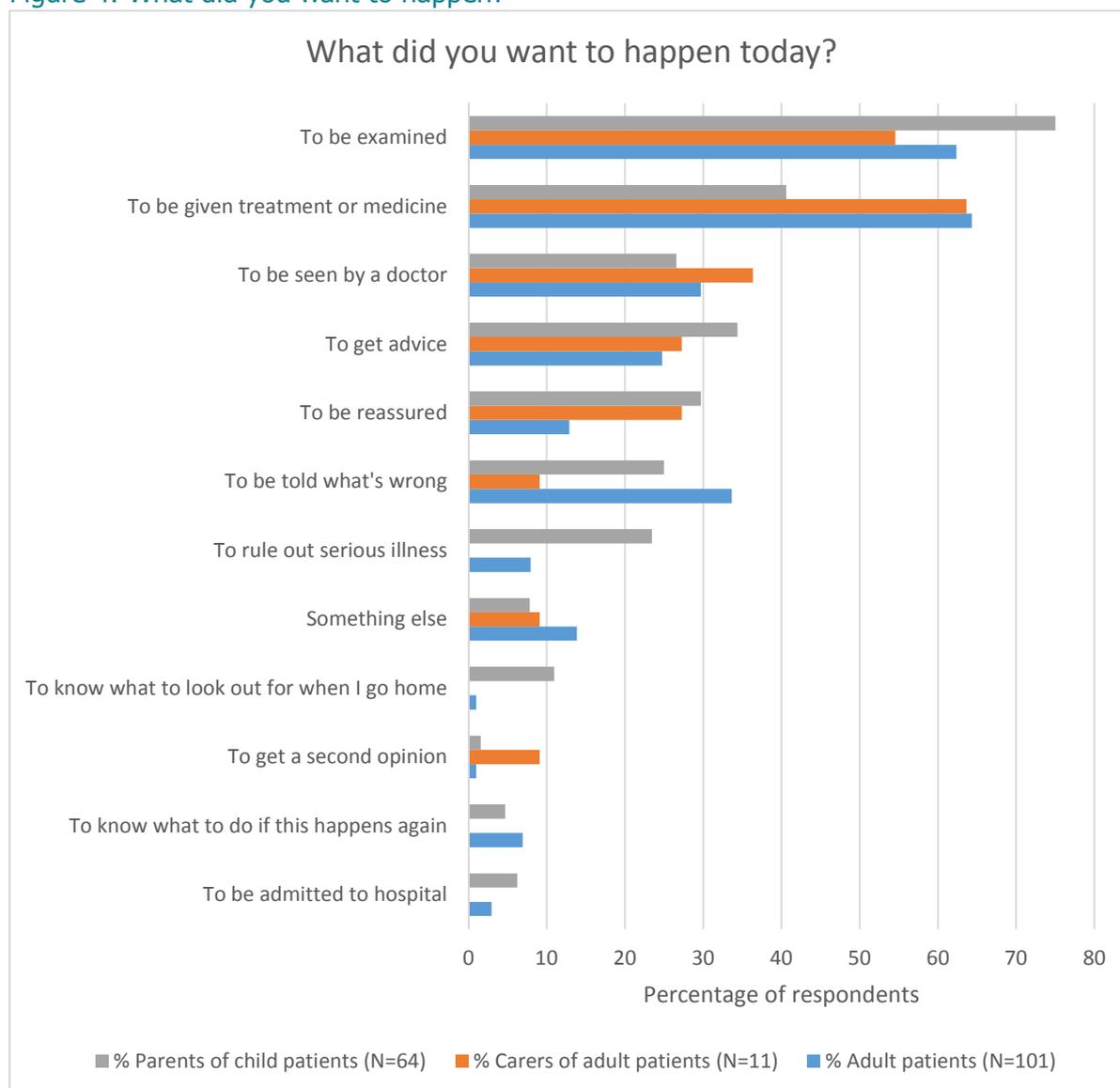


'Other reason' included a range of responses including but not limited to: for an x-ray, thought it was broken, and needed treatment.

What did you want to happen?

Respondents were asked to say what they hoped would happen as a result of their attendance. They were free to tick as many options as they wished from a list. The results by category of respondent are shown in Figure 4. The most common reasons across all categories were 'to be examined' (117/176, 66.5 per cent) and 'to be given treatment/medicine' (98/176, 55.7 per cent), followed by 'to be seen by a doctor' (51/176, 29.0 per cent) and 'to be told what was wrong' (51/176, 29.0 per cent). A total of 35 people (19.0 per cent) said they sought reassurance and only a few respondents reported wanting to know 'what to do if it happens again' (5.7 per cent) or 'what to look out for at home (4.5 per cent).

Figure 4: What did you want to happen?



'Something else' included a range of responses, including but not limited to; checked out, reassured, get stitches and get x-ray

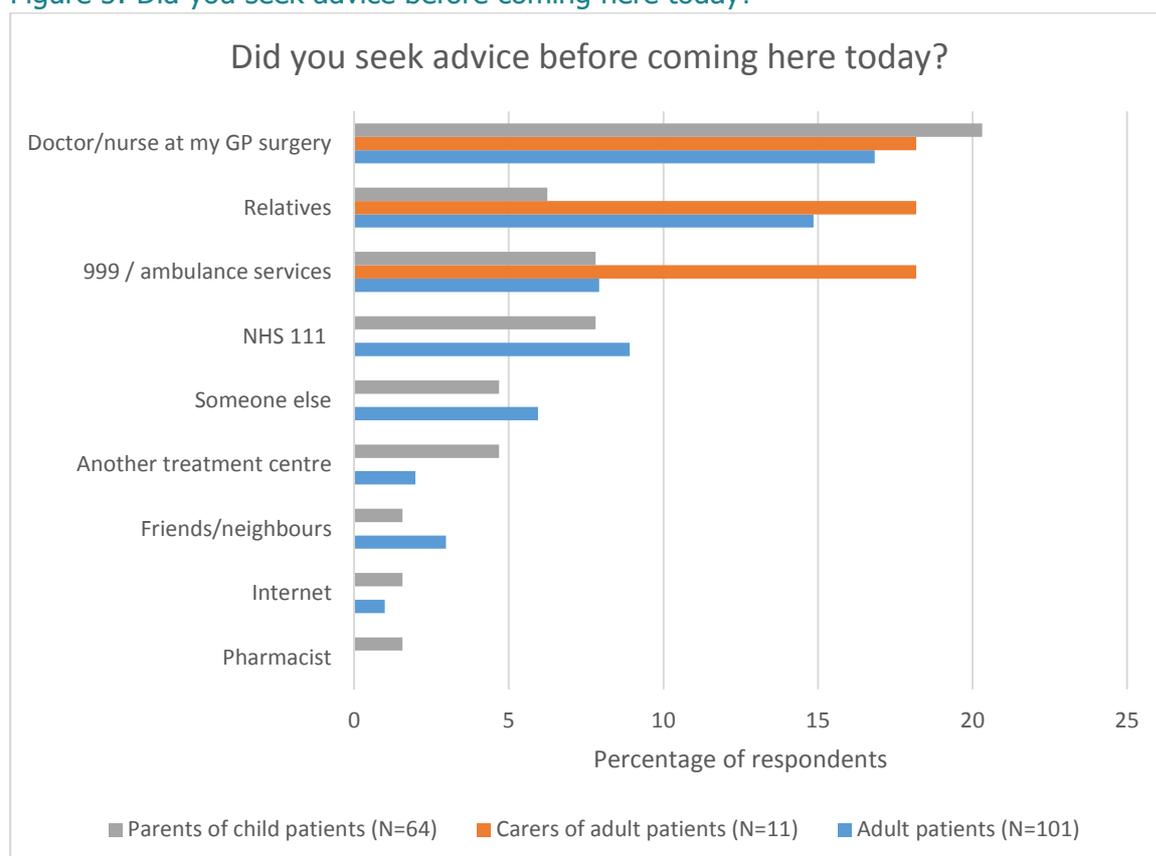
Did you seek advice before coming here today?

Respondents were asked if they had sought any advice before attending the urgent care setting and, if so, who they had contacted. They were able to tick as many options as they wished from a list. The results by category of respondent are shown in Figure 5. The majority (103/176, 58.5 per cent) sought advice from somewhere before attending the urgent care setting. Of the participants seeking advice, 61/101 (64 per cent) were adult patients, 6/11 (54.5 per cent) were carers of adult patients, 36/64 (56.3 per cent) were parents of child patients. The most common source of advice sought before attending urgent care was the doctor or nurse at the GP surgery (32/176, 18.2 per cent) and relatives (21/176, 11.9 per cent). Only one person (0.6 per cent) reported seeking advice from a pharmacist and only two (1.1 per cent) consulted the internet.

The majority of adult patients (excluding carers and parents) sought advice before attending the urgent care centre or A&E (56/101, 55.4 per cent), and some sought advice from more than one source. The most common source of advice was a doctor or nurse at the patient's GP practice (17/101, 16.8 per cent) or from a relative (15/101, 14.9 per cent). The six respondents who turned to 'someone else' mentioned a first-aider at work (n=3), a doctor or nurse outside a GP surgery (n=2) and a support worker (n=1).

Six of the 11 carers of adult patients (54.5 per cent) had sought advice before attending urgent care, consulting the patient's GP, a relative or emergency services.

Figure 5: Did you seek advice before coming here today?



4.2.2 Interviews with service users and focus groups

We collected the views of people using urgent care services in 11 interviews and two focus groups and analysed the results using the same coding framework; results are reported here together. These conversations focused on *why* and *when* people use urgent care services, and the *sources of advice* used and *routes into urgent care* taken by patients.

Five main themes were identified:

- the decision to attend urgent care
- seeking advice
- visiting urgent care
- previous experience
- information for future events.

The first four themes are described here with anonymous quotes used to illustrate the themes and sub-themes identified. The fifth theme describes the information participants felt would be useful to them in future situations and how that information should be provided. These data are presented in Section 4.3.3 of the report.

The decision to attend urgent care: perceived need

All participants said they had experienced symptoms they perceived to require urgent care or advice. The point at which an event and subsequent symptoms became urgent seemed to vary by symptom and between participants. Persisting or worsening symptoms were a trigger for some participants to seek immediate advice or care.

...on the day it happened I didn't do anything about it... it [daughter's finger] had swollen up and it was slightly black. And so I thought, 'Oh, it'll be alright in the morning.' ...the following day it wasn't alright. In fact, it looked worse, so that was why I went to the hospital. [Mother of 11-year-old girl]

It was just the pain in the elbow and the fact that it was just getting bigger, and bigger, and bigger... It was becoming so big that I just thought, 'It's an issue now that, if I leave, it's going to cause me some possible permanent injury.' ...It was just how fast it all happened. If it would have been a lot slower, I would have just booked an appointment [with the doctor]. [Male patient, 45–54 years]

Young mothers in focus group 1 described how they were more concerned about very young children than older children. This level of concern meant they were more likely to seek support from urgent care services.

*Is there a certain age at which you'd kind of worry a bit more? [Interviewer]
Yes, like...newborns to three-year-olds... Because I think they need like to be seen straight away. [Mother, focus group 1]*

Reasons given for this anxiety included concerns about their child's immune system and breathing difficulties, which could be particularly frightening. Parents appeared less worried about children aged more than three years because they can convey their symptoms verbally.

Participants in focus group 1 described a range of symptoms related to fever that they believed to be urgent and to warrant use of urgent care services. These included the child being hot, drowsy, unresponsive, persistently vomiting and limp. For some parents there was a belief that a temperature of 38 degrees centigrade or above required urgent care.

So if it's like 37, it's fine, use Calpol, Nurofen and then if it's like 38, 39 you go straight up there. [Mother, focus group 1]

A particular concern for one mother was dehydration, however she was unsure of the signs to look out for.

Mine's dehydration... Oh, I've forgotten what it is now. I've forgotten the signs.
[Mother, focus group 1]

The fear of delaying care or advice for an injured child may trigger attendance. For one mother whose child fell from his cot, the decision to attend A&E was immediate.

I just felt it imperative to go straight, rushing down there in case he'd broken his leg. You just never know, do you. [Mother of one-year-old boy]

Recognising that a problem may be serious rather than minor was challenging for the participants in both focus groups. Parents in focus group 1 seemed to associate a higher degree of urgency with such illnesses as fever, compared with falls and knocks.

Yes, you just know. I wouldn't take them to the hospital over a fall or a bang unless it was really serious and they were gushing out with blood. But then with a fever, totally different, if they're like – you know, just not themselves and you're worried, then I would go to hospital. [Mother, focus group 1]

However, for an elderly female patient who had previously broken her arm, the decision to attend seemed immediately clear.

I did break my arm in February, but there again I knew I had to go... [regarding the decision to attend A&E] It's made for you, yes. [Female patient, 75–84 years]

The decision to attend urgent care: awareness of and access to different options

The decision to attend urgent care services appeared to have been shaped by participants' awareness of and ability to access urgent and non-urgent care options. Only a few services were mentioned, with A&E often perceived as the only option. There was an awareness that the GP could have been consulted, but this tended to be reported by patients who attended A&E outside usual GP hours or when they decided their health event warranted bypassing the GP. The out-of-hours GP service was not mentioned. For example, mothers in one focus group reported:

Sometimes, if it happens when the doctors are open, I can just go to the doctors... If I don't have to go to the children's hospital, I tend not to. [Mother of two-year-old girl]

I go to the GP first... but this was like 12 at night. [Mother 1, focus group 1]

There was nothing ... in the night... [Mother 2, focus group 1]

Both focus groups described confusion regarding the services offered by different types of urgent care providers. This confusion was due partly to the advice given by NHS 111, which did not match the reality of the local service provision. For mothers in focus group 1 there was uncertainty over which of the local emergency departments accepted children; this seemed to vary depending on the time of day and the age of the child. The participants in focus group 2 appeared more aware of alternatives, such as minor injuries units or walk-in centres, although there had been problems accessing treatment in a minor injuries unit. The example was given of a male who had cut his hand on broken glass. After arriving at the minor injuries unit on the advice of NHS 111, he was told that glass-related injuries required an x-ray, which could not be provided by the unit after 6pm.

Two interview participants described knowledge of minor injuries units, although both had ended up going to A&E, one on following advice (mother of an 11-year-old girl) and the

other (carer of female patient, 45–54 years), because there was no minor injuries unit at the hospital they planned to attend.

Yes, but I knew that there was no minor injury that we could have gone to at that point. [Carer of female patient, 45–54 years]

A female in the 75-plus age group who had suffered a fall was unaware of alternative options to A&E.

I knew I had to have medical attention, and I don't know where else I would have gone. [Female patient, 75–84 years]

The mother of a young boy described how, beyond seeing the GP, she generally considered hospital the only option when her child was ill or had an accident, and she was inclined to bypass her GP if she was uncertain.

'Does this need a GP, does this need Accident and Emergency, or does this need an ambulance?'... If you're unsure.... Just, if it's life threatening, ring 999 and if it's not, take them to the nearest hospital. [Mother of one-year-old boy]

One interviewee in the 75-plus group described how their previous decisions to attend A&E had been determined partly by convenience.

I wasn't going to A&E that day when I did break my arm, and probably would not have gone that day had we not been going away the next day, but thought we should get medical advice. That's why we went. [Female patient, 75–84 years]

The decision to attend urgent care: views about when it is appropriate

Two respondents stated how they would avoid attending A&E unless it was necessary. One had been attending her GP for some time for her problem and felt strongly that people shouldn't use A&E for non-urgent problems.

Because I know people use A&E for stupid things, like a splinter, and a cut finger, and I was never brought up to use A&E like that. You've got something wrong, you go and see your doctor. If it's serious, the doctor refers you to A&E, or obviously, you know, you're in a car accident, things like that. So, like I said, I've never used A&E before. [Female patient, 45–54 years]

The other respondent was the mother of a child with ongoing health issues that had required repeated A&E attendance. One reason for avoiding A&E was to protect her vulnerable child from becoming ill as a result of her attendance.

Because I don't want to go in unnecessarily.... I don't like going into the A&E environment with her. Particularly because I'm always worried about all the other bugs that might be in there. And I wouldn't want to take a child in unnecessarily. [Mother of one-year-old girl]

Members of focus group 2 discussed their concerns about wasting the time of staff in A&E when they had been encouraged to attend the service by friends or relatives. One of the group explained why they did not consider it to be time-wasting if you feel genuinely concerned about your health, but also acknowledged that people need help with decisions on how to use their own and other people's time.

It's not a waste of the health professional's time if you are really worried... people just need to be helped to think about how they use other people's time as well as how they manage their own time I think. [Focus group 2 respondent]

Advice-seeking behaviours and perceptions: NHS 111

Four interviewees described seeking advice from NHS 111 prior to attending an A&E.

Although one recognised that the service provided by NHS 111 may avoid wasting the A&E's

time, two interviewees stated they felt that the NHS 111 service was likely to err on the side of caution and send them to hospital anyway. For the mother of a child with a long-term condition, this was a reason why she would not use the service.

...wouldn't phone 111, I don't think, because I'm not sure they'd be able to really help me in my situation. They'd probably tell me to go in anyway. [Mother of one-year-old girl]

Because they [NHS 111] said they think it was a good idea to get up there, we went up there. [Male patient, 45–54 years]

Mothers in focus group 1 also described how NHS 111 had often advised them to go directly to the children's hospital. One interviewee described how the NHS 111 service had been helpful and was something she used quite frequently, given her young son's ongoing asthma problems.

Sometimes they get me an appointment at [name of hospital] or if they have no spaces... they just say to go up to the children's hospital. [Mother of two-year-old boy]

A carer in focus group 2 described the difficulties experienced when using NHS 111 on behalf of their patient. The call handler wanted to speak to the patient, when the patient didn't want to talk or was struggling to express their feelings, and this had made the situation quite stressful.

One interviewee described how he would like to be able to use a telephone service for advice, one very much like NHS 111, but seemed unaware that it existed.

So maybe a call centre where you can actually phone in just for small injuries which they can then refer it and they can say, 'Right, you need to go to A&E' or 'Wrap a hot towel around it'. [Male patient, 35–44 years]

Advice-seeking behaviours and perceptions: advice from healthcare professionals

Generally, interviewees appeared to act on the advice they were given regarding attending urgent care services, particularly if it was offered by NHS staff. Two interviewees described how contact with their GP had led to their attendance at A&E. One of these patients may not have received the care she potentially needed had she not been attending her GP for an unrelated issue.

...I already had an appointment to see her about something else, so I just showed her my shoulder as it was so red and swollen.... My doctor gave me antibiotics, but then she was worried about it and sent me to A&E. She spoke to the orthopaedic registrar on call, and he asked me to go to A&E, and I spent all day again there because they were worried that I might have sepsis. [Female patient, 75–84 years]

For patients with long-term conditions, one route of advice appears to be the clinical team managing the condition. One mother used them as a trusted mechanism to streamline emergency visits to hospital for her young daughter who has kidney problems.

I mean generally now, I've always rung up the community nurse first-off just because they usually can give me the best place to go. ...occasionally we can't get through to their office, so then what we do is phone the actual ward up.... On that occasion she said to me that you'll need to come in and that you'll have to go in through the A&E services. But to inform A&E that you're part of the renal ward and that they would also be in communication with A&E for us. So hopefully they'll be some joined-up thinking. [Mother of one-year-old girl]

In contrast, a poor experience with non-urgent care staff appears likely to influence future use of urgent care services. A participant who had been seeking advice from her GP for a

long period due a problem with her foot felt that it was the trust she had placed in her GP that led to delayed treatment and worsening of symptoms. She would have attended A&E sooner had her GP not failed to recognise the cause of the problem. The problem wasn't identified until she went to A&E.

I would have loved to have known earlier. Obviously because it would have prevented the outcome.... I just trusted my GP practice. [Female patient, 45–54 years]

For the mothers in focus group 1, there were mixed feelings regarding trust in their GP. Some parents felt they could trust their GP, whereas one mother was more likely to seek the opinion of A&E following her experience.

She [the paramedic] said, '...the doctors know what they're doing.' Really? It took them [the GP] eight months last time to diagnose what he actually got and that took him to the point where he was stopping breathing. So I don't trust doctors. [Mother, focus group 1]

Advice-seeking behaviours and perceptions: advice from relatives, friends, carers and members of the public

Friends and relatives played a role in the provision of advice to the interviewees; these included friends who were present at the time of injury and friends and colleagues observing worsening symptoms over time. For one interviewee, a friend who was an NHS physiotherapist, perhaps seen as trusted expert, directed the respondent to bypass other care options and go direct to A&E.

...seeing as she worked in the NHS I assumed that she knew where the best place to go was, so that's why I went directly there [A&E] rather than trying any other minor injuries unit. [Mother of 11-year-old girl]

For the young mothers in focus group 1, there was consensus that the child's grandmother was a key source of advice when making decisions about urgent care attendance. Some of the group said they would call the child's grandmother in the first instance before phoning NHS 111 or the emergency services. These mothers placed great trust in their own mothers who had been through similar situations in the past.

...if my mum said, 'Take her' I'd take her. If she said, 'Leave her for a couple of hours' then I would leave her. [Mother, focus group 1]

Members of focus group 2 also described seeking advice through friends and relatives, although they appeared to be more cautious about acting upon such advice. There was a suggestion that family and friends might err on the side of caution in case something turns out to be serious. Some members of the group felt people often place too much reliance on advice from those close to them, who can be well meaning yet misinformed.

A patient from focus group 2 described how their carer is an important source of advice when they are unwell. The carer will advise alternative options to urgent care and is able to 'sense-check' whether the patient is making an appropriate decision.

An elderly female who had fallen in public described how bystanders came to her assistance and wanted her to take an ambulance immediately. She, however, decided to be taken home before being taken to A&E by her husband.

Yes, people came to assist me at the time and wanted me to go straightaway in an ambulance. [Female patient, 75–84 years]

Advice-seeking behaviours and perceptions: using the internet and technology

Two interviewees described using the internet to look up symptoms or “google it” prior to attending A&E. Mothers in focus group 1 described using NHS Choices to identify advice on their child’s temperature.

It’s on the NHS website.... So, yes, fever, and it will come up with a list of ...things that you need ...it’s NHS Choices. It’s really good. [Mother, focus group 1]

However, a carer in focus group 2 described how an NHS website had caused him to worry when it advised him to phone an ambulance immediately for his father, despite the situation not requiring such action.

There were mixed opinions among mothers in focus group 1 regarding the utility of seeking advice, including from the internet, about when to attend A&E. Their ultimate choice seemed to be governed by their level of concern, but some parents felt more reassured by seeing a doctor in A&E and this related to whether or not they trusted the information found on the internet.

I’d rather be seen to be honest [than reading something]. [Mother 1, focus group 1]

Sometimes I’d rather go to hospital, because I know that they’re giving them the right treatment and the right stuff. [Mother 2, focus group 1]

Yes, if I was that worried about my kid, then definitely I’d zoom up the hospital. But then if I wasn’t so concerned... [Mother 3, focus group 1]

If you were in two minds then... [Mother 4, focus group 1]

...then I’d probably read it up a little bit, if I wasn’t so concerned, but then obviously if I was concerned I would just go right up to the hospital. [Mother 3, focus group 1]

The mother of an injured child described how she had taken a picture of her daughter’s injury and shown it to a friend, asking for advice. The mothers in focus group 1 also described using mobile phones to ‘Facetime’ their relatives for advice.

Because obviously you’ve got Facetime and all that now. So if you get on Facetime to your mum or something... and I’d be like, ‘Oh, look at her. Is she alright?’ [Mother, focus group 1]

A mother of a young child described how she did not seek advice because her parenting knowledge meant she knew her son had to attend A&E following an accident.

No, I just used my parenting knowledge to know that that was something that you were supposed to do if the child had an accident. [Mother of one-year-old boy]

Visiting urgent care: provision of care and trusted advice

Participants who described a positive experience with urgent care services stated how their needs were dealt with and how they received helpful advice, which they valued. Healthcare professionals were described as “knowledgeable” and “providing good advice at the right level”.

...he seemed to really know what he was doing and gave me really good advice. Yes, I was really well looked after. [Male patient, 35–44 years]

...and the outcome was good because they gave good advice. And they aimed it at the right level for both me and my daughter to understand... [Mother of 11 year-old girl]

Visiting urgent care: expectations of a visit to A&E

Respondents described how the decision to visit A&E is taken with the understanding that there may be undesirable experiences. The main assumption of interviewees and focus group respondents regarding urgent care was that a visit to A&E involves a busy waiting area and long waiting times.

There is always a lot of hanging about, obviously, at these places. [Female patient, 75–84 years]

However, sometimes participants reported being pleasantly surprised.

...I appreciate that in mass-period times that you're going to get busy, but this one [time] I was really pleased... it was only about 20 minutes/25 minutes I had to wait before being seen, which is pretty damn fast. [Male patient, 45–54 years]

One respondent described how her injured son had to be seen by a member of social services to examine his injuries and that this was a “scary” and “intimidating” experience.

...it's a bit scary when you see the nurse or the doctor as a parent because, nowadays, they have to inform social services if your child has an accident like a fall... Immediately, when anyone says, 'social services', you're quite intimidated by that... [Mother of one-year-old boy]

Visiting urgent care: receiving advice and care

Interviewees and participants in focus group 2 described how the advice and care they received in A&E could have been given elsewhere. Two people described how they were given over-the-counter pain relief (ibuprofen or paracetamol) and sent home with no further treatment required. It was unclear whether this had any effect on subsequent decisions to attend A&E. Others in focus group 2 described how the information they received at A&E could have been printed off from the internet, illustrating that their visit had perhaps not been necessary. Three respondents described frustration when being given incorrect information by a nurse or clinician in A&E.

Two interviewees (mothers of young children), spoke positively of being given tools or resources during their recent visits to A&E that were helpful for managing the care of their children in the future. One mother was given a self-management chart for her son's asthma.

I was going there expecting steroids and getting sent home like normal... but this time they helped me more. [Mother of two-year-old boy]

A second respondent whose child has a complex medical history, upon arrival at A&E was given a hospital passport for the first time. This provided useful information for the mother and for the doctors treating her child.

...hospital passport. I wasn't privy to one before... which the doctor said was actually really helpful... it gave a really quick summary of her and previous admissions... and so for me it made me feel more confident as well that they knew what they were dealing with. [Mother of one-year-old girl]

Previous experience: shaping behaviour

Respondents described how their experiences have shaped their actions when it comes to using urgent care services. Members of focus group 2 discussed how people who engage with their GP regularly are able to “push the right buttons” and access the care they feel they need. Partly this was about knowing the right “jargon” needed to navigate potential barriers. Three respondents who cared for children with ongoing health conditions described how this experience had shaped their knowledge and the way they use urgent care. Two of the parents described how they were particularly cautious, with a low threshold for seeking

care, and would take their child directly to A&E in response to certain signs, without considering other care options.

I just take him up to children's [emergency department] on my own. I don't want to wait around ringing 111 when I know that he's bad enough to go up to A&E. [Mother of one-year-old boy]

....a high temperature, it's often a symptom of peritonitis. She's on dialysis overnight, so we have to be very, very alert and we have to take her temperature. And it's one of those things where we're told to go straight in if there's a problem. [Mother of one-year-old girl]

Interestingly, this mother also described how she would struggle to act on similar symptoms if she had another child in the future who was healthy.

...if I had another child I wouldn't be quite sure what I'm meant to do, really. [Mother of one-year-old girl]

Previous experience: knowledge gained by living with a health problem

One participant described her awareness of a potentially serious problem with her feet because of her experience as a diabetic patient.

I was just aware that obviously a lot of diabetics do tend to have their limbs amputated... that was a bit of a real red flag for me, when my toe started to go black.... Because of being diabetic, you've got to take care of your feet and things like that. [Female patient, 45–54 years]

One participant had previously used A&E as a convenient source of care when in London. More recently, following an attendance locally, he had been advised to take painkillers until the injury resolved itself, although this advice seemed unlikely to change his future use of A&E.

Well, I wasn't really happy. They didn't resolve it because at the end of the day, it resolved itself through home remedies.... When I was living back in London there were a few hospitals that I could go to, you get seen a lot quicker and they would give you a good, thorough check. [Male patient, 35–44 years]

So if you were faced with something like that again in Bristol, do you still think you would go there or do you think you'd do anything differently? [Interviewer]
I might try a different hospital. [Male patient, 35–44 years]

4.2.3 Views of healthcare professionals

We asked 23 healthcare professionals for their views on which patients attend urgent care services frequently and the potential role of first aid education to support these groups. This section covers their views on the groups of patients who attend urgent care often. Section 4.3.1 covers which health conditions might be helped by first aid education and section 4.3.2 provides information on which population groups might benefit from first aid education.

Healthcare professionals identified seven patient groups who attend urgent care services frequently:

- patients with long-term conditions, including mental illness
- children, particularly young children
- older people, especially those who are frail or have multiple health needs
- people who use substances
- people referred by their employer or a first-aider at work
- people receiving health or social care at home or in community settings
- the general public experiencing self-limiting infections and minor injuries.

Patients with long term conditions, including mental illness

Healthcare professionals suggested that patients with both physical and mental long-term conditions often use urgent care services and could benefit from support to manage their health. Providing support could minimise the effect of their condition on their general wellbeing and prevent their condition deteriorating.

Patients living with physical conditions such as chronic obstructive pulmonary disease (COPD), diabetes and heart disease were highlighted as examples. For patients with COPD, interventions to help them recognise the symptoms of chest infections, when and how to adjust their medication and, when necessary, select appropriate healthcare advice at the right time, could help avoid an urgent care attendance.

COPD patients: [there's a] high risk of them becoming very ill very quickly. We know that more infections for COPD limits life. [GP 4]

One GP commented that patients with heart disease could benefit from the same type of information to help them stay well and understand how to respond if their condition deteriorates. Keeping healthy was perceived as very important, indeed the concept of 'prevention is better than cure' applied to many patient groups experiencing long-term conditions and for whom hospital attendance or admission is likely.

Many community-based healthcare professionals expressed concern that urgent care is rarely the most appropriate place for people experiencing mental illness, but is often their only option.

Mental health patients. This is a group who could benefit from interventions. You can predict which are at risk of admission/attendance but there's not much in the community to support these people. [Paramedic 2]

Similarly, hospital-based healthcare professionals identified the need for services to support those at risk of mental health crises, such as deliberate self-harm and overdose, stressing these could benefit individuals and their families.

What we need to do is train people in the community to be able to deliver crisis first aid help – often it is a listening ear, sometimes it is something practical that needs to happen (i.e. accommodation somewhere, or support to access a service), sometimes the person just needs some time out from their home environment – all of these things I would consider as 'first aid' interventions but it is really difficult to find a service that will deliver these for people in mental health crisis. [A&E nurse 15]

Children

Families with children, particularly young children, were frequently seen in urgent care services. The most commonly cited reasons for attending included fever, head injuries, suspected fractures, diarrhoea and vomiting, seizures, respiratory illness, falls (especially by toddlers) and poor mental health (particularly deliberate self-harm and overdoses) in older children and adolescents.

Several healthcare professionals observed that many families perceived A&E as the only option for obtaining advice, often despite parents' efforts to gain alternative care for their children. It was suggested that families experienced confusion about how and when to access services such as walk-in centres, NHS 111 and primary care and what these services might be able to offer. In addition, they often experienced access problems, with a lack of timely appointments in general practice and few walk-in centres where paediatric skills were available. This difficulty in attending the right place at the correct time often resulted in families choosing to attend A&E directly.

A lot of families can't get a GP appointment. They aren't available for them. They try and then it's booked up so they come to the children's hospital because they don't know where else to go. [Children's A&E nurse 013]

It is also very clear that a number of GPs say, 'If it doesn't get better, go to the kids' ED [Emergency Department]'. [Children's A&E consultant 017]

One consultant in children's emergency medicine felt that parents were often blamed for misusing emergency services and that this was inappropriate.

If we're not doing a good enough job outside of the hospital with letting parents know what's available, then that's our fault, not the parents' fault. [Children's A&E consultant 018]

Older people

Older people, especially those who are frail or have multiple health needs and are consequently at risk of falling were frequent attenders at urgent care services. The vulnerability of this patient group caused the health professionals great concern. Interviewees felt that the identification of people at risk of falls frequently only occurred after a person had sustained a fall and been seen in urgent care. Consequently, the falls assessment process was usually reactive rather than proactive. A more proactive approach would have the potential to avoid harm and reduce attendance at urgent care. In particular, healthcare practitioners observed that they often saw older people who had fallen but not sustained any injury. They felt that this was an indication of an older person who was failing to cope alone and this reflected inadequate provision of social support or care either at home or in community settings.

These people are often injured in very minor ways, but the main issue remains social. [We] need to create services for social emergencies that have nowhere else to go but A&E, often via ambulance who also have no other option [but to convey them]. [A&E matron 019]

Really, these patients [minimal injury fallers] should never be in an acute medical facility. We need to have a total strategic rethink about where elderly people with acute social problems should go. [Walk-in centre nurse 006]

Another group frequently seen is older people, particularly those with long-term conditions, who become unwell with minor illnesses. While they may cope under usual circumstances, minor illnesses may result in them being unable to manage. This can be exacerbated by

social isolation and, in the absence of support, their choices for care become limited resulting in an urgent care attendance.

Most can manage at home, but a minor illness can disrupt this and make managing impossible – this might be a group where support can be helpful. [GP 003]

[The patient has] usually fallen or they've got a urine infection that they haven't had treated and then they become confused with it... and they don't know what to do but call an ambulance. [A&E nurse 008]

People experiencing such emergencies were typically conveyed by ambulance out of hours as a result of an event such as a fall or illness.

The capacity is not there in the community to support them acutely, but bringing them to A&E is totally wrong. [Walk-in centre nurse 006]

People who use substances

People who inject drugs were considered to be an especially vulnerable group. They were of particular concern because of the risk of complications arising from their addiction (e.g. overdose), but also because they are at risk of neglecting their general health. They often fail to recognise the signs of serious illness, such as the onset of deep vein thrombosis.

One practitioner described encouraging results from a community intervention with intravenous drug users who were taught to administer naloxone injections to friends who had overdosed (naloxone is used to reverse opioid overdose). Although a relatively small user group, the potential to save lives was recognised. This interviewee believed that work could be done to support drug users to identify serious health conditions and make them aware when to seek urgent care.

People referred by their employer or a first-aider at work

Healthcare professionals reported seeing an increasing proportion of people in A&E who had sustained work-related injuries or been taken unwell at work and referred to the A&E by colleagues trained in first aid or by their employer, or because of the requirements of an employer's insurance.

These circumstances cover a variety of situations, but commonly the primary objective in many of these cases was to document an event (accident/injury/illness). Sometimes an employee is advised to see their GP, but if unable to get an appointment that day, they are likely to attend A&E. In some circumstances, first-aiders in the workplace had recommended that employees seek immediate medical attention in order to minimise the risk of missing a serious illness or injury.

They [first-aiders] say, 'We're calling an ambulance from a safety netting perspective', to get someone to check them. Actually, they'd [patient] be quite confident in being dealt with by the first-aiders. [Paramedic 001]

Some people were reported to attend A&E to enable them to continue working, or to legitimise their absence from work.

People who aren't seriously unwell still have a motivation to continue with work and so coming to A&E means, 'I'll do my day's work. If I'm not feeling any better, I'll pop to A&E.' We get huge, huge numbers of people turning up at six, seven or eight o'clock at night with things that they want sorted that evening because they've worked all day and they want to go to work tomorrow. [A&E nurse 008]

These findings complement those found in the survey of people using urgent care services, where three of the respondents had attended A&E because they had been advised to do so by a first-aider or employer.

People receiving health or social care at home or in community settings

People who receive care services in the community include residents of care homes or people living in their own home but with a regular carer. They often have complex health problems.

Healthcare professionals believed that a large patient group seen in A&E includes those vulnerable to falling and at risk of having minor illnesses that tip them towards no longer being able to manage in their homes. People who are frail are more likely to have complex health needs (Bleijenberg et al., 2014) and are more likely to experience falls (Kojima et al., 2015). These episodes result in an attendance at A&E, often on the recommendation of a professional carer. While it is necessary to follow safeguarding processes in such circumstances, older adults residing in care homes may lack safe and appropriate alternatives that would reduce the number of such referrals to A&E.

Care homes as such are correctly plagued by legislation and safeguarding. Not taking an elderly person who's had a fall and subsequently finding that they've had a fracture will trigger a problem for them and so they are probably more overcautious.
[A&E matron 019]

Professional carers who support individual adults in their own home are another group clearly concerned about accountability. Such carers often receive little health training, but as a result of their duty of care towards clients are expected to make decisions about their health. Consequently, professional carers may feel compelled to seek urgent care for their clients for very minor conditions in order to report changes in their health status instantly, devolving assessment and action to a healthcare professional. In order to achieve this, requests for immediate care are made in urgent care if same-day appointments cannot be obtained in primary care settings.

Social isolation was cited as a common reason to refer or convey someone to hospital. The frustration of healthcare practitioners at this was apparent; not only is urgent care inappropriate from a financial perspective, but neither is it in the patient's interest, since hospitalisation could lead to increased risk of infections for already vulnerable people.

We find that more and more people are more socially isolated, even younger people who go to work and have friends, and if they don't have a partner at home, and they have an injury...[they may use urgent care] [Emergency nurse practitioner 010]

The general public experiencing self-limiting infections and minor injuries

Healthcare professionals reported that many members of the general public appeared unsure how to manage self-limiting illnesses. Their difficulties were said to include not knowing options for self-care, lacking confidence in using over-the-counter medication and being unable to interpret health advice, including not knowing how and when to access different care services.

It was reported that people often requested primary care appointments or sought advice from urgent care services without first trying self-care. An important area of misunderstanding among patients was reported to be their knowledge of (or perhaps tolerance of) the duration of a typical illness or pain. If patients experience symptoms or pain for longer than they expect, they are likely to perceive it as a severe problem and to attend an urgent care service. Two healthcare professionals suggested that publicity campaigns were unhelpful in instructing patients how to manage their conditions. Phrases

such as 'if symptoms don't go away, see your GP' were thought to increase requests for healthcare, since patients were unsure about how long symptoms were expected to last.

I do think people are just not appropriately educated about how long minor illnesses take to resolve with self-care. One day of paracetamol is not going to have miraculous results. People do need to be educated that time is sometimes the best treatment and that it is ok to take a couple of days out of their busy lives to recover from illness. [Walk-in centre nurse 007]

Some people say, 'I've just woken up with a sore throat or something,' and you just think, well, why don't you drink lots of water, have salt water gargles and see how you go rather than immediately turning up before the infection, if there was going to be any, has arrived? [Walk-in centre nurse 005]

They've taken no painkillers, they're not taking simple measures before they come to an A&E department. They're not taking paracetamol or ibuprofen. [Children's A&E nurse 013]

Some patients reported difficulty in knowing when to attend urgent care, such as the young parents who had different views regarding when it was appropriate to attend A&E with a child who had a temperature. Similarly, healthcare professionals reported that some patients had difficulty in assessing their own medical conditions. It was suggested that inability to self-care could be the result of inability to assess the severity of a health problem.

People's perceptions of what is wrong with them is very different – worried well to those not realising how ill they are. [Walk-in centre nurse 007]

There are those that turn up with a gaping wound days later who have done nothing about it, and then there are those people that have got a paper cut and come to have a plaster put on it. [Walk-in centre nurse 005]

Generally, minor injuries were more likely to be considered as appropriate attendances than minor illnesses.

You could have a minor injury which is, I'd say, more often than not, very appropriate to come here. You have your minor illnesses; more often than not, is not appropriate for an emergency department. [A&E nurse 011]

Views on social factors affecting use of urgent care services

Healthcare professionals expressed views on why they thought some patient groups may attend more frequently than others. Reasons included the need for reassurance, expectations of being able to access care conveniently, and difficulty in accessing the right type of care.

The need for reassurance: Patients' need for reassurance about their medical condition was expressed by many healthcare professionals and describes the wish to have a health problem "checked out". This was reported to be a common phrase used by patients who were concerned about what healthcare professionals regarded as minor conditions. This behaviour was described across all ages, but some healthcare professionals suggested that they had observed this behaviour more frequently among younger adults.

I suppose most of the time they are a bit like, just check me over. Yes, most of them just want reassurance. It is, yes, most of the time they're absolutely fine. [Emergency nurse practitioner 009]

Expectations of being able to access care conveniently: Many of the healthcare professionals interviewed believed that the perceived convenience of urgent care, i.e. that patients could attend at any time of the day or week and would be assessed and treated

within hours, without an appointment and without having to navigate the complex system often presented by primary care, meant that the urgent care service was chosen in preference.

Twenty-four-hour care is always available if they've got a minor illness or they just kind of want an answer straight away. [A&E nurse 011]

People think that if they go to A&E they won't have to wait for an appointment – they don't want to wait days, weeks or even hours for the GP appointment so go to A&E. [Paramedic 002]

[A patient] said, 'If something's wrong with me, if I get something in my eye, if I have a crush injury, I go to A&E because I know what I'm getting.' [A&E matron 019]

The point raised by the last quote suggests that A&E is branded as familiar to people, consistent and trusted.

Difficulty in accessing the right type of care: The healthcare professionals interviewed expressed sympathy for patients who were struggling to assess the severity of their illness or injury and were then expected to navigate a complex healthcare system and access support at the right point. Inadequate provision in one part of the system was understood to have consequences for urgent care settings.

Because they can't get to their GP. So we've got local GPs here, no fault of their own they've lost their GP or they're understaffed. [A&E nurse 008]

I think it is a system issue. I think patients are so confused about the different health avenues that are available to them that they don't really know where to go. [Walk-in centre nurse 007]

Views on professional factors affecting use of urgent care services

Across the different professional groups, staff recognised that their practice may reinforce patterns of attendance at urgent care for minor illnesses and injuries. All healthcare professional groups described the need to ensure that potentially serious health problems are identified and managed. Community practitioners suggested that referral to hospital urgent care services was not always driven by the needs of the patient, but often resulted from an absence of 'safe' alternatives within the community. As described in Section 4.1.2, hospital-based staff rarely considered attendances to be completely inappropriate and took the opportunity to ensure the patient did not have a serious health problem.

Healthcare professionals acknowledged that patients are seldom turned away, even when alternative services may be more appropriate.

[There are] messages that they shouldn't attend, but then when they do attend they are seen. [A&E doctor 023]

We'd never turn an injured patient away, no matter how trivial. [A&E consultant 020]

This illustrates the complexity of the behaviours that influence attendance at urgent care. Just as patients are anxious they may have a serious condition and need to seek reassurance, so healthcare professionals are cautious not to miss a serious problem. Assessment of the patient in the emergency department therefore reassures both parties. If all attendances, even minor ones, are seen, patient attendance for similar problems in the future is reinforced.

[The department] now gets 20–30 [attendances for minor conditions] per day but there is always one you would never want to miss. [A&E consultant 020]

This was particularly the case for the healthcare professionals working in the children's A&E. These staff were respectful of parents' concerns regarding their children's health and recognised the difficulty in identifying a very sick child from one with a common and self-limiting illness. Healthcare professionals reported the vulnerability of children, who can become sicker more quickly than adults, making it harder for parents and themselves to assess the seriousness of an illness. Everyone in the children's A&E was reported to have a role to play in helping to spot the very sick child.

We have mums bringing in babies that are extremely unwell and the receptionists have recognised this and they've been rushed to resus. They [healthcare professionals] always say to us never, ever think that you're bothering us. We would rather you have ten people that you come to us and we say actually they're fine rather than miss that one child. [A&E receptionist 012]

You can't be too careful now. I think no matter how careful you are, there's still going to be that one child who looks amazing but is actually very sick. [Children's A&E nurse 013]

It is true that young children get sicker more quickly. Parents appreciate that and doctors know that to be true too. I think people aren't willing to compromise or take risks with their children. I think that's fine. [Children's A&E nurse 015]

4.3 First aid education to support people using urgent care services

In this section of the report we describe how the information gained through this study can suggest ways in which first aid education could support people who use urgent care services.

4.3.1 Which health conditions might be helped by first aid education?

Data obtained from the survey, interviews and focus groups with people using urgent care services, and from healthcare professionals providing these services, suggest that members of the public often lack confidence in managing minor illnesses and injuries independently. They also lack knowledge regarding the natural duration of common problems. For example, in the survey of people using urgent care, the most common response to the question: 'what made you seek help today?' was 'I was worried and didn't know what to do'.

Healthcare professionals perceived that first aid was a "lost skill", and that there was increasing expectation among patients that common injuries such as sprains, lacerations and burns should receive urgent care, with first aid seldom attempted before attending. It was also suggested that first aid should be taught in schools, and that this should include information about managing illness as well as injury.

And personally, I think that it's about [self-care and first aid] educating children from the time they're five. We can't do this until the next generation. [Emergency nurse practitioner 010]

I think younger people, up to retirement age, in certain groups of people that you see, they have absolutely no idea about first aid. [Emergency nurse practitioner, 009]

Patients need empowering to make choices for their own health condition – not just getting something very minor checked out. [A&E nurse 011]

In addition to helping people acquire knowledge and confidence to self-care for minor illnesses and injuries, healthcare professionals believed that first aid education should provide information to help people understand which services were available and, importantly, when to use them. The healthcare professionals interviewed believed that information currently provided in health campaigns was insufficient and confusing. Patients' misunderstanding of this information was reported to result in more frequent A&E attendance. Helping the public understand what alternative care providers could offer was seen as particularly valuable.

It's about understanding what you can manage at home and what you can't. [Children's A&E consultant 017]

Big messages for me would be: use your pharmacist first. Use NHS Patient UK because it's got a lot of information. [Walk-in centre nurse 007]

Pharmacists as well, of what they can offer. So, for the families to go to talk to their local pharmacy to get simple remedies. The pharmacy is to explain that they can give them Calpol, paracetamol. [Emergency nurse practitioner 010]

Actually, if you want this sorted out, you need to go to your GP: sometimes, it's a case of telling them or teaching them how to access services appropriately. [A&E matron 019]

For adult users of urgent care services, data from the survey of patients and the interviews with healthcare professionals suggest that advice on the **management of bleeding** would be helpful. Other injuries requiring information on basic first aid included **sprains** and **burns**.

Health professionals suggested that minor illnesses requiring first aid education included **coughs and colds**, including managing people's expectations of the normal duration of illness, and the common symptoms and how to manage them; and **diarrhoea and vomiting**, particularly regarding how to rehydrate adults and children. They also suggested education would help people to make better use of over-the-counter medication for illnesses, injuries and pain.

Other big messages are, with an injury, if it's a soft tissue, just wait and see until the next day. [Walk-in centre nurse 005]

The other group of health conditions that could be helped by first aid education are those that cause **long-term conditions**, such as COPD, diabetes and heart disease.

For children brought in to urgent care services, **falls, fever** and **pain** were the three most common reasons for attendance. Mothers who took part in interviews and focus groups expressed particular concern regarding the management of fever. While healthcare professionals delivering care to children generally accepted that attendance to urgent care for children who were unwell or injured was entirely appropriate, they believed that some health needs could benefit from greater investment in education and support to help families manage situations confidently and present to healthcare services at the right time.

Both **fever** and **head Injury** were suggested repeatedly as conditions that caused anxiety among parents. Greater understanding of these two conditions and how to manage them was thought to have potential to reduce parental anxiety and reliance on urgent healthcare services.

Healthcare professionals understood that fever was a worrying symptom for parents, and they described several relevant misconceptions and issues:

- parents often do not administer paracetamol or ibuprofen
- parents do not understand that fever is a symptom of an illness (and so may continue or recur until the underlying condition is resolved)
- parents do not know that it is acceptable to give paracetamol and ibuprofen, or they lack confidence in giving medication to their children.

Staff reported that many families were reluctant to use antipyretic medication such as paracetamol and ibuprofen, and many had not tried medication before attending urgent care. A common misconception was that healthcare professionals needed to witness the child's temperature at its highest, and to witness the child in distress in order to legitimise their concerns.

They [child] don't have analgesia because they [parents] wanted us to see them in pain. It's kind of a misconception. [Parents think] we're not going to not believe them. [Children's A&E nurse 014]

Healthcare professionals therefore suggested that information promoting the use of appropriate medication to reduce pain and fever should be offered to parents. They suggested that they would like parents to have greater understanding of how these medicines can reduce distress in children, as well as reducing temperature.

Falling and sustaining a head injury was a common reason for attending A&E in the survey of patients, and head injuries in children (particularly very young children) were

mentioned repeatedly by the healthcare professionals interviewed. Usually the head injuries were very minor bumps to the head and often required no medical care.

We see a lot of minor head injuries, and we don't actually do anything for them, and the assessment actually is quite straightforward, and follows a set of pretty simple rules. [Children's A&E consultant 020]

Healthcare professionals suggested that if parents were made aware of age-appropriate warning signs for children who had sustained a head injury, this would help them distinguish between serious and minor injuries and this could significantly reduce attendance at A&E.

A further condition common in child presentations to urgent care settings was **respiratory conditions**. Healthcare professionals felt that support to identify deterioration and seasonal advice to avoid exacerbation of existing conditions would be helpful in these cases.

4.3.2 Who might benefit from first aid education?

The majority of people completing the survey of patients in emergency departments reported seeking advice before attending urgent care services. This suggests that many people actively consider where to attend and seek advice from other sources before attending urgent care. **Parents** and members of the **general public**, including **older people with minor illnesses and injuries**, have the potential to benefit from first aid education regarding specific conditions, as described in section 4.3.1.

Three key issues emerged from this study that may help parents, the general public and older people or their carers:

- knowing what to do when feeling unwell or after sustaining an injury (i.e. how to provide self-care at home)
- being able to judge the severity of a health condition, including understanding what is considered as the normal duration of symptoms associated with that condition and the normal pattern of recovery
- knowing where and when to attend for advice or treatment.

Other groups of potential beneficiaries of first aid education mentioned by healthcare professionals include **people who use substances**. The key issues here included keeping healthy, recognising the potentially serious complications of drug use, and knowing how to respond when someone overdoses on opioids.

This study appears to show that **employers, first-aiders** and **professional carers** use urgent care services to seek reassurance for the employees and patients for whom they are responsible. These professional groups appear to be poorly equipped to deliver their role of providing care in their work or community setting and knowing when to recommend attendance at urgent care services. It was suggested that these groups could benefit from greater support or training to enable them to give appropriate advice regarding use of urgent care services. More research may be required to understand current practices, what information would be valuable and how this should be offered.

This study shows the extent to which the public value the delivery of advice from trusted sources (such as doctors and nursing staff). Further consideration and research may be required to determine how the Red Cross can best demonstrate its 'expert' position, thereby generating trust when delivering first aid education to the public.

4.3.3 How might first aid education be provided?

This section describes the views of participants who were interviewed and took part in the focus groups. We describe the information they thought might be helpful when making decisions regarding how to use urgent care services, and how the information should be received.

Information on how to respond to symptoms

There was agreement that guidance on how to respond to symptoms in terms of seeking urgent or non-urgent care would be useful. One respondent proposed the use of a “quick response card” indicating which services would be appropriate for different problems.

...a 'quick response card' or something... that tells you like a chart kind of thing. Does this need a GP, does this need A&E or does this need an ambulance? Something simple like that, maybe. [Mother of one-year-old boy]

However, in the case of potentially non-urgent events, such guidance would need to give people confidence to wait for a non-urgent care appointment. This might include information on what to expect in the event of symptoms becoming worse. In addition to avoiding unnecessary attendance, such information might be important for ensuring patients seek timely urgent care when necessary.

...if it had taken me two days to see a doctor and it had continued swelling the way it was, I could have been in a bit of trouble. But if it was a case of it's not going to get any worse, if you were quite confident of that from, say, an internet site or something like that... [Male patient, 45–54 years]

So they said the fact that I went made a huge difference. If I'd have slept on it or waited a day or two, even that space of time can make a huge difference there, so it was really important. [Male patient, 35–44 years]

Participants in focus group 2 described the usefulness of having information to help them decide on the normal length of time to leave certain illnesses before needing to seek help. Opinions of what was a normal length of time to leave a cough varied substantially, ranging from five days to six weeks.

Several participants recognised the challenge associated with providing helpful information since there is a huge range of health problems and it is difficult to provide advice that is specific enough to be helpful, yet broad enough to be generally relevant.

If it was quite specific to what you had, you could then say, 'Okay, that fits me to a bill' and it says, 'following this criteria, you should be okay just to book a doctor's appointment'. I would have probably just booked a [doctor's appointment]. [Male patient, 45–54 years]

I suppose, where does it end? Because you could cover lots of different things, couldn't you? [Female patient, 45–54 years]

Participants in focus group 2 felt that illness was more complex than injury because of the wide array of conditions that exist and the variation in how quickly they progress. Injuries were thought to be more straightforward because an injury either “looks bad or it looks minor”. In contrast, other interviewees thought it could be challenging to recognise injuries that were sufficiently serious to need a visit to A&E.

The fact that I could move my fingers freely and there was some movement in my hand and wrist made me question whether it was broken.... If I'd broken a bone in my leg, I would have been in a lot of pain, but I think because of that, there was some doubt or confusion about how serious the injury was. [Male patient, 35–44 years]

So, for example, telling you that, that a straight finger doesn't mean it's not broken, and an almost painless finger doesn't mean it's not broken. [Mother of 11-year-old girl]

Information on alternative care options

Participants in focus group 2 and interviewees suggested that it would be useful to have information on which care option is most appropriate, and this should include details on the urgent care services available in the local area, including opening times and facilities. They recognised that urgent care services change over time, so infrequent users may be unsure of what is available. The evenings may be a period of heightened anxiety and, therefore, people are more likely to attend urgent care at this time. They also considered it to be important that information was aimed at carers, with the carers who took part in focus group 2 describing "having a battle" to access the right help for the people they care for. Out-of-hours GP services were seldom discussed during interviews, with one respondent suggesting there may be an information gap regarding out-of-hours services.

But of course if you don't really know if you're just panicking or you don't know what you're doing, really, that's when you go [to A&E]... I don't even know really what the situation is out of hours either, so I don't know, there's a gap missing, really, a little bit of where that information might be... Yes, evenings in particular would be the panic station, I wouldn't know quite what to do. [Mother of one-year-old girl]

Information for parents of young children

Two parents described the need for specific guidance for parents with young children or those expecting a baby. This should include who to contact and where to attend if a child is unwell, and information on helping a child that has a raised temperature.

Guidelines, I suppose things like guidelines with temperatures with babies. What is actually quite urgent and what isn't urgent... [Mother of one-year-old girl]

Similarly, the mothers taking part in focus group 1 suggested it would be helpful to have information on how to decide when treatments can be given at home and when the issue warrants urgent care.

Treatment that you can do or give yourself sort of thing or whether you do then need to go straight to...[A&E] [Mother 1, focus group 1]

For like the main... the main things that toddlers go for, like young kids go for breathing [problems]. [Mother 2, focus group 1]

Simple tools appeared to be quite empowering. One mother was given a "wheeze chart" by an A&E doctor when she attended with her son who had repeated asthma attacks. This tool appeared to have a substantial impact, giving her confidence to manage her son's asthma on a day-to-day basis, knowing how much medication to give and how often, how to advise his nursery each day, and when it was necessary to go to A&E.

By following the wheeze chart, I think I'm preventing it from happening because I know what I'm doing now more so than I did before because nobody had ever given me that... I can catch it before it gets worse... if I see any of those signs I will go to A&E... that one silly little bit of paper has helped me so much. [Mother of two-year-old boy]

First aid skills training

Generally, the interviewees did not feel there were skills that could help them with their decision about whether or not they needed to go to urgent care. However, two interviewees and one of the focus groups highlighted the potential of first aid training. One respondent,

who had previous experience of first aid courses, described how they had failed to help him self-manage his swollen elbow and that the courses he had been on had not aimed to enable self-care, but focused on the care of other people who were acutely unwell.

Yes, I've done small first aid courses for work.... But that is very broad, very general... that was all for breakages, cuts and all of that, people being unconscious and stuff like that. So, nothing that I've been taught in any of those... is anything that could have taught me about internal joint issues.... Realistically, those are sort of taught for treating other people, not your own self, sort of thing. [Male patient, 45–54 years]

...do you think... the information that you get from, say, first aid for new mums, does not cover certain things then? [Interviewer]

No, it doesn't cover any of those or where you could go to even learn those things.... I mean, even if new mums know it, this is where they can go to do a first aid course once the baby is born or before the baby is born even whilst they're pregnant on maternity. [Mother of one-year-old boy]

A mother of a young child expressed her concern regarding the lack of regulation of paediatric first aid courses, and the need for paediatric first aid from a reputable source. She thought this was something that could be offered to new mums, childminders and nannies.

I think all childminders should have to do it through an organisation such as the Red Cross because, at the moment, they only have to do a council-approved paediatric first aid course to be a registered childminder. [Mother of one-year-old boy]

A mother of a young child interviewed suggested that paediatric first aid should focus on specific issues, such as breathing problems when a child has bronchiolitis. This was also discussed by the mothers in focus group 1 who were concerned about the care of young babies with fever. They also suggested that it was just as important, if not more so, for fathers to attend paediatric first aid.

If there was the first aid for fever and what to do and everything and like [role play] and all that sort of stuff. [Mother 1, focus group 1]

Yes, that would be good.... Yes, [I'd] definitely go to that. [Mother 2, focus group 1]

To be quite fair I think the dads need to go on it more than us. [Mother 3, focus group 1]

Mechanisms for receiving information in future

Participants suggested a range of formats for delivering information on how and when to self-care and how and when to use urgent care services. A number of respondents described how they would use booklets or leaflets to access information.

...on a leaflet or anything, that's fine. You can read it at your own pace, can't you, but I would say leaflets rather than A4 pieces of paper. Yes. [Female patient, 45–54 years]

However, others questioned the value of leaflets.

I certainly wouldn't keep a piece of paper about a potential broken bone. Yes, I wouldn't keep that in my file, and if I did I'd never find it at the right moment. [Mother of 11-year-old girl]

The diversity of opinions indicated the need for multiple formats to meet the preferences of different individuals. One interviewee demonstrated that individuals even have different preferences at different times.

I mean electronic is obviously very neat and you've got it on your phone... maybe, something where you could download it or PDF... I'm very technological, but I quite like paper in some senses. I'd probably have it pinned on the board at home.
[Mother of one-year-old girl]

One interviewee described how they would like to use an online tool and described a website similar to NHS Choices, seemingly unaware of its existence. The notion of being able to enter symptoms into an online resource for specific feedback seemed popular.

If there was an official NHS thing you could go on there, and you could put your symptoms in and it would give you a general thing on there, you might be able to work out from that. [Male patient, 45–54 years]

In a flow chart form where you put in, you know, [a] symptom checker. [Mother of 11-year-old girl]

Older participants in focus group 2 felt less able to interact with electronic resources or use the internet, although they acknowledged they may have family members who could help them. One young mother had been frightened by what she had read on the internet and this was now a deterrent for her using the internet for future guidance.

You see I think with me, the last time I like read something up on the internet... I went to the hospital thinking, '...she could die.' Got there, 'Oh no, you just need to give her Calpol'. [Mother, focus group 1]

Two respondents described the benefits of face-to-face communication and the reassurance gained by talking to an expert, although they understood this could be delivered through technology.

I suppose being told something face to face is a lot easier to take in, sometimes.
[Female patient, 45–54 years]

If there was a video, I don't know whether the... if literally there was a doctor that would just take video calls and they could have seen the elbow over a video link... you do feel a lot more reassured when you're talking to somebody or that person can see you. [Male patient, 45–54 years]

Healthcare professionals who were interviewed recognised that television is an important route to help disseminate healthcare information to parents of children and suggested that advertisements could help parents understand how to manage pain and fever, how and where to access urgent care when required, and what information can be provided by alternative sources of advice (e.g. pharmacists).

5. Conclusions

The document analysis used publicly available sources of information to explore the context in which urgent care services are provided and used. The analysis showed that advice on *how* and *when* the public should use urgent care services is contested and confused. The public are sometimes blamed for the pressures on urgent care services, yet service-related factors are likely to play an equal, if not greater role. Clearer and more consistent messages for the public about when to go to urgent care and where they can attend may be helpful.

This research suggests that people are frequently using urgent care services following injuries (particularly falls), and for the management of pain and common illnesses (particularly fever in children). For the majority of patients engaging in the study, the decision to attend was driven by the fact that they were 'worried and didn't know what to do' or they had sought advice from elsewhere and this had led them to an urgent care setting. Public messages implying 'better safe than sorry' appear to encourage attendance. For many, the urgent care service provided the trusted advice and reassurance sought.

Our findings highlight that many members of the public try to consider their options when seeking urgent advice and care. Many patients we spoke to had sought advice from other services (e.g. their GP surgery or NHS 111) before attending A&E. Despite a desire to use A&E services appropriately, patients and carers seem to struggle to make judgements about when a condition is 'minor' or 'serious', and at which point a symptom indicates that A&E services are required. They may also lack the knowledge and confidence they need to self-care, especially regarding over-the-counter medicines and the normal duration of illnesses and injuries. This leads to fears that something is wrong because it is not improving, when in fact it just needs more time to resolve. The range of services available, and the degree to which these services vary in the conditions they treat and the facilities they offer, is complex. In addition, these services vary between locations and change frequently. The responses received from participants in this research suggest that some were unaware of the existence of some services that could support them, such as NHS Choices or out-of-hours GP services.

The research showed that first aid education has the potential to help the general public manage their own minor illnesses and injuries. In addition, there were specific groups for whom first aid education could be targeted. These include the parents of young children, older people (particularly those at risk of falling or becoming acutely unwell after minor illnesses), people with long-term conditions including mental illness, employers and first-aiders, professional carers, and people who use substances. There is potential to expand existing first aid education and training to encompass information on the management of minor illnesses and injuries in addition to dealing with life-threatening conditions. First aid education could also be tailored to the needs of certain audiences. For example, parents of young children should learn how to manage fever, head injuries, and diarrhoea and vomiting; people with long-term conditions need to know how to stay healthy, recognise exacerbations and how to respond accordingly; first-aiders should be given confidence to manage minor problems at their place of work; and people who use substances need to be able to spot complications arising from drug use and know how to manage them appropriately. There is therefore a considerable diversity in the needs and characteristics of the different groups and so different approaches will be needed to reach them, with the first aid education being delivered through a variety of formats.

6. Recommendations

Four areas of recommendation have emerged as a result of this research, to:

1. Explore the opportunities for first aid education
2. Target first aid education to the needs of specific groups
3. Help the public understand when and where to seek urgent health advice and care.
4. Promote self-care, resilience and prevention.

6.1 Explore the opportunities for first aid education

This research highlights opportunities to develop the content and delivery of first aid education. There is a specific opportunity to consider how to promote the management of minor illnesses and minor injuries to the general public. This would include helping people to understand the timescales for the natural history of common conditions and recognise when illnesses and injuries have become urgent situations. In addition, we would promote the practice of taking painkillers before attending A&E, especially for parents to reduce pain and fever in children.

6.2 Target first aid education to the needs of specific groups

There is an opportunity to address the needs of specific population groups in developing first aid education. The groups identified in the research were patients with long-term conditions (including mental illness), parents of young children, older people, people who use substances, employers and work-based first-aiders, professional carers (in home or community settings), and members of the general public who have self-limiting infections and minor injuries. Some targeted first aid education (e.g. head injury guidance for parents of young children) may require additional work to develop the evidence base and the recommendations for first aid responses. We recognise that there may be other potential recipients of targeted first aid education not identified in this research – for example, young informal carers.

6.3 Help the public understand when and where to seek urgent health advice and care

First aid educators could play a role in supporting public understanding of the complexity of the urgent care system through using a range of media and other channels to communicate with members of the wider public. This would support people to navigate the healthcare system successfully at times of need, and enable the public to access the right type of care at the right point in time, through understanding the full range of support options available (including where there are local arrangements that provide alternatives to A&E). Recommendations in this area may include the development or refinement of public guidance on how to recognise when illnesses and injuries have become conditions that need urgent care.

6.4 Promote self-care, resilience and prevention

First aid educators have the opportunity to play a role in supporting the public to stay healthy and independent for longer, by helping them to manage long-term conditions and enabling them to provide self-care at home for minor illnesses and injuries. This should be done in collaboration with the relevant health professional groups and bodies to encourage clear and consistent advice across agencies, to promote self-care, deliver first aid education courses, and signpost to other resources.

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Appendix 1: Methodology

This section provides more detail on the methods used during the different component studies within this project. Ethical approval for the survey of people using urgent care settings, the interviews with healthcare professionals and patients/carers, and the focus groups was given by the Research Ethics Committee of the University of the West of England, Bristol (Reference: HAS.16.03.115), and from the West Midlands (South Birmingham) NHS Research Ethics Committee (Reference 16/WM/0235), together with approval from the Health Research Authority.

Document analysis

An investigation of publicly available documents was conducted to assess the factors that influence delivery and use of urgent care services. Documents that are not routinely examined, for example patient literature, public documents, publicity material and internal health organisational policies, were collected and analysed using a technique known as document analysis.

As explained by Bowen (2009), document analysis is a systematic process to review and interpret printed and electronic material (that has been recorded without a researcher's intervention), to generate new knowledge. Such documents can be considered as 'social facts' (Atkinson and Coffey, 2004), and their analysis can reveal useful information about the context behind people's observed actions and self-reported motivations. When used as a research tool in conjunction with surveys, interviews and focus groups, analysis of documents can add an informative layer that can be used to challenge or support observed practice. We included this analysis to: a) support the generation of an overview of urgent care decision-making processes from studies using different methods (sometimes referred to as 'triangulation'); and b) highlight contextualising themes that may be harder to identify using traditional methods such as surveys and interviews.

The process of conducting the document analysis followed five stages:

1. Locating and identifying sources

Documents were collected between January 2016 and October 2016. All sources that were potentially relevant were considered, including:

- documents already known to the research team
- documents collected in research settings during component studies 2 and 3
- documents encountered by the research team during the analysis period
- documents referred to by healthcare professionals during staff interviews.

2. Superficial examination

Each document was reviewed initially by one researcher within the process of including/excluding a source. Superficial examination consisted of each document being read several times to consider its relevance to the topic and its overall suitability for inclusion in more detailed analysis and interpretation.

3. Allocating sources to domains

Sources that remained in the process at this stage were allocated to one of four domains:

Domain 1: public messages about using urgent care

Domain 2: clinical guidelines and policies for healthcare professionals delivering urgent care

Domain 3: service delivery policies relating to the organisation of urgent care services

Domain 4: social media/media

Documents collected within the social/media domain (D4) were considered for inclusion only if they were produced or published during Jan–Oct 2016, in order to reflect the experiences of members of the public using urgent care services at the time empirical data collection took place.

4. Thorough examination and 5. Coding and interpreting

Having obtained documents adequately reflecting each of the four domains, a detailed analysis was begun with a thorough examination and interpretation of each source, conducted by one researcher. Documents were inspected for recurring themes, phrases and key words (examination) before consideration was given to the meaning (interpretation). This was achieved by applying codes to text and giving attention to conflicting accounts, inconsistencies and possible alternative interpretations. A proforma was used to record the assessment of each document. Proformas enabled comparison with other examples within the domain, and so the analysis was iterative and cyclical.

Between January and October 2016, 67 documents were initially allocated to domains. Six documents collected early in the study and allocated to domains were eliminated from the analysis at a later point; four because the full source could no longer be obtained online, and two because the documents were due to be updated and the date had expired. Therefore, a total of 61 documents were included in the document analysis (Table 1) and inspected for recurring themes, phrases and key words, and coded. The number of documents in each domain were: Domain 1= 22, Domain 2 = 12, Domain 3= 11 and Domain 4= 16. For quality assurance, one-third of documents (n=20) were independently reviewed by two other members of the research team who each received ten documents for analysis. Conflicting observations were resolved by discussion. Concordance proved to be high, with consistency in the interpretation of these sources between researchers.

Table 1: Sources used in the document analysis

| No. | Domain | Document ¹ | Date ² |
|-----|--------|--|-------------------------------|
| 1 | D1 | Avoiding unnecessary trips to A&E – Bristol Community Health webpage advising public about which conditions can be treated and the most appropriate services to use | Published 4 January 2015 |
| 2 | D1 | Bristol Royal Infirmary Emergency Department webpages – advice published on University Hospitals Bristol NHS Foundation Trust’s website highlighting the urgent care services available in Bristol with contact numbers | Accessed 30 March 2016 |
| 3 | D1 | ChooseWell webpage – national campaign designed to assist the public in choosing healthcare services and provide information about common conditions | Accessed 30 March 2016 |
| 4 | D1 | ChooseBetter webpage – NHS campaign started in Leicester but adopted throughout UK on appropriate A&E use | Accessed 10 May 2016 |
| 5 | D2 | Draft guidelines for safe staffing in A&E departments – published for consultation by National Institute for Health and Care Excellence | Published January 2015 |
| 6 | D2 | South West Ambulance Trust Appropriate Care Pathway Policy – to support staff in providing care as an alternative to conveying to emergency care | Published 19 November 2014 |
| 7 | D2 | Royal College of Emergency Medicine Triage | Published |

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|----|----|--|-----------------------------|
| | | Position Statement –defining the activities of triage | April 2011 |
| 8 | D2 | Clinical Presentation Guidelines for use in Minor Injury Units – Published by Worcester Primary Care Trust | Published April 2013 |
| 9 | D2 | Transforming Urgent and Emergency Care: making better use of Community Pharmacies – Pharmaceutical Services Negotiating Committee publication | Unknown |
| 10 | D2 | Access to Children’s Emergency Department – Information for GPs, published by NHS Bristol | Unknown |
| 11 | D2 | Urgent Care Services Bristol and South Gloucestershire – published by NHS Bristol | Unknown |
| 12 | D2 | Enhanced Service Specification for GPs – Unplanned Admission Direct Enhanced Service, published by NHS England | Published 23 March 2015 |
| 13 | D2 | Support for urgent care – information for Bristol GPs, published by Bristol Community Health | Unknown |
| 14 | D2 | Urgent Care Update Report – Bristol Clinical Commissioning Group | Published April 2016 |
| 15 | D4 | Online News articles relating to A&E/urgent care use – BBC News | Accessed 12 May 2016 |
| 16 | D4 | Mumsnet chat discussion – thread 2658501 | Accessed 10 June 2016 |
| 17 | D1 | Guidance on Norovirus infections – produced by Public Health England for A&E Departments | Unknown |
| 18 | D1 | Think ABC before A&E (Green poster)– NHS campaign document placed in North Bristol NHS Trust A&E department | Unknown |
| 19 | D1 | Injured or feeling unwell? We’re here to help – NHS leaflet | Accessed February 2016 |
| 20 | D1 | Parent’s guide to head injury – information for parents attending the children’s emergency department | Unknown |
| 21 | D1 | Pulled elbow – information for parents attending the children’s emergency department | Published 10 September 2012 |
| 22 | D1 | Sprained ankle – information for parents attending the children’s emergency department | Published August 2008 |
| 23 | D1 | Parent’s guide to soft tissue injuries – information for parents attending the children’s emergency department | Unknown |
| 24 | D1 | Parent’s guide to diarrhoea and vomiting – information for parents attending the children’s emergency department | Unknown |
| 25 | D3 | House of Commons Briefing Paper – A&E Statistics | Published 17 July 2015 |
| 26 | D3 | A&E attendance for children and young people – published by Newcastle & Gateshead Clinical Commissioning Group | Published June 2015 |
| 27 | D3 | National audit office report on emergency admissions – published by Department of Health | Published October 2013 |
| 28 | D3 | Emergency Departments Case for change – London Health Programme document to plan future urgent care services | Published February 2013 |
| 29 | D1 | This summer Think! Why A&E? – Poster designed by Blackpool Clinical Commissioning Group | Published 2014 |
| 30 | D4 | News article covering the doctors’ strike – published | Accessed |

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| | | in the Daily Mail | 28 April 2016 |
| 31 | D4 | Mumsnet chat discussion: stitches – thread appearing on site | Accessed 16 August 2016 |
| 32 | D3 | What's going on in A&E? – Publication by the Kings Fund | Published 8 April 2014 |
| 33 | D3 | Time to act: survey results on the co-location of GP services and A&E – publication by Royal College of Emergency Medicine | Published May 2015 |
| 34 | D2 | Operations Plan – South West Ambulance Service NHS Trust | Published April 2014 |
| 35 | D4 | News article: NHS crisis plan to cancel operations and appointments as winter draws in – Daily Telegraph | Published August 2016 |
| 36 | D4 | Mumsnet chat discussion – A&E time-waster | Accessed 26 August 2016 |
| 37 | D4 | A&E delays reach new record level – BCC news article | Accessed 14 April 2016 |
| 38 | D4 | Mumsnet chat discussion – husband to A&E | Accessed 11 July 2016 |
| 39 | D4 | Mumsnet chat discussion – WWYD (What would you do) A&E hurt ankle | Accessed 14 September 2016 |
| 40 | D1 | Think ABC before A&E (Orange poster) – NHS campaign document placed in University Hospitals Bristol NHS Foundation Trust A&E department | Unknown |
| 41 | D1 | Over 60? NHS poster | Unknown |
| 42 | D1 | Website description of A&E and minor injuries unit services – published by North Bristol NHS Trust | Accessed 30 March 2016 |
| 43 | D1 | Get the right care first time – publication by Nottingham Clinical Commissioning Group | Accessed 30 March 2016 |
| 44 | D1 | Urgent care services in England – published on NHS Choices website | Unknown |
| 45 | D1 | Winter health advice – published on NHS Choices website | Accessed 30 March 2016 |
| 46 | D1 | F.A.S.T public campaign to help recognize strokes – published by NHS Choices | Unknown |
| 47 | D1 | Persistent Cough – publication by NHS Choices to encourage consultation for coughs persisting longer than three weeks | Unknown |
| 48 | D4 | Mumsnet chat discussion – AIBU (Am I being unreasonable) Tingly boy - 131016 | Accessed 25 September 2016 |
| 49 | D3 | Triage and minimizing crowding in Emergency Departments: Effectiveness Matters – publication by the Centre for Reviews and Dissemination, York | Published Spring 2015 |
| 50 | D3 | New models of Out of Hours care by General Practice – news story from UK Government | Published 4 December 2014 |
| 51 | D3 | High quality care for all – NHS England summary of how to support A&E in England to meet targets on waiting times | Accessed 30 March 2016 |
| 52 | D3 | NHS England A&E Gateway Plan – NHS England proposal to improve A&E performance | Published 9 May 2013 |
| 53 | D1 | A&E Won't kiss it better – NHS advertisement to inform the public on appropriate service use produced by Surrey | Published 2016 |

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|----|----|---|-----------------------------|
| | | (Sutton) Clinical Commissioning Group (webpage) | |
| 54 | D2 | Five stepped approach to Triage – Manchester Triage document | Unknown |
| 55 | D4 | Report on A&E – published in the Guardian | Accessed 10 August 2016 |
| 56 | D3 | In my opinion by Chris Ham (Chief Executive of the Kings Fund) –published in the British Medical Journal | Published 2015 |
| 57 | D4 | Article on people attending A&E inappropriately – published by the Daily Mail | Published 9 March 2016 |
| 58 | D4 | Mumsnet chat discussion – Mum to A&E | Accessed 20 June 2016 |
| 59 | D4 | News report on A&E misuse blamed for hospital black alert – BBC News | Published 5 January 2016 |
| 60 | D4 | Bristol hospital black alert – Bristol Post reporting locally on hospital capacity | Published 5 January 2016 |
| 61 | D4 | Call demand over Easter Bank Holiday weekend – press release by South West Ambulance Service NHS Trust | Accessed 30 March 2016 |

¹ Further source information may be available from the authors on request

² The date under 'Published' is the date of publication of a document that was downloaded, and under 'Accessed' it is the date that a web page was viewed.

Survey of people using urgent care services

The survey aimed to enhance understanding of who attends A&E, their reasons for attending and their route into the urgent care system. This information can then be used to consider the potential role of first aid education to help selected groups of patients make informed decisions regarding the use of urgent care services.

We surveyed patients attending urgent care settings across four sites in Bristol: the adult and children's A&Es at University Hospitals Bristol NHS Foundation Trust; the A&E at North Bristol NHS Trust; and the walk-in centre at South Bristol Urgent Care Centre. We recruited a convenience sample of patients from those booking in for urgent care during the periods when the researcher was visiting that setting. Surveys were completed during three visits to each setting. Visits varied by time of day and day of the week. Patients were made aware of the study by flyers and information available at the A&E reception desk. The text on the poster and flyers was translated into the top five languages used by residents in Bristol who do not have English as their first language (Polish, Somali, Urdu/Punjabi, Arabic and Romanian). Patients were approached only after triage, once urgent care had been provided, and when advised it was appropriate to do so by the clinical staff. Patients were reassured that participation was voluntary and would neither influence the care received nor delay their treatment or affect their place in the queue. Parents of children under 16 years were asked to complete the survey on behalf of their child. Carers of adult patients unable to complete the survey independently were asked to complete the survey on behalf of the patient. Survey participants were asked to consent to take part at the beginning of the survey.

Patients were asked to complete a short paper-based survey (Appendix 2) exploring their reasons for attending the urgent care setting on that day and their expectations of what would happen to them as a result of their attendance. The survey questions were designed in collaboration with staff in the emergency departments and the questionnaire was designed so that the majority of responses could be recorded by ticking boxes to ease completion. Patients were able to complete the survey independently or with support from the researcher. The survey was available in English. Telephone translation services were

available in the departments if required. No patient-identifiable information was collected. One question at the end of the survey asked if the participant would be happy to take part in a more detailed interview. In this situation, contact details were collected for the participant. Data from the surveys were entered into a Microsoft Excel spreadsheet. A 10 per cent sample were double data entered to check accuracy. Data were analysed using SPSS software to produce descriptive statistics.

A total of 176 people completed the survey. Sixty-four surveys (36.4 per cent) were completed by parents on behalf of their child, 101 surveys (57.4 per cent) were completed by adult patients and 11 surveys (6.3 per cent) were completed by the carer of an adult patient. Further details are provided in Table 2.

Table 2: Sources of data from survey study, by setting and category of analysis

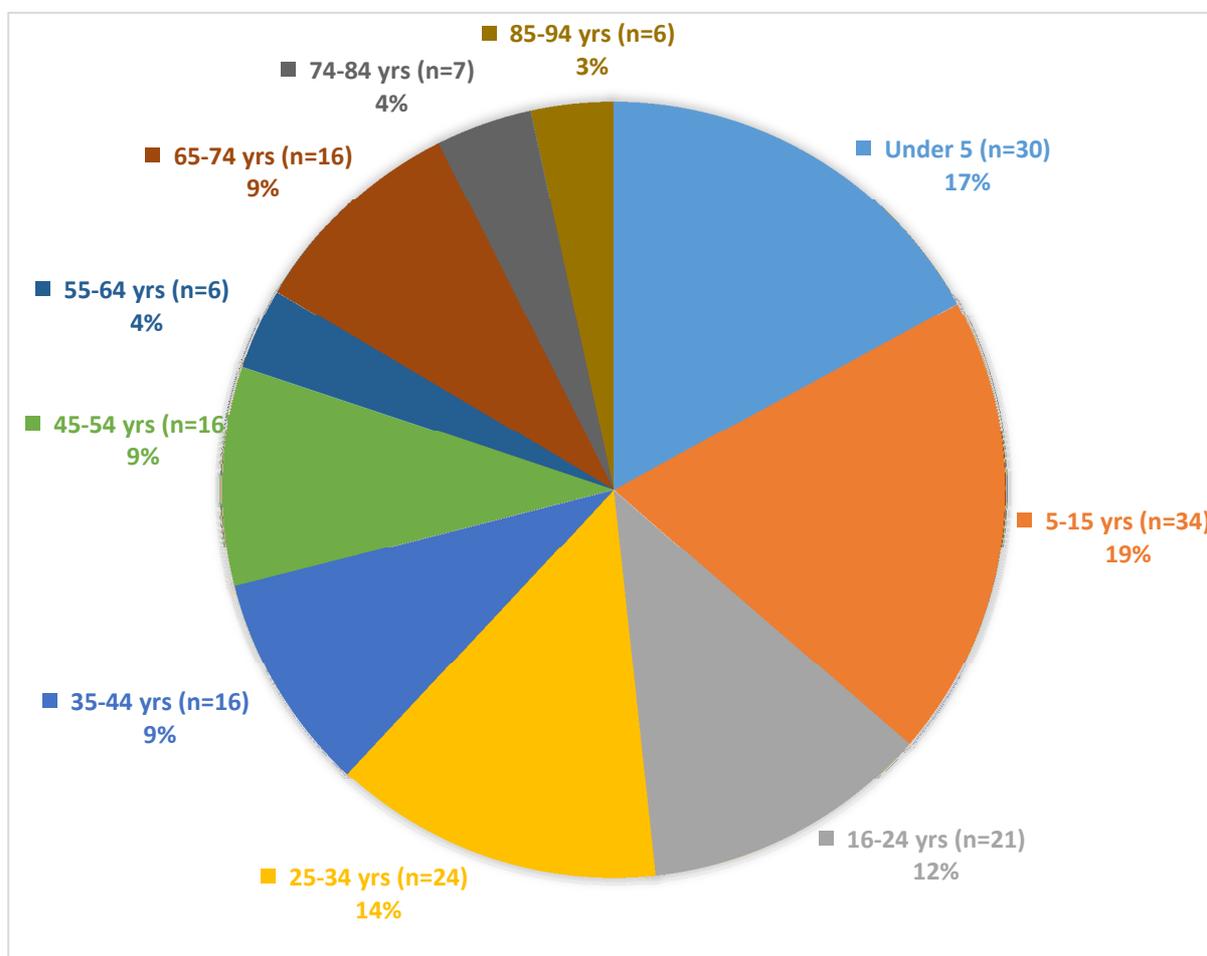
| Source of data | Parents of child patients | Adult patients | Carers of adult patients | Total | % |
|-------------------------------------|----------------------------------|-----------------------|---------------------------------|--------------|--------------------------|
| Children's A&E department | 43 | 0 | 0 | 43 | 24.4 |
| Adult A&E department | 0 | 38 | 5 | 43 | 24.4 |
| Adult and children's A&E department | 9 | 48 | 5 | 62 | 35.2 |
| Urgent care centre | 12 | 15 | 1 | 28 | 15.9 |
| Total | 64 | 101 | 11 | 176 | 99.9%¹ |

¹ Percentages do not total 100 due to rounding

Age of patients in the survey

In this survey a child is defined as a patient under the age of 16 years. Sixty-four of the questionnaires were completed for children (36.4 per cent), 83 respondents were working-age adults of 16–64 years (47.2 per cent), and 29 were over the age of 65 years (16.5 per cent), see Figure 66.

Figure 6: Age distribution of all survey respondents

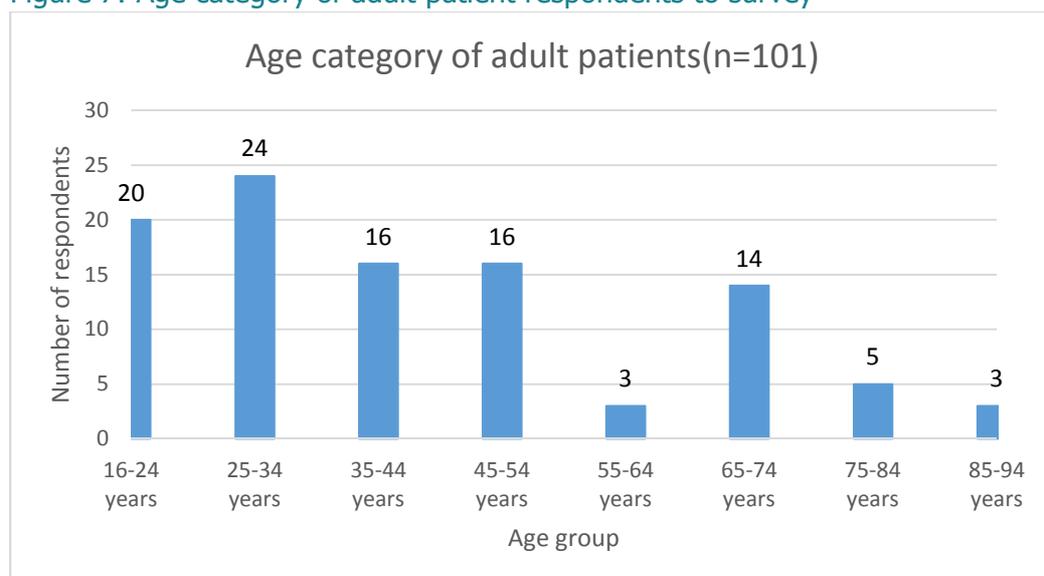


Note: Each segment of the pie chart is labelled with the age range for that segment, the number of completed questionnaires included in that segment, and the proportion of all questionnaires that the segment represents.

For children being taken to urgent care services, the largest group of child attendees were children under the age of 1 year (13/64, 20.3 per cent), and 46.9 per cent of attendees (30/64) in this sample were under the age of 5 years. The mean age of all child attendees for whom questionnaires were completed was 5.9 years. For adult patient respondents, 79/101 (78.2 per cent) were working-age adults aged 16–64 years (

Figure 7). For the 11 patients who were with a carer, 10/11 (90.9 per cent) were aged 55 years or older. One patient with a carer was in the 16–24-year age category.

Figure 7: Age category of adult patient respondents to survey



The survey was a convenience sample and was not intended to be representative of the population of Bristol. However, to help set the survey results in context, the Joint Strategic Needs Assessment for Bristol (Bristol City Council, 2016) estimates that in 2016 the proportion of the Bristol population under the age of 16 years was 18.6 per cent; the proportion aged 16–64 years was 68 per cent; and the proportion aged over 65 years was 13.2 per cent. Our convenience sample therefore has over-sampled children and older people.

Sex of the patients in the survey

The majority of respondents were male (110/176, 62.5 per cent). Boys and men are known to attend urgent care due to injuries more frequently than girls and women (Table 3).

Table 3: Sex of survey respondents

| Sex of patient | Child patients | Adult patients | Adult patients with carers | Total | % |
|----------------|----------------|----------------|----------------------------|-------|-------|
| Male | 42 | 62 | 6 | 110 | 62.5 |
| Female | 22 | 39 | 5 | 66 | 37.5 |
| Total | 64 | 101 | 11 | 176 | 100.0 |

Ethnic group of patients in the survey

People completing the survey were asked to state their ethnic group. Almost all (172) of the respondents were happy to provide their ethnic group (Table 4), and 85.5 per cent (145) were from white ethnic groups and 15.7 per cent (27) were from non-white ethnic groups. This is similar to proportions reported in the Joint Strategic Needs Assessment for Bristol, which estimates 16 per cent of the population were from black and minority ethnic groups (Bristol City Council, 2016).

Table 4: Ethnicity of survey respondents

| Ethnicity | Child patients | Adult patients | Adult patients with carers | Total | % |
|---|-----------------------|-----------------------|-----------------------------------|--------------|--------------|
| White British | 42 | 73 | 10 | 125 | 71.0 |
| White Irish | 0 | 1 | 0 | 1 | 0.6 |
| Any other White background | 10 | 8 | 1 | 19 | 10.8 |
| Mixed – White and Black Caribbean | 0 | 0 | 0 | 0 | 0.0 |
| Mixed – White and Black African | 3 | 0 | 0 | 3 | 1.7 |
| Mixed – White and Asian | 0 | 3 | 0 | 3 | 1.7 |
| Any other mixed background | 0 | 0 | 0 | 0 | 0.0 |
| Chinese or other ethnic group – Chinese | 2 | 0 | 0 | 2 | 1.1 |
| Chinese or other ethnic group – Other | 0 | 0 | 0 | 0 | 0.0 |
| Black or Black British – Caribbean | 1 | 2 | 0 | 3 | 1.7 |
| Black or Black British – African | 3 | 4 | 0 | 7 | 4.0 |
| Other Black background | 2 | 0 | 0 | 2 | 1.1 |
| Asian or Asian British – Indian | 0 | 2 | 0 | 2 | 1.1 |
| Asian or Asian British – Pakistani | 0 | 1 | 0 | 1 | 0.6 |
| Asian or Asian British – Bangladeshi | 0 | 1 | 0 | 1 | 0.6 |
| Other Asian background | 0 | 3 | 0 | 3 | 1.7 |
| Prefer not to say | 0 | 0 | 0 | 0 | 0.0 |
| Question not answered | 1 | 3 | 0 | 4 | 2.3 |
| Total | 64 | 101 | 11 | 176 | 100.0 |

Long-term conditions

The people completing the survey were asked if they had a physical or mental health condition or illness lasting, or expected to last, for 12 months or more. Thirty-eight (21.6 per cent) respondents reported having a long-term condition (

Table 5). In the 2011 Census the proportion of the Bristol population living with a long-term condition or disability was 16.7 per cent (Bristol City Council, 2012).

Table 5: Respondents reporting having a long-term condition

| Long-term conditions | Child patients | Adult patients | Adult patients with carers | Total | % |
|-------------------------------|-----------------------|-----------------------|-----------------------------------|--------------|--------------|
| Yes | 9 | 22 | 7 | 38 | 21.6 |
| No | 52 | 74 | 4 | 130 | 73.9 |
| Don't know | 1 | 1 | 0 | 2 | 1.1 |
| Prefer not to say/no response | 2 | 4 | 0 | 6 | 3.4 |
| Total | 64 | 101 | 11 | 176 | 100.0 |

Interviews with people using urgent care services

The aim of component study 4 was to help identify patient groups who attend A&E and describe their reasons for doing so in terms of clinical condition, behavioural and environmental factors through the completion of in-depth interviews. Potentially eligible participants were those completing the urgent care user survey. These participants were asked if they would be interested in taking part in a longer discussion regarding their visit to the emergency department. Patients who agreed to be contacted gave a preferred method of contact (either phone or email). A researcher then attempted to contact the patient. The opportunity to take part in a telephone interview lasting up to 30 minutes was explained. Those patients agreeing to take part provided verbal consent and a topic guide was used to inform the interview (

Figure 8). The guide was flexible and sought to explore three key areas: a) the context in which people use urgent care services; b) 'typical' health events that may result in attendance at urgent care; and c) information that may support decisions on future use of urgent care.

Interviews were audio-recorded when agreed. All transcripts were fully anonymised and verbatim transcription was conducted by an independent transcription service. Transcripts were checked for errors and were read and re-read for familiarity prior to analysis. Qualitative analysis software (NVivo 10, QSR, Southport, UK) was used to manage all qualitative data. All interviews were analysed by one researcher and a subset shared with all members of the research team for double coding. Analysis followed a pragmatic thematic analysis (Braun and Clarke, 2006) and techniques were based on the principles of constant comparison (Strauss and Corbin, 1998). Because the interviews with service users and the focus groups explored the same broad dimensions, analysis of both components were encompassed within the same coding framework. Quotes were chosen to illustrate the themes and sub-themes identified.

From the 176 respondents who completed the survey, 23 expressed an interest in participating in an in-depth interview study. Of those initially agreeing to be contacted, 11 were contactable later in the study and took part in an interview. Characteristics of the participants who completed interviews are described in Table 6. Interviews lasted between 8 and 26 minutes.

Figure 8: Topic guide for interviews with people using urgent care

Helping people who use A&E and other urgent care services Interview topic guide

Pre interview

Thank the participant for agreeing to take part in the study – recap purpose of the study, offer opportunity for questions. Take consent and confirm that the interview will be recorded. Provide research team details and emphasise how to withdraw from the study if necessary.

The interview

Interviews will vary depending on patient / carer experience and health needs, but conversations should include the three main areas of discussion below adapted as required.

Opening questions/understanding the context

- Are they the patient or someone providing care support?
- Do they think of themselves as a generally healthy person?
- Are they someone who has had to use urgent care services a lot?

This health event:

- What was the health event that led them to use urgent care?
- How did they know something was wrong? What happened first?
- What made them feel that they needed to go to A&E/MIU/WIC?
- Did they speak to anyone for advice before going to A&E/MIU/WIC? Who? What advice did they seek? If not, why not?
- Did they visit anyone for advice before going to A&E/MIU/WIC? Where? Why there? What happened? If not, why not?
- What happened at A&E/MIU/WIC? Was that what they thought would happen? What did they want from their visit?
- How did they feel about the advice they were given?
- Looking back at that visit, has the experience changed the way they feel about their health or about urgent care services?

In the future:

- If they were in the same situation, is there information or advice that would be helpful to know before having to decide to go to A&E/MIU/WIC?
- Are there any practical skills that they might have found helpful to know before having to decide to go to A&E/MIU/WIC?

Conclude discussion

- Is there anything that we haven't mentioned that you would like to tell us about how you what might help you cope better before having to go to urgent care?
- Thank participant and offer shopping voucher as a thank you for their participation.

Table 6: Characteristics of participants completing telephone interviews

| No. | Sex of patient | Age of patient (years) | Interviewee | Reason for attendance |
|-----|----------------|------------------------|-----------------|-----------------------------------|
| 1 | Male | 35–44 | Patient | Fell off bike |
| 2 | Male | 35–44 | Patient | Possible broken wrist |
| 3 | Female | 45–54 | Patient | Problem with blood flow to foot |
| 4 | Male | 35–44 | Patient | Pain |
| 5 | Female | 45–54 | Carer (husband) | Fall |
| 6 | Female | 75–84 | Patient | Fell onto face |
| 7 | Male | 45–54 | Patient | Infected elbow |
| 8 | Male | 1 | Parent (mother) | Fall |
| 9 | Female | 11 | Parent (mother) | Possible broken finger |
| 10 | Female | 1 | Parent (mother) | High temperature, kidney problems |
| 11 | Female | 2 | Parent (mother) | Asthma |

Focus groups

The aim of holding focus groups was to explore the emerging findings of the other component studies and validate or refute them. Participants were intended to be members of the public who may not have recently visited A&E, but who may have past experience of attendance. Participants were therefore intended to be future potential users of urgent care services.

The focus groups were selected to reflect the potential beneficiaries of first aid education identified from the previous component studies. We used established networks to identify groups of potential users who currently meet routinely. This had the advantage of exploring the views of a group of people who were already known to each other and therefore more likely to be comfortable expressing their views in front of other people already known to them.

Focus groups were intended to have up to eight participants. Potential participants were provided with information about the study and given the opportunity to ask questions before deciding whether or not to take part. Focus groups were planned where possible to take part in the setting where the group usually meet. Consent to participate was sought prior to the discussion, which was facilitated with a topic guide (Figure 9), and were audio-recorded where possible and permission agreed. Audio files were transcribed verbatim and analysed thematically using the same approach as in the service user interview study. Quotes were selected to illustrate themes and sub-themes identified through analysis.

Figure 9: Topic guide used for focus groups

Helping patients and carers who use A&E and other urgent care services **Focus group topic guide**

Pre focus group

Thank the participants for agreeing to take part in the study – recap purpose of the study, offer opportunity for questions. Take consent and confirm that the focus group will be recorded. Provide research team details.

The focus group

The focus group will vary depending on participants' experience of urgent care services and their health needs / needs of those they care for. Conversations should include the three main areas of discussion below adapted as required.

Opening questions / understanding the context

- Recognition that they may be patients or carers themselves, and have a range of health needs
- Explore range of experience of using urgent care services within the group.

Previous experience:

- When someone is poorly - How do they know whether or not they need to go to A&E/MIU/WIC?
- Do they usually speak to anyone for advice before going to A&E/MIU/WIC? Who? What advice did they seek? If not, why not?
- Do they usually visit anyone for advice or treatment before going to A&E/MIU/WIC? Where? Why there? What happens? If not, why not?
- What tends to happen at A&E/MIU/WIC? Is that what they thought would happen? How did they feel about advice they were given?

In the future:

- If they, or other people, were in the same situation, is there information or advice that would be helpful to know before having to decide to go to A&E/MIU/WIC?
- Are there any practical skills that they or someone in their situation, might have found helpful to know before having to decide to go to A&E/MIU/WIC?
- Are there other groups of people that they think the British Red Cross could help in addition to / instead of, themselves?

Conclude discussion

- Is there anything that we haven't mentioned that you would like to tell us about how you what might help you cope better before having to go to urgent care?
- Thank participants and offer opportunity to enter a prize draw for a shopping voucher as a thank you for their participation.

Two focus groups were undertaken. The first was with a group of five mothers who were regular attenders at a children's centre young parents' group. The group was facilitated by two members of the research team and two of the young parents' group facilitators. The second focus group was comprised of older patients and carers who were part of an urgent care users patient group. This focus group was facilitated by one member of the research team who was already known to the group members.

Interviews with healthcare professionals

The aim of this study was to understand the views of healthcare professionals regarding the potential for first aid education to support people to make informed decisions about using urgent care services, with a particular focus on those populations who were considered to use urgent care services frequently.

In recognition of the pressures placed upon healthcare professionals during their working day and the consequent limitation on their ability to contribute to research, we used a qualitative method described as a 'conversation with a purpose' (Burgess, 1988). Using this technique, the principles of qualitative interviews can be applied; however, conversations with a purpose use a focused set of questions, enabling busy professionals and practitioners to contribute to research by including their opinions in a short interview, while not excluding their participation by requiring them to take part in a long interview.

We identified potentially eligible participants using three approaches: a) via gatekeepers; b) via snowballing; and c) using professional contacts within the research team. The primary method of recruitment was via members of the study's steering group, who acted as gatekeepers. Steering group members were approached and asked to suggest names of individuals for us to contact, and to support introduction to the individuals where necessary. In addition, members of the research team established relationships with staff in the urgent care settings across the city during the study. For community-based healthcare professionals, the research team drew on their own network of contacts to identify gatekeepers and potential participants. Having completed the interviews, participants were asked if there were any of their colleagues they believed would be able to offer an opinion for our study. Towards the end of recruitment, the research team assessed the interviews to date and identified gaps in terms of under-represented job roles/grades of staff. Gatekeepers and our own contacts were used to purposively select individuals from under-represented professional groups.

Interviews were conducted by two researchers who worked independently. A topic guide (Figure 10) was devised by the research team in collaboration with the study steering committee and the Red Cross. The topic guide was flexible and adapted and refined by the researchers in some instances to test emerging themes and/or to identify contrasting accounts in order to add strength to the analysis. The topic guide covered information regarding the role of the interview (to obtain context), views on frequently attending patient groups, and asked for suggestions on areas for first aid education. Interviews were audio-recorded where possible and agreed, and contemporaneous notes were taken where audio-recording was not used. Audio-recorded interviews were transcribed verbatim unless particularly short, in which case they were analysed by listening to the recording supported by the notes from the interview. All interviews were coded by one researcher with a quarter of the interviews being double coded by a second researcher to ensure the reliability of the analysis. A thematic analysis (Braun and Clarke, 2006) was conducted. Techniques were based on the principles of later versions of grounded theory (Strauss and Corbin, 1998) to gain deeper understanding of the issues that healthcare professional believed to be important in relation to public use of urgent care, and the areas they identified as important

for first aid intervention. Themes identified early in the analysis were fed in to subsequent interviews as the researcher attempted to identify deviant cases and contrasting viewpoints to ensure rigour within the analysis. Verbatim quotes were selected (and anonymised if necessary) to illustrate and represent the themes identified.

In total, 23 healthcare professionals were interviewed between June and November 2016; 14 staff working in acute hospital A&E settings and 9 staff working in community or walk-in centre settings (Table 7). Seventeen of the 23 interviews were audio-recorded. Fourteen were transcribed verbatim, representing the views of 15 participants (one recording included two healthcare professionals interviewed at the same time). Nine interviews were analysed by listening to the recording and using notes taken during the interview.

Table 7: Participants by job title and occupational setting

| | Job title/grade | Occupational setting | Patient population served |
|----|-----------------------------------|-----------------------------|----------------------------------|
| 1 | Paramedic | Community | Adult and children |
| 2 | Paramedic | Community | Adult and children |
| 3 | General Practitioner | Community | Adult and children |
| 4 | General Practitioner | Community | Adult and children |
| 5 | Nurse Band 8 | Walk-in centre | Adult and children |
| 6 | Nurse Band 8 | Walk-in centre | Adult and children |
| 7 | Nurse Band 7 | Walk-in centre | Adult and children |
| 8 | Nurse Band 6 | A&E | Adult and children |
| 9 | Emergency Nurse Practitioner | A&E | Adult and children |
| 10 | Emergency Nurse Practitioner | A&E | Adult and children |
| 11 | Nurse Band 5 | A&E | Adult and children |
| 12 | Reception Lead | A&E | Children |
| 13 | Nurse Band 5 | A&E | Children |
| 14 | Nurse Band 5 | A&E | Children |
| 15 | Nurse Band 6 | A&E | Children |
| 16 | Junior Doctor | A&E | Adult and children |
| 17 | Consultant Doctor | A&E | Children |
| 18 | Consultant Doctor | A&E | Children |
| 19 | Nurse Matron Band 8 | A&E | Adult and children |
| 20 | Consultant Doctor | A&E | Adult |
| 21 | Drug and Alcohol Support Worker | Community | Adult |
| 22 | Senior Mental Health Practitioner | Community | Adult |
| 23 | Junior Doctor | A&E | Adult |

Figure 10: Topic guide for interviews with healthcare professionals

Supporting Attendance through First aid Education (SAFE) study

Interview topic guide for HCPs discussion with a purpose

Pre interview

Thank the participant for agreeing to take part in the study – recap purpose of the study, offer opportunity for questions. Take consent and confirm that the interview will be recorded. Provide research team details and emphasise how to withdraw from the study.

The discussion

The conversations with participants will last between 10 and 30 minutes. The three categories below have been designed to obtain data from those participants who are able to offer less of their time, to cover the main purposes of the discussion. These topics will be expanded upon if time allows during longer conversations.

Context

- Participant background e.g. job title, length of time qualified/working at the current setting.
- Could you tell me about the department/setting including how patients arrive via referral or self-presentation?

Patients

- What types of presentations are common to the Department/setting?
- What factors/issues do you believe contribute to decision-making to attend for these conditions?

First aid interventions

- In your opinion, which of the illnesses/injuries that you frequently experience in this setting could benefit from interventions such as first aid/self-care education and skills?
- To what extent do you believe first aid/self-care education would alter attendance frequency and habits at (various) urgent care settings?

Conclude discussion

- Anything else?
- Thank participant and check if they can nominate colleagues who may be interested in participating.

Appendix 2: Survey form

This form was used for adult patients. Amended versions of these questions were used for parents of child patients and for carers of adult patients.



The SAFE Study (Supporting Attendance through First aid Education)

Adult Patients' Survey

1. I understand that I am being invited to take part in a survey as part of a research study. I understand that taking part is voluntary.
2. I understand that the information I give will be kept safe and my contribution will be confidential.
3. I understand that data collected during the study may be looked at by individuals from [Bristol Royal Hospital for Children / Bristol Royal Infirmary / North Bristol NHS Trust] or from regulatory authorities such as the University/NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to the data collected today. This data will not contain my name/name of the patient or any other identifying details.

4. Do you consent to taking part in this survey?

Yes

Q1) Are you? (*tick only one*)

- Male
- Female

Q2) How old are you? (*tick only one*)

- 16–24 years
- 25–34 years
- 35–44 years
- 45–54 years
- 55–64 years
- 65–74 years
- 75–84 years
- 85–94 years
- 95 years or more

Q3) What health problem has brought you here today?

(*tick all that apply*)

- I have a temperature / fever
- I have a rash / skin condition
- I have a breathing problem (e.g. coughing, wheezing)
- I have a tummy problem (e.g. vomiting, diarrhoea)
- I had a seizure or fit
- I am in pain
- I have an infection / cold or flu-like illness
- I hit my head / knocked myself out
- I have a problem with my mental health
- I have a heart problem (e.g. pain or rhythm problem)
- I have a burn or scald
- I fell and hurt myself
- Another sort of accident (*what?*) _____
- Another problem (*what?*) _____

Q4) Why did you come here today? (*Please tick all that apply*)

- I was worried and didn't know what to do
- I thought it was serious
- I was told to come (*by whom?*) _____
- I was close by
- I wanted to be seen today
- I've been here before
- My GP would have sent me anyway so I came straight here
- I'm not local / I don't have a GP here so I came here
- I couldn't get to see anyone else
- I didn't know where else to go
- Another reason (*please specify*) _____

Q5) What did you want to happen today? (tick all that apply)

I would like:

- To be examined
- To be given treatment or medicine
- To get advice
- To be admitted to hospital
- To be told what's wrong
- To be reassured
- To rule out serious illness
- To be seen by a doctor
- To get a second opinion
- To know what to look out for when I go home
- To know what to do if this should happen again
- Something else? *(please specify)* _____
- I'm not sure

Q6) It can be difficult to know where to go, or what to do when you are unwell.

Did you seek advice before coming here today? If so, who from? (tick all that apply)

- A relative
- A friend / neighbour
- A doctor / nurse at my GP surgery
- A pharmacist
- The internet *(what did you look up?)* _____
- NHS 111 telephone advice
- 999 / emergency services / ambulance services
- Another treatment centre *(which one?)* _____
- Someone else *(who?)* _____
- No, I didn't seek any advice

Q7) Have you been here before with the same or a similar problem? (tick only one)

- Yes
- No
- I'm not sure / I can't remember

Q8) Is there something that you would like to have been able to do to help yourself before coming here? (tick only one)

- Yes *(what?)* _____
- No
- I'm not sure

Q9) Is there any information that might have helped you, or others decide what to do when you became poorly like this? (tick only one)

- Yes (what?) _____
- No (Please go to question 11)
- I'm not sure (Please go to question 11)

Q10) If you'd have known this / how to do this, do you think you would have come here today? (tick only one)

- Yes, I would still have come here today
- No, I would have gone to the GP
- No, I would have gone to the pharmacist / chemist
- No, I would have phoned NHS '111'
- No, I would have gone to another treatment centre (where?)

- No, I would have known what to do at home
- I don't know

Q11) Is there anything we haven't mentioned that you would like to tell us about relating to how you decide what to do when you are unwell? (tick only one)

- Yes, (what?) _____
- No

Q12) Would you be willing to take part in a discussion to help us find out more about how we can help patients make decisions when someone is poorly? You can talk to the researcher if you want to find out more about this before you decide.

(tick only one)

- Yes (please provide your name and phone and / or email address)

- No, thanks

Q13) How would you describe your ethnicity? (tick only one)

- White – British
- White – Irish
- Any other White background
- Mixed – White & Black Caribbean
- Mixed – White & Black African
- Mixed – White & Asian
- Any other mixed background
- Chinese or other ethnic group – Chinese
- Chinese or other ethnic group – Any other
- Black or Black British – Caribbean
- Black or Black British – African
- Any other Black background
- Asian or Asian British – Indian
- Asian or Asian British – Pakistani
- Asian or Asian British – Bangladeshi
- Any other Asian background
- I would prefer not to say

Q14) Do you have a physical or mental health condition or illness lasting, or expected to last for 12 months or more? (tick only one)

- Yes (please state) _____
- No
- I don't know
- I'd prefer not to say

Q15) Do you have any health conditions or illnesses that affect you in any of the following areas?

(tick all that apply)

- Vision (e.g. blindness or partial sight)
- Hearing (e.g. deafness or partial hearing)
- Mobility (e.g. walking short distances or climbing stairs)
- Dexterity (e.g. lifting and carrying objects)
- Learning or understanding or concentrating
- Memory
- Mental health
- Stamina or breathing or fatigue
- Socially or behaviourally (e.g. associated with autism, attention deficit disorder or Asperger's syndrome)
- Other (please specify) _____
- None of the above
- I'd prefer not to say

Thank you for taking part in the survey.
If you have any further questions, please ask the researcher.



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