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Evidence Brief

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Making sense of urgent care: how and why do people use health services?

Urgent care typically describes healthcare for non-life threatening conditions requiring prompt attention ('same day' or within 24 hours). In England, urgent care services have proliferated partly to divert people from attending overcrowded emergency departments but also to address policy concerns of patient choice and improved access to care.

This wider choice of services has led to a complex landscape of urgent and emergency care where boundaries between different services are blurred. Service users are often confused about which service to use. This includes using emergency care for 'non-emergency' health problems. Research around this topic has often focused on the 'inappropriate' use of emergency services. However, categorisations of 'appropriate' or 'inappropriate' behaviours are simplistic.

This Evidence Brief describes the findings of a two-year study undertaken by the University of Southampton and NHS collaborators at University Hospitals Southampton and South Central Ambulance Service. This research examined the amount and nature of effort ('work') service users undertake to make sense of urgent care and seek help from health services.

What is urgent care?

Urgent care services are often not clearly defined but are positioned somewhere between general practice (GP) and emergency care [1]. Urgent care typically describes care for non-life threatening conditions requiring attention on the same day or within 24 hours. These services are mainly designed to assess and manage unforeseen conditions during 'out-of-hours' (evenings or weekends). In England, urgent care services include the NHS 111 telephone service, GP out-of-hours, urgent treatment centres, and minor injuries units.

The importance of understanding how and why people use urgent care

In England, urgent care provision has been expanded in recent years. For example, access to alternative services such as NHS 111 was introduced. This telephone service was designed to signpost people to the services most appropriate for their needs.

This urgent care expansion was partly to manage demand for crowded emergency departments (EDs) [1]. Evidence suggests 12%-40% of ED attendances are 'inappropriate' [2]. Offering urgent care alternatives may increase timeliness of treatment, or offer more convenient, less burdensome options for patients.

However, the urgent care landscape is somewhat fragmented and the near continual reconfiguration and extension of services creates confusion. This may hinder service users' understanding of urgent care and encourage 'inappropriate' service use.

Choosing between urgent (and emergency) care service options is complex, particularly when ill or injured. Service users are required to distinguish between 'routine', 'urgent' or 'emergency', and between an array of possible services. Service availability may vary according to time and day of the week [3]. Complex interacting factors influence why people use healthcare. There are existing theories about psychological (individual) and social factors that help explain how people seek help from health services [4]. However, the research described in this Evidence Brief has focused more specifically on the 'work' that people do to 'make sense' of urgent care and how this shapes urgent care use [3,5].

Study design

Mixed methods study:

- Literature review of policy and research evidence to compare how policy, health providers and service users defined and conceptualised urgent care.
- Four citizens' panels, with 41 panel members in total, to deliberate and agree definitions of urgent care: (1) Polish community (2) a wider service user group (3) health professionals (4) Clinical Commissioning Group staff.
- Serial semi-structured qualitative interviews to examine sense-making and help-seeking. Three groups of service users were selected because they are high users of urgent care or they face particular challenges in navigating healthcare: (1) at least 75 years old (2) 18-26 years old (3) East Europeans.

Patient work: choosing, accessing, and navigating services

The amount, type and nature of the work undertaken to make sense of urgent care was a key theme in the analysis. Three related, but distinct, types of work were identified: illness, moral and navigation work. The study also revealed that

work is both individual and shared or delegated across social networks (friends, family, and colleagues). This work varies by social context (e.g. family circumstances) and time.

Illness work

People make sense of illness by interpreting the severity of symptoms and their psychological state [6], assessing risks, and making decisions about accessing services. Symptoms that were perceived as sudden, unusual or serious, or that interfered with daily life (e.g. impaired mobility), often prompted people to seek help.

Uncertainty about symptoms often provoked anxiety. People reporting lower levels of anxiety tended to seek reassurance from NHS 111, but those who were more worried used the ED. Managing uncertainty about symptoms entailed 'risk assessment and management work'. Participants sought reassurance from health professionals or members of lay networks to 'be on the safe side'. NHS 111 was often a first port of call, particularly for younger and East European participants.

Moral work

'Moral work' describes the work that service users undertake to present themselves as an appropriate or responsible user of healthcare [7]. Service users were often conflicted between their desire to represent themselves as a 'credible patient' and a desire to delegate illness work to healthcare professionals. Moral work involved being a 'good self-manager' (taking responsibility for own health, using knowledge to manage risks) to enable 'appropriate' judgements about symptoms. Service users weighed up the risk of harm against taking action.

Participants were keen to demonstrate their responsibility, providing examples of when they had not sought help. Many described themselves as 'copers' (tolerating symptoms, using self-care). Not accessing services was a sign of stoicism. Many service users were acutely aware that 'unnecessary' service use might deprive care from those 'who really need it'.

Navigation work

'Navigation work' involved identifying and making sense of the range of services on offer and finding out how to access them. Service users made choices between what was available (e.g. staffing, resources, technology), accessible (the ease with which a health service can be physically reached), and acceptable (e.g. convenient opening hours).

There was considerable confusion about when to access urgent care services. In contrast, there was greater confidence about the services provided in the ED. For example, participants mentioned that the ED had specialist facilities such as X-ray. Choosing to attend an ED maximised the chances that the facilities needed would be available – thus avoiding the risk of a potentially wasted journey.

One of the key drivers of service use was perceived waiting time. Urgent care services were viewed as available and more convenient than General Practice, primarily because an appointment was not required.

Conclusions

This study illustrated the work involved for the public to make sense of and access urgent and emergency care services. The researchers distinguished between three distinct types of work: illness work (assessing symptoms, need and risk), moral work (assessing 'appropriateness', justifying choices and decision making) and navigation work (assessing what is available, accessible and acceptable).

Understanding this work may help move the focus from blaming people for 'incorrectly' making sense of health services and making 'inappropriate' decisions. Instead, patients need to be supported in their efforts to understand and access health services. Peoples' 'wrong choices' are usually not deliberate – they are a consequence of the work that they do.

Recognising that different or additional work may be required for different groups (e.g. different age groups and migrant populations) can inform service design and signposting. However, this must be directed at the work these groups have to do. For example, some migrant groups will have no experience of non-hospital based urgent care. They need support to navigate this different care landscape.

At a structural level the impact of the frequent reconfiguration of urgent and emergency care services on patient work should be considered.

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