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Convenience, quality and choice: patient and service-provider perspectives for treating primary care complaints in urgent care settings

Abstract:

Aim: To investigate why patients chose to attend two, nurse-led, minor injury units (MIUs) to access primary healthcare services rather than attend their GP practice.

Background: Since the 1980's, healthcare organisations in the UK and elsewhere have implemented an increasingly consumer-orientated model of healthcare provision. As a result, patients with non-urgent presentations are attending Emergency Departments (EDs) and other urgent care facilities in growing numbers.

Methods: A comparative case study approach was adopted and between October 2014 and May 2015 the researcher was embedded as a participant observer as part of the emergency nurse practitioner team at two, nurse-led, MIUs (site A and B). During this time, 40 patients, 17 service-providers and 1 senior manager were interviewed.

Results: Patients and service-providers at both sites identified convenience and quality of care as the principle reasons patients presented for primary healthcare services at MIUs rather than their GP practice. Service-providers were aware that by providing treatment, they established a precedent and a sense of expectation for future care.

Conclusion: Patients are acting rationally and predictably in response to healthcare policy promises regarding choice, expectation created by service-providers, and local demographic factors.

Key words: choice, co-location, nurse practitioner, primary care, urgent care centres, qualitative research

24

25 **Introduction**

26 Choice is typically considered to be an intrinsically worthwhile activity since it is closely linked to the
27 notion of individual autonomy. This view is reinforced at a political and cultural level in the UK (and
28 elsewhere) and consumerist notions of personal choice and expediency influence an increasing
29 variety of social and personal behaviors including healthcare decision-making. Since the 1980's,
30 successive UK Governments have implemented an increasingly consumer-orientated model of
31 healthcare where patients are encouraged to choose when, where and by whom their healthcare is
32 delivered [1]. In the decade between 2000-2010, more than 230 walk-in centres opened across
33 England (UK) in order to modernise the National Health Service (NHS) "to be more responsive to
34 patients' busy lifestyles, and offer patients more choice" [2]. At the same time, millions of pounds
35 have been spent on poster campaigns, radio-advertising and apps to 'educate' patients about how to
36 make the most appropriate use of healthcare services in order to avoid duplication of work and
37 streamline those with greatest need [3]. There is an apparent contradiction, therefore, between
38 encouraging choice and convenience for the individual patient, and ensuring services and resources
39 are employed in the most efficient and equitable manner for all [4]. The aim of this paper is to
40 investigate why patients chose to attend two, nurse-led, minor injury units (MIUs) to access primary
41 care services rather than attend their General Practitioner (GP). This is important at a time when
42 primary and secondary care services in the UK are expected to offer high levels of choice and
43 convenience to patients whilst making significant efficiency savings. MIUs provide urgent care for
44 minor injury and illness (on a walk-in basis) and are usually staffed by emergency nurse practitioners
45 (ENPs). ENPs work autonomously and may administer medications using patient group directions
46 (i.e. a direction to a nurse from a doctor to supply/administer prescription-only medicines to
47 patients using their own assessment of patient need). GPs are primary care doctors who provide free
48 healthcare services to patients registered with their practice. They treat all common medical

conditions and are able to refer patients to hospitals and other secondary care services for specialist treatment. When patients attend MIU, a copy of their notes is sent to their GP practice.

Background

It is well reported that patients with non-urgent presentations are attending Emergency Departments (EDs) and other urgent care facilities (e.g. MIUs) in Australia, Canadian and the US in growing numbers [5, 6, 7, 8, 9]. Between 2003/4 and 2014/15, the number of attendances at English (UK) EDs and MIUs increased by more than 35% [10]. Part of the reason for this is that some patients present with relatively minor health problems that could be treated in other settings [11, 12]. As a result, many EDs and urgent care providers offer co-located primary care services to streamline those who are unable, or unwilling, to access primary care services elsewhere [13]. This usually involves a GP working alongside ED or MIU staff, with all patients registered on arrival and referred to the GP, ENP or ED team depending on the nature of their complaint. A 2011 study to estimate the potential for alternative providers to reduce demand on a UK ED, found the most frequent reason for presenting with primary care complaints was advise to attend from somebody else, usually a healthcare professional [11]. The study also noted that few patients believed they would be seen more quickly in the ED or that it was more convenient. A 2014 study at Sandwell and West Birmingham Hospital Trust found that the 200,000 ED attendances each year were largely “not for life threatening accidents and emergencies, but for the kinds of symptoms and worries that primary care can and should be dealing with” [12]. However, the authors proposed that patients were “largely behaving rationally” based on the “offers” the organisation had put in place and “the expectation” this had created. This view is supported by a study from 2013 that investigated how patients with long terms conditions chose between available healthcare options during a crisis [14]. The authors concluded patients were highly knowledgeable and discriminating when making choices regarding their healthcare and that it was wrong to suggest they required education to reduce their

emergency care use. Between September 2014 and February 2015, the Patients Association (PA) and the Royal College of Emergency Medicine (RCEM) undertook an open access survey to explore how and why patients accessed EDs [15]. Patients were asked if they had tried to access primary care treatment before attending the ED and almost a quarter (23%) reported that they had contacted their GP to make an appointment beforehand. Of these 23%, almost half (45%) had been informed that they could be seen by their GP the same day with an average appointment time of within three hours of their telephone call. The PA and RCEM report commented that the “inescapable message” from the survey is that patients are reluctant to wait as little as three hours if they perceive their care need to be urgent [15]. This is exacerbated by advice from some healthcare professionals who, it is suggested, could act to reduce ED attendance. The report concluded that these behaviours emphasise the lack of trusted alternate care providers and that the decision to attend the ED, with a primary care complaint, is the result of patient confidence and convenience. According to Healthwatch England, many “GPs simply aren't flexible enough to meet consumers' needs” at a time when health and social care is under significant pressure [3]. Anna Bradley, Chair of Healthwatch England, commented that suggesting patients were to blame for attending the ‘wrong’ healthcare provider was not helpful and the wrong way to view the issue. She acknowledged that patients should not attend the ED unless their need was urgent but argued that the health and social care sector needed to offer a “more consumer friendly experience” if the situation was to improve. In summary, the literature suggests that patients will continue to present at EDs and urgent care providers for primary care services if it is more convenient for them to do so. This is exacerbated by the fact that EDs are frequently considered to be more accommodating and flexible than primary care services and offer a greater variety of treatment options.

Methods

The data presented in this paper forms a discrete subset from a multiple embedded case study exploring consumer attitudes and behaviour when accessing healthcare. According to Yin, case study design should be considered when asking “why” questions, when the researcher has little control over the behaviour/events being investigated, when investigating contextual conditions that are relevant to the phenomenon being studied, and when the boundaries between the context and the phenomenon are not clear [16]. Two MIUs, situated at hospitals in the south of England (UK) were selected as research sites since they serve large communities with multiple and diverse needs. The MIUs represent bounded social systems (cases or units of analysis) in which patients have an opportunity to make choices regarding the provision of healthcare and the treatment they receive. Between October 2014 and May 2015, 21 patients and 10 service-providers participated in semi-structured interviews at site A, and 19 patients and 7 service-providers at site B (table 1). A senior manager with responsibility for all ENPs working for the Hospital Trust was also interviewed. Although their role was primarily non-clinical, they had worked as an ENP in the past and continued to provide clinical training/supervision on a limited basis. Patient interview participants were recruited using critical case sampling throughout the data collection period (no more than two per day). It was not practical to employ a sampling technique that required prior knowledge of personal attributes, behaviours, experiences, qualities etc because of the high number of potential participants that accessed the service on a largely unpredictable and unplanned basis. Patient interview participants were first identified at reception and asked if they were willing to ‘provisionally consent’ to be interviewed following consultation/treatment. If they agreed, the patient was provided with a copy of an interview participant information sheet and re-approached once their treatment had been completed. This ensured that they had an opportunity to read the information provided and consider whether they were still willing to continue with the interview prior to providing written consent. The patient interviews lasted for between 30 and 40 minutes on average. Many patients declined to be interviewed when first approached - always on the basis that they lacked time or had other commitments. Service-providers (including the senior manager)

received an individual written invitation to participate in the research before data collection commenced. Interviews took place by appointment and lasted for between 40 and 50 minutes on average. No service-providers declined to be interviewed and all interview participants received a transcript for member checking. In addition, the researcher was embedded as part of the ENP team at site A (Oct 2014 - Feb 2015) and site B (Feb 2015 - May 2015) in order to sample contacts between patients and service-providers in-situ as a participant observer. The researcher worked 8 hour shifts on a variety of days of the week (table 1), typically between 08.00 and 21.00 since data collection opportunities at site A were limited before/after these times (site B was closed). Only two patient interview participants were selected each shift (at random intervals) to distribute the sample across the data collection period at each site and to allow the researcher to work/make FNs during each shift. In total, 21 female patients were interviewed at site A and B, and 19 male patients (table 1). The age range is also comparable overall, with an average age of 49.7 years at site A and 50 years at site B (table 2).

Data sets

As part of the ENP team, the researcher also received regular e-mail correspondence from the senior manager including the weekly report from the short message survey Friends and Family Test (FFT) outlining patient satisfaction/dissatisfaction at each site (ranked numerically on a scale of 1-6 with qualitative comments). From April 2013, every NHS hospital has been required to ask patients accessing emergency care (and other clinical services) whether they would recommend the care and treatment they received to friends and family [17]. Consequently, data were collected using three different instruments: patient and service-provider interview, field notes derived from participant observation and comments from the FFT survey. Individually, these sources of evidence provide some insight into patient and service-provider's views but any conclusions drawn are limited and unfocused. It is essential, therefore, that the different strands are considered collectively and

149 triangulated in order to identify/exclude alternative explanations and guard against potential bias.
150 Consequently, service user/provider interviews, FFT reports and FNs were scrutinised for key
151 words/phrases, ideas and themes and marked with a coded label using data analysis software NVivo
152 10. Thematic analysis is a method for identifying, categorising and analysing patterns or themes
153 within data. This involves six distinct stages: immersion in the data, generating preliminary codes
154 across the data set, collating the codes into potential themes or patterns, reviewing the themes in
155 relation to the coded extracts/data set as a whole, ongoing analysis to refine the specifics of each
156 theme and, finally, producing the report [18]. The principle emerging theme from the data sets was
157 the disproportionate number of patients presenting (particularly at site B) with problems or
158 conditions that would traditionally have been dealt with by their GP or practice nurse. The interview
159 questions for patients and service-providers did not directly refer to this phenomenon although it
160 formed part of the broader narrative regarding healthcare consumer decision-making and choice.
161 For example, patients were asked why they chose to attend MIU, and service-providers were asked
162 why they thought patients attended MIU rather than an alternative healthcare provider (including
163 EDs). FFT responses from site A were more numerous than site B but this was expected since site A is
164 a larger department and is open for a greater proportion of the time (table 1). Although the
165 researcher undertook more shifts at site A than site B, this reflects the initial 'bedding-in' period as
166 they orientated themselves to the organisational culture of the field. The study was submitted for
167 approval to the NHS research ethics committee (REC) in May 2014. Favourable ethical opinion was
168 provided in August 2014 (REC reference: 14/LO/0908).

170 *Rigour*

171 In order to establish the rigour of qualitative research, the researcher must acknowledge and guard
172 against the temptation to over identify with the research subjects or social setting they are
173 investigating. This process of critical self-reflection helps to ensure the researcher continues to

approach their subject from the point of view of an outsider or stranger [19]. Techniques for enhancing credibility during data collection include prolonged engagement/persistent observation in the field, triangulation of data collection tools/sets, and member checking [20]. The first helps to ensure that the researcher is able to gain an understanding of the organisation or setting they are studying and to establish a trusting relationship between themselves and the participants. The second helps to compensate for the individual limitations of the data collection tools and exploits their respective advantages [16]. The third consists of asking participants to review and confirm the authenticity and accuracy of the data collected and all interview participants at site A and B received a transcript by e-mail or post (as preferred). In order to minimise the incidence of leading behaviour, observer effect and bias (e.g. selection, instruction and confirmation) only unsolicited interactions that occurred between patients and other service-providers (i.e. not the researcher) were eligible to be recorded as FNs. Similarly, patient interview participants were not treated by the researcher at any point during their care.

Site A and B

Site A is situated at a general hospital and provides a 24-hour, nurse-led, MIU service, 7 days a week, 365 days a year. It also hosts an out-of-hours GP service after 6pm which is by appointment only. In addition, a separate GP collective (GPc) provides a walk-in service between 11.00-21.00 Monday-Friday, and 08.00-20.00 at weekends (table 1). The service was piloted in August 2009 to cater for the large number of patients presenting at site A, and the adjacent Emergency Care Centre (ECC), with primary-care complaints. The service is funded by the Hospital Trust and patients can self-refer on a first-come-first-served basis. Site B is situated at a small community hospital and also provides a nurse-led MIU service. However, it does not provide a 24-hour service and is open between 09.00-19.00, Monday to Friday, and 10.00-18.00 at weekends/bank holidays (excluding Christmas and Boxing Day when it is closed). Like site A, site B hosts an out-of-hours GP service after 6pm and a

daytime service operated by the same GPc from 11.00. Unlike site A, the daytime GPc service is by appointment only and patients must be referred by their own GP practice (or by an ENP from site B) via a local service hub. The service was launched in March 2015 to provide additional support to local GP surgeries that were struggling to meet demand for primary care services and is funded by the Prime Minister's GP Access Fund. Site A town does not have any lower super output areas (LSOAs) ranked within the top 10% most deprived in England [21]. Site B town, on the other hand, has four LSOAs ranked within the top 10% most deprived in England, one of which is within the top 5% most deprived.

Results

First choice of care provider

The principle emerging theme from the data sets was the disproportionate number of patients presenting (particularly at site B) with problems or conditions that would traditionally have been dealt with by their GP or practice nurse. However, the thematic analysis revealed three further themes that contributed to this: first choice of care provider, second opinion/accessing further care, and regular attenders, which will now be explained. It is important to acknowledge that not all patient interview participants at site A and B attended MIU as their first choice of primary care provider. However, those that did, explained that convenience and quality of care were the principle reasons they had presented. For example, when asked why they had attended MIU, patient 05 at site A (P/05/A) replied:

“Because this is where I came last time and last time they sorted it out straight away...It takes two weeks to get a doctor's [GP] appointment and when this happens I can't really

222 wait that long. I need it fixed quickly. It affects my work. I'm supposed to be working on
223 Monday" (32-year-old male, undertaker).

224 Similarly, at site B, P/11/B remarked:

225 "I was quite happy to come here because I live nearer to this hospital than I am to my GP. I
226 would have been quite happy to do either...[but]...I wasn't sure if I went down to my [GP
227 practice] if they'd have a dressing and, if I needed another dressing, which actually it did,
228 whether they'd have had the right one down there" (61-year-old male, retired engineer).

229 Another patient who presented at site B with their child, stated they had not attempted to make an
230 appointment with their GP because of the practice's telephone triage system (FN: Mar.25, 2015).

231 They explained that the process was complicated and involved waiting for a call-back interview. The
232 patient reported, with some frustration, that there was no guarantee of an appointment and that if
233 the telephone call was missed ('because you were on the toilet') the whole process would have to
234 start again. The patient felt that the system discouraged people from making appointments and they
235 had chosen to attend site B because - in their opinion - it was quicker and more convenient. Service-
236 providers at site A and B also identified convenience as the main reason that patients attended MIU
237 rather than their GP, and service-provider 01 at site A (SP/01/A) commented:

238 "...they come here to us because it's easy access. You just turn-up and you know someone
239 will see you...With a GP it's more complicated, you have to phone first to get an
240 appointment that may not be convenient for you. It may take a bit longer to get through on
241 the phone. They may not get in to see the doctor they want to. There are more steps I
242 suppose, whereas here you just walk through the door." (ENP, 40-year-old female).

243 At the same time, service-providers were aware that lack of choice also dictated where patients
244 attended for care and the senior manager remarked:

245 “A high proportion here [site A] drive and park and pay. A high proportion there [site B] bus
246 or walk. So, if you want to get somewhere quickly. If you haven’t got a vehicle...you go to
247 where you can” (senior manager, 57-year-old female).

248 Service-providers at both sites were conscious of the customer service element of their role and
249 reported how they tried to ensure patients felt welcome and valued even when an alternative care
250 provider was more appropriate for their needs. However, they were also aware that this often
251 contributed to a sense of expectation and SP/08/A commented:

252 “Quite often we will get a family of four or five turn-up all with different problems.
253 They...use it [site A] for a check-up basically. And obviously we are very nice so they think
254 ‘they are very nice, they are very helpful.’ Even if we say to them ‘you need to register with a
255 GP’” (ENP, 31-year-old male).

256 SP/07/A explained how consumerist notions of personal choice and expediency contributed to this
257 way of thinking:

258 “I think people do view it [healthcare] as more of a consumer experience. They’re used to
259 going to the supermarkets and having an express service and I think that transition has come
260 into healthcare to a certain extent. The expectation is that ‘I’ve presented here for an
261 express service, this is a hospital and will treat me quickly’. Whereas if they are going to a GP
262 set-up then they expect a slightly different type of approach” (ENP, 49-year-old female).

263 Similarly, the senior manager commented:

264 “It is a learnt experience. I went there and they made it all better, they made me feel better.
265 I’ll go there again. If you go shopping and you go to a shop and the very first time you go in,
266 they’re rude...[you think] ‘I’ll go back to the one I know because I know they’ll be nice. Even
267 if they haven’t got exactly what I want they’ll be lovely and understand’ ...People have their

268 favourite supermarket because of the experience they've had in it and what they've found
269 and people do that with healthcare" (senior manager, 57-year-old female).

270 Despite some concerns regarding increasing workload, service-providers at both sites were generally
271 sympathetic to those who chose to attend MIU rather than their GP. SP/05/B identified the practical
272 difficulties that many patients faced:

273 "If I were a working man and I wanted a GP appointment nowadays I would have to phone
274 up at eight o'clock that morning, perhaps phone half a dozen times because I was in a
275 queue, eventually you get through. If I were very, very lucky I might be told I can have an
276 appointment that day. Chances are, I'll be told...'phone back tomorrow morning.' Now I'm a
277 working man, I've told my boss I might not be in that day. So what's easiest? Don't even
278 bother. Turn up at the minor injuries unit...because you can just pitch up and the hospitals
279 are under legislative pressure to process people within four hours. So you don't have to
280 make any phone calls, no receptionist to deal with, you can just go along to your local
281 casualty department, you'll sit in the waiting room, you'll sign and the GP will see you in a
282 hospital environment with all the investigations and nurses available. What would you do?
283 It's a no brainer" (GPc GP, 46-year-old male)

284 SP/07/B also explained how, in some circumstances, ENPs encouraged patients to attend MIU rather
285 than their own GP practice:

286 "When you've got a little old lady that lives just up the road here and she has to get a taxi
287 three times a week to go to [GP practice] what are you going to say?...It's against everything
288 I believe in to say to that lady 'no, I'm sorry, you have to pay £7.50 to get the taxi to go and
289 sit in the GP practice for an hour waiting for the practice nurse. And then you have to pay for
290 the return instead of just walking across the road'" (ENP, 48-year-old female).

291

292 *Second opinion and accessing further care*

293 Another reason that patients presented at site A and B with primary care complaints was to receive
294 a second opinion or as a way of accessing further care. Sometimes this was beneficial for the patient
295 and on other occasions it was not. For example, a patient presented at site B with a history of
296 chronic pain (FN: Apr.01, 2015). They had seen their GP five days earlier who had prescribed
297 medication and provided advice regarding management. The patient explained to the ENP that they
298 did not like 'taking tablets' and disagreed with the advice they had received. The ENP could only
299 reiterate the GP's advice and encourage the patient to take the medication as prescribed. Service-
300 providers at both sites also explained how some patients employed strategies that were intended to
301 gain advantage for themselves when accessing treatment or investigations. For example, SP/04/A
302 remarked:

303 "Some come in because the investigations are taking too long. The GP has organised
304 everything but it is not happening quick enough, so by coming to [site A] I can get it done
305 easier, quicker, on the spot...There are a few who will not tell you that their GP has actually
306 organised it and will then try to make the symptoms worse than they actually are. You then
307 have no other option than to get them sorted on the spot" (GPc GP, 42-year-old male).

308 Service-providers at both sites recognised that it was only a small minority of patients that
309 attempted to game-the-system in this way but there was also a feeling that it was becoming more
310 common as expectations regarding flexibility increased. The senior manager drew attention to the
311 fact that patients often responded to media comment:

312 "[Patients] expect to be able to do their day's work and then come to MIU at their
313 convenience. They pick up on certain things in the media and the television. The Prime
314 Minister now obviously wants seven days a week, 24-hour healthcare available. They've
315 heard that headline...You have to say 'we try but...if we bring you back to clinic [at 19.30]

316 and I need a physio they haven't gone 24-hours yet'. So it is not always that simple" (senior
317 manager, 57-year-old female).

318 Whilst most of those who attended site A and B to see the GP had attempted to make an
319 appointment with their own practice, a small number, for a variety of reasons, had not. For example,
320 one patient presented at site A complaining of general illness for two months. They reported that
321 they had tried to phone their GP that morning but after "seven minutes of waiting" had decided to
322 attend site A instead (FN: Feb.11, 2015). However, because of the time of day (before 11.00) no GP
323 was available and the patient was seen and assessed by an ENP. The ENP discussed the patient's
324 clinical presentation with an ECC medic who recommended that they needed to see a GP. The ENP
325 advised the patient to wait and book in to see the GP at 11.00 but because their companion had
326 another appointment at this time they were reluctant to do so. Consequently, they telephoned their
327 GP practice from the waiting room and made an appointment for later that afternoon. Although this
328 type of activity is frustrating for staff, SP/04/A explained how co-located services could help to
329 reduce hospital admission if employed sensibly:

330 "I think most places in England need to have GPs working in acute services...It works pretty
331 well. You have a consultant on the floor there. So you don't have to admit every patient to
332 ECC that you want an opinion on, you can actually have a chat with them and see if there is a
333 different way to go about things rather than admitting the patient. Most patients don't
334 actually want to be admitted" (GP GP, 42-year-old male).

335 SP/05/B suggested that primary care services may undergo an even more radical transformation in
336 the future:

337 I've had people come along today, not emergencies but urgent primary care issues,
338 vulnerable people, elderly who have been offered appointment for [three weeks' time]. Well
339 that's just absurd isn't it...so they pitch up at the minor injuries unit...It seems the natural
340 choice to come here. That's why they'll be this natural amalgamation. It cannot be

341 stopped...They'll be lots of specialists, nurses and other healthcare workers working to
342 algorithms on evidence-based principles" (GPc GP, 45-year-old male).

343

344 *Regular attenders*

345 The large number of patients presenting at site B with primary care complaints is reflected by the
346 discretionary funding arrangements for the GPc (see above). SP/02/B explained:

347 "...access to the GP services is proving a challenge in [site B town] as far as I can see and that
348 is probably [site B's] biggest issue. The first thing people say is 'I just can't get a GP
349 appointment. I rang a GP this morning and well there is not an appointment for three
350 weeks'" (ENP, 39-year-old female).

351 Service-providers at site B also drew attention to the increasing number of patients who presented
352 because they were unable to make practice nurse appointments. This resulted in frequent repeat
353 attendances and SP/03/B commented:

354 "We end up seeing the patients over and over and over again, you end up starting to feel for
355 the patients and you build a rapport with the patients" (ENP, 34-year-old female).

356 In April 2011, a new set of clinical quality indicators was introduced by the Department of Health to
357 measure the quality of care delivered by EDs in England [22]. One of the clinical quality indicators
358 was unplanned re-attendance within seven days of the original attendance. The purpose of this
359 indicator was to reduce avoidable re-attendances to less than 5% per month by improving care and
360 communication delivered during the first attendance. However, this can be difficult to achieve when
361 patients are discharged from hospital but are unable to access appropriate follow-up care
362 elsewhere. In order to manage the high number of 're-attending' patients requiring practice nurse
363 treatment, site B created a clinic system. Although this allowed ENPs to manage care in a planned
364 and negotiated fashion, it also seemed to increase patient expectation and SP/02/B commented:

365 “We have a lovely gentleman who comes every day for redressing...He shouldn’t be here but
366 to be fair to him he has certainly made the attempt to go to the practice nurse but he is the
367 first to say ‘I prefer it here anyway’ ...we are very grateful but again we are the product of our
368 own success. We shouldn’t be having daily dressings and daily repeats and people saying
369 ‘well last time I was here the lady was so nice’” (ENP, 39-year-old female).

370 The senior manager also commented that the strong sense of community and belonging that existed
371 at site B had probably contributed to its popularity and further encouraged repeat attendance:

372 “...a lot of it at [site B] is they have brilliant treatment and they go again regardless of what is
373 wrong...the one thing I have noticed down there is that they have immense trust in their
374 nurses...Their head could be hanging off and they would pitch up because they recognise
375 them. It’s like...in the old days when you always had your own GP, [site B] has become that.
376 They are too good if you know what I mean...You don’t see that so much at [site A]” (senior
377 manager, 57-year-old female).

378 This phenomenon is exacerbated (at both sites) by the FFT survey that encourages patients to rate
379 the care they received and to ‘recommend’ it to others. The results and comments from this survey
380 are often published and patients can read about positive experiences or how the organisation
381 intends to remedy poor experiences. In either case, the feedback tends to read as an endorsement
382 of the service and patients are encouraged to return. For example,

383 “[Site A] is the nearest place to go that i know of, other than the doctors [GP], and that could
384 involve a long wait because of appointments” (Site A, FFT 01/2015).¹

¹ Grammar, punctuation, spelling and syntax in all FFT/text message quotations is reproduced as originally written.

385 *"I had received poor care from my GP and was looking at a longer recovery. However the*
386 *nurse at the hospital tried a different treatment option which worked. She was very kind and*
387 *helpful. I left feeling relieved"* (Site B, FFT 04/2015).

388 Members of the public are increasingly familiar with consumer rating reports such as TripAdvisor
389 and the customer focused language of the FFT does not identify or differentiate between
390 'appropriate' and 'inappropriate' attendance.

392 **Discussion**

393 Whilst there is a great deal of homogeneity between site A and B in terms of management structure,
394 clinical governance and the type of service they provide, there are also important differences that
395 can, to a greater or lesser extent, be explained by environmental and demographic factors. For
396 example, site A serves a more affluent population that benefits from well-organised primary care
397 services. Whilst it was not always possible for patients to make an appointment with their GP, at a
398 time that suited them, a service was offered. Consequently, many of those who presented at site A
399 to see a GP (during the day) did so because it was either more convenient for them or because they
400 wanted a second opinion. Very few patients presented at site A to receive care normally provided by
401 a practice nurse and, when they did, it was out of choice and not necessity. Although this was
402 discouraged, since it represented duplication of services, patients were not turned away once they
403 had waited to be seen. At site B, on the other hand, patients were referred to the GPc because their
404 GP practice was unable to provide an appointment that day. Similarly, the large number of patients
405 presenting for wound dressings etc did so, often on a regular and negotiated basis, because practice
406 nurse appointments were unavailable or inconsistent. The first theme that helps to explain the
407 disproportionate amount of primary care provided at site A and B is first choice of care provider.
408 Although not all patient interview participants attended site A and B as their first choice for primary
409 care, those that did, explained that convenience and quality of care were the principle reasons for

410 this decision. Service-providers at both sites were generally sympathetic regarding the practical
411 difficulties many services users faced when trying to access primary care services at a convenient
412 time. This seems to refute the findings from the 2011 study that found few patients who presented
413 for primary care at a UK ED believed it was more convenient or that they would be seen more
414 quickly [11]. Although site A and B were MIUs, rather than EDs, the PA and RCEM survey also lends
415 support to the view that convenience, waiting time and confidence are strong motivating factors
416 when presenting for primary care at EDs [15]. The second theme that helps to explain why large
417 numbers of patients attended site A and B to receive primary care services is second opinion/access
418 to further care. On some occasions this had positive outcomes for patients and, on others, it
419 resulted in repetition of the original advice and duplication of work. Service-providers at both sites
420 identified that a small minority of patients attempted to employ strategies intended to gain
421 advantage for themselves when accessing treatment or investigations. They also felt this behaviour
422 was becoming more commonplace as expectations regarding flexibility increased. Healthwatch
423 England stated that many GPs were not flexible enough to meet consumers' needs and that the
424 health and social care sector needed to offer a more consumer friendly experience in order to
425 discourage patients from attending EDs with primary care complaints [3]. Increasing choice and
426 flexibility certainly has the potential to improve patient experience by increasing options and
427 offering greater convenience. However, it can also lead to negative disconfirmation and
428 dissatisfaction if services do not meet expectation regarding access and/or quality. The final theme,
429 regular attenders, is particularly associated with site B and intersects with the other themes in
430 relation to trust, expectation and consumerist notions of choice. It was noted that an increasing
431 number of patients at site B were attending to receive regular treatment, often for a considerable
432 period of time, because of inadequate primary care provision. This contributed to a strong sense of
433 trust and familiarity between service-providers at site B and the local community they served and
434 resulted in patients returning to receive care out of choice rather than necessity. Service-providers
435 at both sites were aware that by providing treatment to those who attended with primary care

complaints, they established a precedent and a sense of expectation for future care. They also suggested that consumerist notions of personal choice and expediency contributed to this way of thinking and the senior manager compared the reasons for attending a favourite supermarket with the reasons for attending a healthcare provider. This view was reinforced by the FFT survey that encouraged patients to rate their experience and 'recommend' it to others. This supports the findings from the Sandwell and West Birmingham study that concluded patients attending the ED with primary care issues did so for largely rational reasons based upon the expectation created by the healthcare provider [13]. It also supports the findings from the 2013 study that concluded patients were knowledgeable and discriminating when making choices regarding their healthcare during a crisis [14]. It seems likely, therefore, that patient numbers will continue to rise at both sites (and elsewhere) as patients 'vote with their feet' and attend the care provider that offers the most convenient and trusted destination.

Limitations

The chief limitation is generalisability since site A and B are both situated in the south of England. Although they are located in different geographical areas and contrast demographically, there is a high degree of ethnic homogeneity (only two interview participants were non-Caucasian) that may not be representative elsewhere in the UK/world. Another issue that should be acknowledged is the possibility of selection and sampling bias. Although the patient interview participants were selected throughout the data collection period, most were satisfied (to a greater or lesser extent) with the care they received at the point of delivery. This almost certainly reflects a degree of selection bias in that many of them were treated relatively quickly (a source of satisfaction) and therefore had the time and inclination to discuss their care, views etc. Similarly, although critical case sampling is an appropriate choice for this study design it is vulnerable to errors in judgment by the researcher and possible bias. A further study, with stricter sampling criteria, may assist in ascertaining conclusions

that are more robust. Finally, NHS patients receive free healthcare at the point of delivery and cost is not a determining factor in the decision making process. This is not representative of most other healthcare systems outside the UK. However, aside from financial factors, the research reveals common human traits (e.g. trusting healthcare practitioners, convenience, ease of access, etc) and therefore has relevance beyond the UK.

Conclusion

The evidence from the UK and elsewhere suggests that patients will continue to access EDs (and other urgent care providers) with primary care complaints if it is more convenient for them to do so, even when alternative provision is offered/available. Whilst rising patient numbers at EDs is a cause for concern, this (and other) research confirms that patients are presenting for rational and predictable reasons. These include decisions based upon access, trust and quality of care criteria in a similar way to other consumer choices. At site A, where GP services were generally good, this often resulted in duplication of work. At site B, where GP services were generally poor, patients presented in the first instance because of limited choice and service availability. However, once their need/s had been met, they often returned to site B as their first choice of care provider. On the one hand, site A and B are simply responding to a consumer-orientated model of healthcare provision, reinforced at a political and cultural level in the UK, where patients are encouraged to choose when, where and by whom their healthcare is delivered. On the other hand, they are generating further demand by meeting - and sometimes exceeding - patient expectation. There remains a contradiction, therefore, between encouraging choice and convenience for the individual patient, and ensuring services and resources are employed in the most efficient manner. One way to discourage patients from attending ED's with primary care complaints, is for primary care providers to address service provision issues (where necessary) and incorporate greater flexibility re: access [3]. However, co-located primary care, working alongside ENPs, also seems to offer benefits for local

communities and closer working between primary and secondary care practitioners should continue to be encouraged [12]. ENPs in particular seem to offer a valuable stepping-stone between primary and secondary care services and greater utilisation of the clinic model (adopted at site B) might provide a means to incorporate greater flexibility, and improve patient satisfaction, at both settings.

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