

Jessica Drinkwater, Peter Salmon, Susanne Langer, Cheryl Hunter, Alexandra Stenhoff, Elspeth Guthrie and Carolyn Chew-Graham

Operationalising unscheduled care policy: a qualitative study of healthcare professionals' perspectives

Abstract

Background

UK health policy aims to reduce the use of unscheduled care, by increasing proactive and preventative management of patients with long-term conditions in primary care.

Aim

The study explored healthcare professionals' understanding of why patients with long-term conditions use unscheduled care, and the healthcare professionals' understanding of their role in relation to reducing the use of unscheduled care.

Design and setting

Qualitative study interviewing different types of healthcare professionals providing primary care or unscheduled care services in northwest England.

Method

Semi-structured interviews were conducted with 29 healthcare professionals (six GPs; five out-of-hours GPs; four emergency department doctors; two practice nurses; three specialist nurses; two district nurses; seven active case managers). Data were analysed using framework analysis.

Results

Healthcare professionals viewed the use of unscheduled care as a necessary component of care for patients with long-term conditions. Those whose roles involved working to targets to reduce the use of unscheduled care described a tension between this and delivering optimum patient care. Three approaches to reducing unscheduled care were described: optimising the system; negotiating the system; and optimising the patient.

Conclusion

Current policy to reduce the use of unscheduled care does not take account of the perceptions of the healthcare professionals who are expected to implement them. Lipsky's theory of street-level bureaucrats provides a framework to understand how healthcare professionals respond to imposed policies. Healthcare professionals did not see the use of unscheduled care as a problem and there was limited commitment to the policy targets. Therefore, policy should aim for whole-system change rather than reliance on individual healthcare professionals to make changes in their practice.

Keywords

general practice; healthcare systems; out-of-hours medical care; policy; primary health care.

INTRODUCTION

Unscheduled care is defined in the UK as any healthcare provided with less than 24 hours' notice.¹ International and current UK health policy aims to reduce the use of unscheduled care by moving from a reliance on costly hospital and out-of-hours emergency services to more proactive and preventative management of long-term conditions in primary care and the community.²⁻⁵ GPs and other healthcare professionals working in community settings are tasked with implementing policies, including reduction of the use of unscheduled care by patients with long-term conditions.⁶ The UK primary care quality and productivity indicators provide financial incentives to general practices to reduce the use of unscheduled care.⁶

Many different healthcare professionals are involved in the provision of unscheduled care for patients with long-term conditions, including GPs, practice nurses, district nurses, and emergency department clinicians. More recently, other roles have been created in response to a policy shift towards case management for people with long-term conditions.^{2,3} These include active

case managers, with nurse or allied health professional backgrounds, introduced to case manage patients with complex problems, with the explicit aim of reducing hospital admissions through improved routine care and self-management.^{7,8} Similarly, specialist nurses in both primary and secondary care are seen as having a key role in the management of people with long-term conditions and preventing the use of unscheduled care.⁷ Introduction of the new general medical services contract allowed GPs to opt out of responsibility for 24-hour care, leading to out-of-hours doctors making more management decisions.⁹

Previous research has explored healthcare professionals' views on the appropriateness of patients' use of unscheduled care, or their perceptions of why patients use unscheduled care.¹⁰⁻¹³ However, it is not known what healthcare professionals believe their roles and responsibilities to be in reducing the use of unscheduled care. The CHOICE (Choosing Health Options In Chronic care Emergencies) research programme is a 5-year National Institute for Health Research (NIHR)-funded award to design

J Drinkwater, MBChB, BSc, academic clinical fellow/ST4 GP trainee, Centre for Primary Care, Institute of Population Health, University of Manchester 5th floor, Williamson Building, Oxford Road, Manchester. **P Salmon**, MSc, DPhil, FBPsS, professor of clinical psychology, Division of Clinical Psychology; **A Stenhoff**, MSc, BSc, research assistant (qualitative), Department of Mental and Behavioural Health Sciences, Institute of Psychology Health and Society, University of Liverpool, Liverpool. **S Langer**, PhD, senior research fellow, Department of Mental and Behavioural Health Sciences, Institute of Psychology, Health and Society, University of Liverpool. **C Hunter**, PhD, senior research assistant (qualitative), CHOICE Project, Manchester Mental Health and Social Care Trust, Manchester Royal Infirmary, Manchester. **EA Guthrie**, MSc, MD, FRCPsych, professor of psychological medicine and medical psychotherapy, Manchester

Royal Infirmary, Manchester. **C Chew-Graham**, MD, FRCGP, professor of general practice research, Research Institute — Primary Care and Health Sciences, Keele University, Keele, Staffordshire.

Address for correspondence

Jessica Drinkwater, Centre for Primary Care, Institute of Population Health, University of Manchester 5th floor, Williamson Building, Oxford Road, Manchester, M13 9PL.

E-mail: jdrinkwater@doctors.org.uk

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How this fits in

UK health policy aims to reduce the use of unscheduled care by increasing proactive and preventative management of long-term conditions in primary care. Healthcare professionals do not generally see the use of unscheduled care as a problem for patients with long-term conditions. Reducing the use of unscheduled care will require healthcare professionals to be engaged in the policy agenda, in order to implement it. Policy should aim for whole-system change rather than reliance on individual practitioners to change patients' use of unscheduled care.

an intervention to address the use of unscheduled care (defined in this study as emergency department and out-of-hours care) by patients with long-term conditions.¹⁴ This article reports the results of a nested qualitative study that aimed to explore healthcare professionals' perceptions of the reasons why patients with long-term conditions use unscheduled care, and the healthcare professionals' understanding of their own role in relation to reducing the use of unscheduled care. The work of Lipsky (1980), who identified public service workers as 'street-level bureaucrats', is used to provide a framework for illuminating differences in healthcare professionals' understanding of and way of working with a national policy.¹⁵

METHOD

Study design

This was a qualitative study using semi-structured interviews to collect data.

Sampling and recruitment

Healthcare professionals with different responsibilities around unscheduled care in northwest England were invited to participate. GPs and practice nurses were identified from practices already involved in the CHOICE study.¹⁴ GPs working in out-of-hours services were identified through the local out-of-hours provider. Emergency department doctors were identified from the three main hospitals within the recruitment area for the CHOICE study. Active case managers, specialist nurses, and district nurses were identified through snowballing, using local networks of healthcare professionals. Purposive sampling of healthcare professionals aimed to generate a mix of ages, sexes,

and clinical experience.

Healthcare professionals were initially approached by e-mail or letter, containing an invitation, information sheet, and consent form. This was followed up by e-mail or telephone, to seek initial verbal consent.

Data collection and analysis

Data collection was by face-to-face, semi-structured interviews at a time and place that were convenient for the healthcare professional, usually at their place of work. Interviews lasted 19–93 minutes (mean 44 minutes). Topic guides were developed with reference to the literature and study aims. Healthcare professionals were asked about their role in relation to patients with long-term conditions, their perceptions of reasons why patients use unscheduled care, and their role in managing patients' use of unscheduled care. The topic guide was refined throughout data collection, taking account of ongoing analysis. Interviews were audiorecorded with consent, and transcribed verbatim.

Initial thematic analysis was undertaken by authors from different professional backgrounds: primary care, psychology, social anthropology, and psychiatry. Themes were developed through individual reading and rereading of transcripts, and regular discussion among all authors. Analysis followed a framework approach,¹⁶ whereby a thematic framework was developed and refined through constant comparison of data between and within accounts. Individual transcripts were mapped onto this framework using QSR NVivo8.

RESULTS

Forty-three healthcare professionals were invited to participate and 29 agreed: six GPs; five out-of-hours GPs; four emergency department doctors; two practice nurses; three specialist nurses; two district nurses; and seven active case managers. The healthcare professionals had varying levels of experience and different clinical backgrounds; some also had line management roles or were involved in local policy development around long-term conditions or unscheduled care.

Two main themes are presented: whether healthcare professionals perceived the use of unscheduled care as a problem; and their approaches to reducing the use of unscheduled care. These themes are described in detail, using illustrative data. Identifiers indicate participants' profession (ACM, active case manager; DN, district nurse; ED doctor, emergency department

doctor; HCP, healthcare professional; OOH GP, out-of hours GP; PN, practice nurse; SN, specialist nurse) and participant number. Ellipses (...) signify omitted text. Square brackets denote explanatory text.

Is use of unscheduled care seen as a problem?

All healthcare professionals described the use of unscheduled care as an understandable and necessary part of care for patients with long-term conditions, and recognised exacerbations as a normal part of the disease process, for example, describing exacerbations as expected yet unpredictable:

'People with chronic diseases, it's episodic isn't it? So somebody might phone with an exacerbation of their COPD [chronic obstructive pulmonary disease] but the next one might be 8 months away and the next one 3 months after that.' (HCP10 — OOH GP)

GPs, practice nurses, and district nurses discussed ways of managing exacerbations within primary care. However, they recognised the limitations of this, and the necessity of emergency department services for severe exacerbations:

'He'd [COPD patient] been to hospital loads of times, but that's not so much because he doesn't know his disease I suspect, it's 'cause he's just at the severe end and he'd end up at hospital anyway, but as I say, we started the treatment just to sort of, optimise the chances of not going in [hospital]. But there's still a reasonable chance that he will go in.' (HCP17 — OOH GP)

Healthcare professionals did not describe the use of unscheduled care by patients with long-term conditions being precipitated by solely social or psychological factors, although some healthcare professionals acknowledged a link between anxiety and breathlessness in a few individual patients with COPD.

All emergency department doctors were explicit in describing the use of unscheduled care by patients with long-term conditions as legitimate:

'The traditional definition of emergency care would be that it's to provide care for any person who believes that they are suffering from an emergency condition, which requires either urgent investigation, or urgent treatment. So it's defined by the patient.' (HCP11 — ED doctor)

They justified this view by referencing policies and protocols within emergency services that emphasise patient safety:

'Our general policy, except with a few very minor exceptions, is that we do see everybody who comes and if you don't do that, and turn them away, unless you turn them away to something that's appropriate and timely, you can make mistakes.' (HCP23 — ED doctor)

GPs working in out-of-hours services described this setting as inherently more risky because they lacked prior knowledge about individual patients. This affected their decision making, as they could not draw on an understanding of a patient's typical behaviour, and they described prioritising patient safety:

'I think that somebody who's a diabetic or COPD or asthmatic who presents acutely (...) you don't really have much information about them and you have got somebody who's acutely unwell and oftentimes the safest thing to do will be to send them to hospital.' (HCP29 — OOH GP)

Unlike emergency department doctors and healthcare professionals involved in providing routine primary care, active case managers and specialist nurses were performance managed against the policy aim to reduce the use of unscheduled care, and they discussed the use of unscheduled care as an issue that they were responsible for tackling. However, many described a tension between this policy aim and their beliefs about how best to support and manage patients. One active case manager referred to the divergence between patient feedback, suggesting she was 'doing a good job', and perceived pressure to meet targets to reduce the use of unscheduled care:

'You [active case manager] felt you knew you were sort of doing a good job from the feedback that you got from the patient, but you never really felt like that when it came from your sort of performance. I mean you look at performance management, the difficulty with performance management is it doesn't really capture, it doesn't always capture good outcomes for patients. It captures good outcomes for, I suppose, finance. Well it can, it's a difficult one because some of the, a lot of our stuff (...) is about prevention. Um it is difficult to capture prevention in the short term, isn't it?' (HCP26 — ACM)

One specialist nurse reported spending time with patients to reduce the use of

unscheduled care, but disclosed concerns that patients may become dependent on this service:

'We do have a cohort of patients like that who will phone up purely for us to go out just to reassure them that they are fine (...). They will be phoning us on a Friday afternoon for that reassurance, 'cos they know that we're not here Saturday, Sunday. And a lot of that is anxiety related, and maybe we perpetuate that because we go out and we say "Look, you're fine, we've done all your obs, you are fine. We have no concerns about you". But if we didn't do that, they would have gone to A&E and we might have stopped that visit over the weekend. So, I don't know if we're perpetuating it, or we're avoiding other things happening, I don't know.' (HCP13 — SN COPD)

Other active case managers and specialist nurses described the difficulty of managing patients with multiple problems in a highly complex healthcare system, and suggested that avoiding unscheduled care was not always possible, despite healthcare professionals' best efforts. An example of this complexity is illustrated next; this active case manager describes intensive case management being undermined by the out-of-hours service's response to exacerbations:

'I see [patient with end-stage COPD] probably two, three times a week. I've done as much as I possibly can, the GP's very good, we've had about probably three family conferences (...) the out-of-hours doctors who don't really know her (...) go in, see her and think "Oh my God, this lady's really poorly, this should be done, that should be done", even though it's an ongoing thing.' (HCP21 — ACM)

Thus healthcare professionals framed patients' use of unscheduled care as understandable in terms of the clinical course of long-term conditions. However, patients' use of unscheduled care was described as a problem by some healthcare professionals, reflecting their role in relation to policy on unscheduled care. At one extreme, emergency department doctors described their role as treating patients safely, with no pressure to reduce the use of unscheduled care. At the other extreme, active case managers described a conflict between needing to reduce the use of unscheduled care, because of performance-management targets, and providing what they perceived to be good clinical management.

Approaches to reducing the use of unscheduled care

Healthcare professionals discussed different approaches to reducing the use of unscheduled care, again reflecting their roles within the health system. Three main approaches were: 'optimising the system'; 'negotiating the system'; and 'optimising the patient'.

Optimising the system. GPs framed the problem of use of unscheduled care in the wider healthcare system. They recognised that patients may need clinical care urgently, but discussed opportunities to reduce the use of unscheduled care by directing patients to other settings. They described potential systemic solutions, such as improved communication between primary and secondary care, in order to identify patients who were not using the system 'correctly':

'Until I'm convinced that we're getting all the information from casualty about who's been, 'cos although they seem to send us letters I'm not 100% sure that we're getting all of them, until they make some clinical sense, because there's absolute rubbish written on most of them and you don't know which bit of bone they fractured or, really, was that serious or was it not. In fact the only way you can tell it was serious is they kept somebody in and then it's probably not serious either.' (HCP7 — GP)

Similarly, this GP suggested improving triage mechanisms so that patients could be helped to understand which service to use for which problem:

'Up until now I don't think there's been enough kind of triaging really (...). Some people are turning up [to the emergency department] when in fact if they could just speak to somebody they might have had a different outcome.' (HCP12 — GP)

At the extreme, two GPs even suggested fee-for-service as a system change that would discourage use of unscheduled care:

'At the end of the day it's [emergency department and out-of-hours care] free so why not [use it]? (...) [Charging patients for attendance] just makes you [the patient] think a little bit more about whether you really need some unscheduled care or not.' (HCP10 — OOH GP)

Negotiating the system. Practice nurses, active case managers, and specialist

nurses did not discuss trying to influence the way the wider healthcare system worked. Frustration was common in their accounts, as they described a lack of clinical autonomy and professional power despite their responsibilities for addressing the use of unscheduled care. For example, they were not directly linked to the formal information flow about patients, to the extent that they might not know about patients in their care using unscheduled care, compromising their potential to respond:

'No, often I don't get to find out [if a patient has used unscheduled care] (...). The GPs would have a look at it [discharge summary], action it and then, you know, file it in the patient's notes (...). The GPs might ask them to come and see me for a review.' (HCP16 — PN)

This practice nurse described advising patients about symptom control and about avoiding the use of unscheduled care, but she was unconfident that this would be supported by other team members:

'From my personal point of view, I find it quite frustrating I suppose, in a way, that I'm probably about the only person within the practice that has a keen interest in respiratory disease. And sometimes it's a bit of an uphill, an uphill battle. My barriers with clinicians sometimes are the patients are coming in being prescribed antibiotics, having numerous chest infections but they're not then feeding them into me.' (HCP18 — PN)

To overcome their lack of formal influence, some practice nurses, active case managers, and specialist nurses described negotiating informal pathways. For example, one active case manager used her informal links with secondary care to get information about patients:

'You only know if the family ring up you know, the next day and say, "oh by the way, they've gone in", or sometimes we'll not know for days, that the patient has gone in (...). We just literally don't know. It's just by sheer luck (...). So, as soon as we find out, to improve communication, we go down, we go on to the wards, we speak to the staff, we write our details in their notes, please contact us, our phone number. Sometimes it works, other times it doesn't.' (HCP21 — ACM)

A practice nurse described making

herself more accessible to patients so that they would contact her in a crisis rather than using unscheduled care:

'I just gave him [the patient] a bit of an open door, if he'd turn up at reception, which he's done a couple of times, "I need to see [practice nurse]" (...). Then often I'd squeeze him in and see him (...). "I'll make this appointment and come back and see me then but, in the meantime, you've got my phone number". And I speak to him on the phone.' (HCP16 — practice nurse)

Optimising the patient. GPs, practice nurses, active case managers, and specialist nurses described changing individual patients' behaviour as a key mechanism to reduce the use of unscheduled care, suggesting that they might teach patients to control their symptoms better. They described this approach as 'self-management':

'Well of course you can make a difference, I see my role as instructing people, training them and trying to help them self-manage themselves, and part of self-management is when to seek advice, um, when they're unwell (...). And, you know, I think if you can drill certain responses into people then, um, you know, eventually they will learn.' (HCP7 — GP)

Most healthcare professionals who discussed optimising patients' behaviour in this way described using educational strategies, predominantly giving information, rather than using behaviour-change strategies:

'Education, education, education (...). Patient education for all um chronic diseases I think is so badly dealt with (...). "So these are why we manage you [to the patient], this is how we manage you, this is why we're monitoring you. Um these are why we do your track, err your checks, your annual reviews, to check to your lung function to see if it's deteriorating, to make sure you're taking your medication properly because if you're taking it properly, it's gonna reduce the risk of infections."' (HCP16 — practice nurse)

All GPs, practice nurses, active case managers, and specialist nurses discussed how their knowledge of individual patients was a tool to understand where to focus efforts to optimise the patient, and thus reduce the use of unscheduled care. They described this knowledge as building over time, as part of an ongoing healthcare

professional–patient relationship:

'I think it's just getting that they're [the patient] confident in you and your ability and that you've got some sort of rapport going with a patient. And sometimes that does take quite a long time to build up that sort of rapport that you've got with a patient so that they trust you really, in a way. So to make changes it isn't always easy but it's something that you develop. And this is why I say nothing ever happens quickly, you've got to build that patient and get to know that patient and have that rapport.' (HCP18 — practice nurse)

With practice nurses and GPs, this relationship could be sustained over time, but for active case managers, the time-limited nature of their interventions created an additional tension when working with patients:

'So usually it's [active case manager service] about a 12-week period of interventions, so where people are referred to us, we go away and we work with them and just see what we can do to kind of improve the situation [...]. There's a lot of people, even though you're preventing hospital admissions and GP input, they phone you a lot, you know, and you can't really discharge those patients.' (HCP4 — ACM)

DISCUSSION

Summary

Owing to the high financial costs of unscheduled care services and the increasing burden of long-term conditions, reducing the use of unscheduled care by patients with long-term conditions is a major policy issue across all levels of the UK health system and internationally.^{3–5} This is the first study to explore the perceptions of a range of healthcare professionals about the use of unscheduled care by patients with long-term conditions.

Across the sample of different healthcare professionals involved in the provision and reduction of unscheduled care for patients with long-term conditions, use of unscheduled care was viewed as a necessary component of care, recognising exacerbations as inevitable in long-term conditions. However, some healthcare professionals saw the use of unscheduled care as a failure to meet policy targets, on which they were performance managed. Approaches to reducing the use of unscheduled care depended on the healthcare professional's role. Thus GPs discussed the need to optimise the system to

direct patients to more appropriate services. Practice nurses, active case managers, and specialist nurses reported negotiating, or bypassing, the system to help patients to avoid the use of unscheduled care. Both groups of healthcare professionals reported strategies to optimise the patient through attempting behaviour change. Emergency department doctors and out-of-hours GPs did not see it as their role to reduce patients' use of unscheduled care.

Strengths and limitations

Data were analysed by researchers of different professional backgrounds, thus increasing the trustworthiness of the analysis.¹⁷

Healthcare professionals in one geographical area were interviewed. Although, even within this area, perspectives and roles varied, this study may not reflect the range of perspectives elsewhere in the UK (with different policy initiatives) or internationally (in different healthcare systems).

The interviews were conducted over an 8-month period during the introduction of the new quality and productivity indicators, which target GPs to reduce the use of unscheduled care.⁶ These new targets may affect how GPs discuss their role in relation to reducing the use of unscheduled care.

Comparison with existing literature

The work of Lipsky, identifying public-sector workers as 'street-level bureaucrats', provides a framework within which to analyse these data that describe the perspectives of different healthcare professionals on operationalising a health policy dictated from above, which may be at odds with clinical decision making, and striving to resolve the conflicts associated with working directly with the consumers of public services.¹⁵ In Lipsky's analysis, 'street-level bureaucrats' develop mechanisms to help them to 'process workloads expeditiously'.¹⁵ Checkland showed how GPs and practice nurses responded in this way to National Service Frameworks, implementing changes only when this expedited their work.¹⁸ Lipsky argues that the decisions of 'street-level bureaucrats' and 'the devices they invent to cope with uncertainties and work pressures effectively become the public policies they carry out'.¹⁵ Thus while policy aims to reduce the use of unscheduled care, GPs interpret their role to be supporting patients navigating through a complex system. GPs described illness exacerbations as inevitable, and as often requiring resources

beyond primary care. Therefore, GPs saw a role for unscheduled care services to take on the workload of managing exacerbations.

GPs describe solutions that optimise the way patients with long-term conditions use the existing system. However, the solutions described could be viewed as beyond their individual control to implement. This suggests that GPs see reducing the use of unscheduled care as outside their remit. Patients view unscheduled care as one of several healthcare options available to them, complementing routine care, and not necessarily as a failure of self-management or routine care.¹⁹

Lipsky argues that 'street-level bureaucrats' respond to the pressures on them by 'developing conceptions of their work and of their clients that narrow the gap between their personal and work limitations and the ideal dictated by policy'.¹⁵ This is exemplified by the practice nurses, active case managers, and specialist nurses who described finding ways of negotiating the system, in order to reduce the use of unscheduled care and meet targets, despite their relative lack of power and influence on the healthcare system. Practice nurses, active case managers, and specialist nurses were often frustrated by their lack of influence in the teams in which they work. Some described directing patients to seek help from themselves rather than unscheduled care, which they recognised may create dependency and appears at odds with the policies aimed at patient self-management.^{2,5,7}

Lipsky also defines 'street-level

bureaucrats' in terms of the characteristics of their work situations, particularly the autonomy they enjoy in face-to-face consultations, and the limitations inherent in working with limited resources.¹⁵ Healthcare professionals in this study described using consultations with patients to attempt to change patient behaviour, therefore maximising their resources. However, as described by healthcare professionals here, there is a conflation of the notions of behaviour change and 'self-management' with simple information giving. While there is evidence that supporting self-management in people with long-term conditions can reduce hospital admissions,²⁰ there remains a question as to whether information giving alone can be effective in achieving behaviour change.^{21,22}

Implications for practice and research

Current policy to reduce the use of unscheduled care does not take account of the perceptions of the healthcare professionals who are expected to implement policies, and the constraints on their work. Thus system changes, rather than reliance on individual practitioners to make changes in their practice, are required. Adopting a whole-system approach with a focus on patient self-management strategies has been shown to be effective elsewhere.²³ This approach requires that healthcare professionals can support behaviour change in patients, which has training implications and will require investment of resources by clinical commissioning groups.

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REFERENCES

1. O’Cathain A, Knowles E, Munro J, Nicholl J. Exploring the effect of changes to service provision on the use of unscheduled care in England: population surveys. *BMC Health Serv Res* 2007; **7**: 61.
2. Wilson T, Buck D, Ham C. Rising to the challenge: will the NHS support people with long term conditions? *BMJ* 2005; **330(7492)**: 657–661.
3. Department of Health. *Our health, our care, our say*. London: Department of Health, 2006.
4. Wanless D, Forder J, Fernandez J, *et al*. *Securing good care for older people: taking a long-term view*. London: King’s Fund, 2006.
5. Department of Health. *Improving the health and well-being of people with long-term conditions*. London: Department of Health, 2010.
6. NHS Employers. *Quality and Outcomes Framework guidance for GMS contract 2011/2012*. London: NHS Confederation (Employers) Company, 2011.
7. Department of Health. *Supporting people with long term conditions: liberating the talents of nurses who care for people with long term conditions*. London: Department of Health, 2005.
8. Challis D, Abell J, Reilly S, *et al*. *Evaluating active case management in Greater Manchester*. Manchester: Personal Social Services Research Unit, 2008.
9. NHS Employers. *Investing in general practice: the new general medical services contract*. Leeds: NHS Employers, 2003.
10. Griffiths C, Kaur G, Gantley M, *et al*. Influences on hospital admission for asthma in south Asian and white adults: qualitative interview study. *BMJ* 2001; **323(7319)**: 962.
11. Malone RE. Whither the almshouse? Overutilization and the role of the emergency department. *J Health Polit Policy* 1998; **23(5)**: 795–832.
12. Jones IR, Ahmed N, Kelly M, *et al*. With an attack I associate it more with going into hospital: understandings of asthma and psychosocial stressors; are they related to use of services? *Soc Sci Med* 2008; **66(3)**: 765–775.
13. Chew-Graham C, Rogers A, May C, *et al*. A new role for the general practitioner? Reframing ‘inappropriate attenders’ to inappropriate services. *Prim Health Care Res Dev* 2004; **5(1)**: 60–67.
14. *CHOICE project*. Manchester: Manchester Mental Health and Social Care Trust, 2011. <http://choice.mhsc.nhs.uk/home.aspx> (accessed 17 Jan 2013).
15. Lipsky M. *Street-level bureaucracy: dilemmas of the individual in public services*. New York: Russell Sage Foundation, 1980.
16. Ritchie J, Spencer L. Qualitative data analysis for applied policy research. In: Bryman A, Burgess R (eds.). *Analysing qualitative data*. London: Routledge, 1994, pp. 173–194.
17. Henwood KL, Pidgeon NF. Qualitative research and psychological theorizing. *Br J Psychol* 1992; **83(1)**: 97–111.
18. Checkland K. National Service Frameworks and UK general practitioners: street-level bureaucrats at work? *Sociol Health Illn* 2004; **26(7)**: 951–975.
19. Langer S, Chew-Graham C, Hunter C, *et al*. Why do patients with long-term conditions use unscheduled care? A qualitative literature review. *Health Soc Care Community* 2012. [Epub ahead of print].
20. Lorig KR, Sobel DS, Stewart AL, *et al*. Evidence suggesting that a chronic disease self-management program can improve health status while reducing hospitalization: a randomized trial. *Med Care* 1999; **37(1)**: 5–14.
21. Wilson PM, Kendall S, Brooks F. Nurses’ responses to expert patients: the rhetoric and reality of self-management in long-term conditions: a grounded theory study. *Int J Nurs Stud* 2006; **43(7)**: 803–818.
22. Macdonald W, Rogers A, Blakeman T, Bower P. Practice nurses and the facilitation of self-management in primary care. *J Adv Nurs* 2008; **62(2)**: 191–199.
23. Bower P, Kennedy A, Reeves D, *et al*. A cluster randomised controlled trial of the clinical and cost-effectiveness of a ‘whole systems’ model of self-management support for the management of long-term conditions in primary care: trial protocol. *Implement Sci* 2012; **7(1)**: 7.