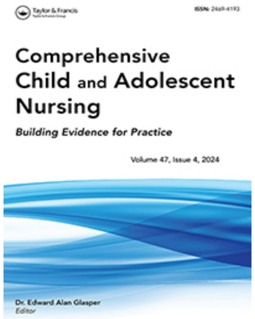

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Reframing the Narrative: An Exploratory Study of the Concerns, Expectations and Experiences of Parents Who Bring Their Child to an Emergency Department with Non-Urgent Illness

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ABSTRACT

Parenthood inevitably includes caring for a child suffering from mild–moderate illness requiring access to health care. Most childhood illnesses can be managed in the community, and parents are encouraged to attend the most suitable primary care service for their needs. Yet the number of children visiting emergency departments with non-urgent illness continues to rise annually, with child attendance representing over 25% of the total workload. This study investigated why parents chose to bring their child to an emergency department and explored the concerns, expectations and experiences of parents when making this decision. Parents of children aged 0–16 years presenting with non-urgent conditions were approached over an 18-month period to participate. Prior to discharge, focused interviews were used to explore the antecedent decision-making factors leading up to attendance, and parents' experiences of urgent care were explored. Parents often experienced complex journeys prior to attending the emergency department following multiple health care contacts and referrals from other providers. For most parents, attending the department was a considered decision, often prompted by their experience of interaction with professionals. Health professionals were powerful agents controlling resources and knowledge, but they were influenced by pressures and targets within the health service. The NHS is a complicated system that parents tried to navigate, but they were thwarted by its complexity and conflicting messages. When their child was unwell parents wanted a service that was simple to access, and that would offer a standard of care that would reassure and empower them to continue to care for their child. The findings challenge assumptions that lead nurses to criticize parents for misuse of emergency care, and highlight the culpability of health professionals and systems in generating increased demand for urgent care. It is important for nurses and others to reframe their perception of parental decision-making.

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Background

Rise in attendance at emergency departments (ED)

Attendance at type 1 emergency departments (a consultant-led, 24-h service with full resuscitation facilities)[1] is rising annually and placing the UK National Health Service (NHS) under continued and unsustainable financial pressure. The latest complete dataset from NHS Digital (2024) show that there were 25.5 million attendances in 2022–2023, an increase of 4% over the 25.3 million in 2021–2022. This in turn surpassed the 2020–2021 17.4 million by 39.8%. Additional evidence from the UK indicates that the rising numbers of patients and the associated rise in financial costs affect the availability and quality of emergency care (NHS England, 2019); exacerbate failure to treat patients within 4 h (The Kings Fund, 2022); and cause delays in commencing treatments and reduced compliance with guidelines (Jarvis, 2016). An Australian report noted delays in treatment and pain management, longer waiting times, and negative impact on patient dignity and privacy (Unwin et al., 2016). Consistently, children represent 20–30% of all UK ED attendances (NHS England, 2023; Royal College of Paediatrics and Child Health, 2022), with the 0–4 years age group representing approximately half of these (Office for Health Improvement & Disparities, 2024). A substantial proportion attend for non-urgent illness or injury (Simpson et al., 2022).

The COVID-19 pandemic exerted significant reduction on attendance at pediatric EDs in Ireland (Conlon, McDonnell, et al., 2021), Canada (Goldman et al., 2020), Italy (Lazzerini et al., 2020), and the UK (Roland et al., 2020). Despite widespread concern that many parents of children in need of urgent medical review might have delayed attendance, a review of attendances across EDs in the UK and Ireland found that "red-flag" symptoms were reported in 81 (6.0%) of 1349 patients. Of these, only two (2.5%) were felt to have been delayed in presenting and neither of these patients was admitted to hospital" (Roland et al., 2020, p. e32). However, the overall picture of decision-making behavior by parents during lockdowns is complex and multifactorial, with problematic sampling while restricted to remote or online methods (Neill et al., 2021). Regardless, it is clear that the general increase in numbers of children brought to the ED, including those whose need could be met in less-pressured services, was disrupted during the pandemic, but has since continued to rise.

Parental anxiety, media influence, and encouragement to seek a consultation

Life-threatening illnesses are at an all-time low, yet evidence from Ireland and the UK shows that the fear of potential loss of a child has intensified (Conlon, Nicholson, et al., 2021; Gill et al., 2013; Rowe et al., 2015). Media campaigns to raise awareness of meningitis and sepsis have inadvertently increased parental anxiety regarding children with a minor illness as the symptoms for serious bacterial infection are vague and nonspecific (Holden et al., 2017; Neill et al., 2014; Watson & Blair, 2018).

The Internet has become the first choice for information for parents when their child is unwell (Neill et al., 2014). Advice is also often sought from other parents in online social groups who offer a mixture of interpretations of symptoms and possible diagnoses based on their own experience and 3rd party reports. Research from the USA, Scotland, and the UK records that the potential seriousness of the illness is usually emphasized, and parents encourage one another to seek professional help (Bryan et al., 2020; Doyle, 2013; Rowe et al., 2015). Such increasing worry becomes a serious driver for urgent reassurance, and parents in Northern Ireland and England have described a sense of relief when arriving at the emergency department (Butun & Hemingway, 2018; Gill et al., 2013; Rowe et al., 2015). Across the UK, parents may secure multiple contacts with health professionals until they feel reassured that they have accessed the best care for their child (O'Cathain et al., 2019; Ogilvie et al., 2016; Woolfenden et al., 2000). The ED is often the preferred option for its simple access, 24-h availability, perceived expertise of the staff, and the availability of rapid diagnostic testing (Holden et al., 2017). The risk of being perceived to be a negligent parent may reinforce this. In a study of French parents, Costet Wong et al. (2015) noted intense psychological motives driving attendance at the ED. Seeking reassurance, concern for the child's suffering, and being considered to be a responsible parent were strong factors.

Perception of severe illness

Evidence from Ireland suggests that parents are able to recognize their child being unwell but have difficulty grading severity (McGovern et al., 2017). Parental anxiety for a sick child can bring a misaligned perception of urgency, lowering the threshold to seek advice, and justifying attendance at the ED in Ireland and the UK (Nicholson et al., 2020; O'Cathain et al., 2019). McLauchlan et al. (2020) found parental uncertainty and low tolerance of risk were key drivers for attending EDs in the UK. Parents anticipated rapid assessment and equally rapid intervention and treatment if required.

It felt safer to wait in the ED than to worry at home. Researchers in Northern Ireland and the Netherlands conclude that when parents fear loss of control of the situation they prefer to hand responsibility to health professionals (Butun & Hemingway, 2018; Hugenholtz et al., 2009). Cautious professionals in the USA (Canares et al., 2014), the UK (O'Dowd, 2015; Watson & Blair, 2018), and Australia (Turbitt & Freed, 2016) may also over-investigate when caring for children in the ED. Higher levels of concern for younger children promote increased likelihood of referral into secondary care (Canares et al., 2014; Cecil et al., 2015). Studies have found that around 50% of parents in England received advice to attend emergency department from another HCP, suggesting a reluctance to manage acute health problems and any potential risk (Mason et al., 2017).

Choosing ED rather than primary care

Parents would choose to see their GP but often reported difficulties in obtaining urgent GP appointments (Butun & Hemingway, 2018; Conlon, Nicholson, et al., 2021; Gnani et al., 2016). However, most parents would prefer to use the most appropriate service for their child (McLauchlan et al., 2020). Successive UK governments have been keen to divert non-urgent patients away from EDs by encouraging the use of alternative services such as minor injury units, walk-in centers, NHS helplines, and pharmacies, but the confusing array of urgent care options may lead parents to default to the ED. Two studies from the UK evidence this (Holden et al., 2017; Rowe et al., 2015). Realising that GPs lacked specialist pediatric knowledge and would probably refer them to hospital anyway; lack of consistent advice and management doctors; and time constraints of appointments were often cited. Parents reported mixed notions of the UK telephone advice service NHS111, which was held not to be useful in urgent situations, partly because the telephone operators were not clinically trained, partly because they would likely refer the case to the ED anyway, often transported by an ambulance called by NHS111. (More recently, NHS111 operators are able to make GP appointments directly.) Walk-in centres were often especially busy with long waiting times. In contrast, parents valued the child-friendly environment of the ED and being reviewed by experts in the management of sick children. Instilled in the paediatric nurse is the delivery of family and child-centered care, an inclusive concept of parental partnership and care of family members as well as the child (O'Connor et al., 2019).

Professionals' attitudes to inappropriate or non-urgent attendance

Studies in the UK found doctors who reviewed children's ED attendance records retrospectively rated over 30% (Prince & Worth, 1992) and 60% (Watson & Blair, 2018) of attendances to be "inappropriate" (a notable percentage increase over 18 years, though additional factors such as less sustained pressure in EDs in 1992 may have exerted an effect). Professionals in Northern Ireland (Butun & Hemingway, 2018), Scotland (Patton & Thakore, 2012), and Ireland (Conlon, McDonnell, et al., 2021) focus on parental lack of knowledge when considering the appropriateness of children's attendance. There is frustration at the perceived failure of the parent to recognize that a child is suffering from a mild illness only, and an expectation that the parent should manage the illness without intervention from the emergency department. A historic review of staff attitudes in England and Wales found "blaming the patient" for "inappropriate attendance" to be common, with clinicians often exhibiting less sympathy and understanding, and more irritation and frustration (Sanders, 2001). Staff can convey criticism for seeking urgent medical attention for a minor childhood illness (Neill & Coyne, 2018).

Summary

The causes of persistent increase in parents taking children to the ED are clearly multifactorial. They include concern that symptoms of mild acute illness could represent the prodromal stage of much more serious conditions. Misleading media messages, risk-averse health professionals, and over-complicated systems to access alternative provision further promote the decision to default to the ED, even if only for reassurance.

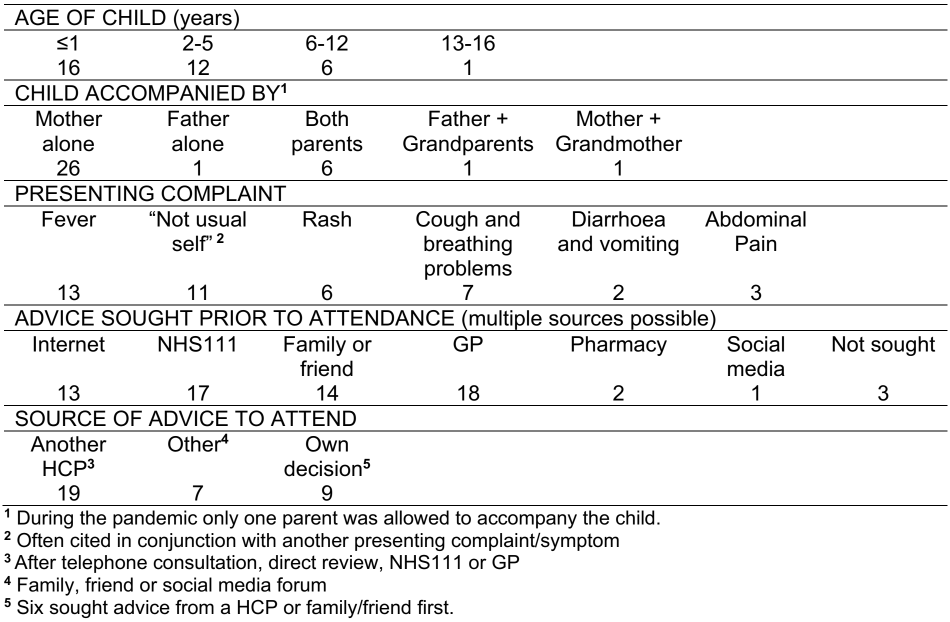
Study design

This was an exploratory study of a clinical and service-management issue, addressing the research question of "What are the concerns, expectations and experiences of parents who choose to bring their child to the emergency department with mild or moderate acute illness?" Parental behavior and the social processes involved in the decision to attend the emergency department were studied through a pragmatic qualitative design.

Using purposive sampling over 18 months, parents of children age 0–16 years presenting with non-urgent conditions were approached to participate in the study. Prior to discharge, focused interviews were conducted to explore the antecedent decision-making factors leading up to attendance. Ten parents with children who met the inclusion criteria and were representative of the ethnic backgrounds of the study population commented on the study's purpose and design while in the department. On six occasions, both mother and father were present. Parents in the PPI group advised approaching potential participants after their child had been triaged and when their own anxiety had been reduced. They thought that the researcher should wear a uniform, conveying reassurance that clinical support would be readily available should the child's condition change during the interview. They preferred hand-written notes to be taken during the interview rather than audio-recording. All thought the study to be both worthwhile and needed.

Sample

The study population was adults with parental responsibility for children aged 0–16 years brought to the emergency department with an acute illness and triaged with a Manchester Triage System score of 3 or 4 (Mackway-Jones et al., 2013). An interpreter was available, but all participants were able to understand and speak English. Children whose clinical or social issues identified by the triage nurse could be aggravated by inclusion were excluded. Any safeguarding concern, or children who had a child protection plan in place or who were accompanied by a foster carer were excluded. Since looked after children often suffer worse health than others, partly because of deprivation, neglect or abuse (Department for Education and Department of Health and Social Care, 2015; Department of Health, 2009), they are seen more frequently in EDs (Kossarova et al., 2017; Office for National Statistics, 2023). The expected threshold for securing medical assessment is lower in such cases in the UK. A sample of 50 participants was planned. However, restrictions imposed by the COVID-19 pandemic drastically reduced attendance by children in emergency departments throughout the UK, curtailing recruitment to 35 parents (see Figures 1 and 2).



AGE OF CHILD (years)						
≤1	2-5	6-12	13-16			
16	12	6	1			
CHILD ACCOMPANIED BY[1]						
Mother alone	Father alone	Both parents	Father + Grandparents	Mother + Grandmother		
26	1	6	1	1		
PRESENTING COMPLAINT						
Fever	"Not usual self"[2]	Rash	Cough and breathing problems	Diarrhoea and vomiting	Abdominal Pain	
13	11	6	7	2	3	
ADVICE SOUGHT PRIOR TO ATTENDANCE (multiple sources possible)						
Internet	NHS111	Family or friend	GP	Pharmacy	Social media	Not sought
13	17	14	18	2	1	3
SOURCE OF ADVICE TO ATTEND						
Another HCP[3]	Other[4]	Own decision[5]				
19	7	9				

[1] During the pandemic only one parent was allowed to accompany the child.
[2] Often cited in conjunction with another presenting complaint/symptom
[3] After telephone consultation, direct review, NHS111 or GP
[4] Family, friend or social media forum
[5] Six sought advice from a HCP or family/friend first.

Figure 1. Summary of demographic data.

	2020											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Data collection periods and number recruited	10		7					7				
Lockdown periods												
	2021											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Data collection periods and number recruited	11											
Lockdown periods												

Figure 2. Data collection and lockdown periods.

Data collection and analysis

Data was collected using semi-structured, focussed interviews. Following triage, parents were invited to participate in the study. Information was given along with the consent form, and time was allowed for the parents to consider these. The interview began following medical assessment in the patient cubicle. A number of closed questions elicited previous exposure to the emergency department, the child's age and features of their illness, the time of attendance, and if the parent had previously consulted any other health care provider. Additional data was available from the patient record. Open questions explored making the decision to attend emergency department and the feelings generated by that decision; what parents anticipated and expected from their visit; what instilled parental confidence in a healthcare experience; and the type of service they would like to have available when their child was unwell. After this, parents were also asked to reflect on their visit to the department, considering whether the experience matched their expectations, the impact on their confidence, and thoughts about how they would react should the child become unwell again in the future. In seven cases, parents opted for a follow-up interview by telephone 2 days after discharge, while the majority felt able to complete the study in a single interview. The restrictions imposed during the pandemic were implicit in the decision. Hand-written notes were made, and these were checked for accuracy with the participants. Taking notes seemed to allow parents time to marshal their thoughts and recall previous experiences. Field notes were added to explain, supplement and clarify what had been discussed. The framework method was adopted for data analysis, following the step-by-step process detailed by Braun and Clarke (2013) and by Smith and Firth (2011).

Ethical issues

A risk analysis approach was adopted (Long & Johnson, 2007), identifying actual or potential risks to participants and then working to eradicate, minimize or prepare for the occurrence of the risk. To counter the risk of perceived coercion clear information about the study was provided in a printed information sheet, explaining the study, emphasizing the voluntary basis of participation and what this would entail, and assuring of the right to decline or to withdraw at any time without needing to provide an explanation. The sensitivity of the subject and the vulnerability of the participant was acknowledged in the information sheet, and should the participant begin to experience any distress, the interview would terminate immediately, and appropriate support would be offered within the department. However, no distress was expressed or evident during the study, and participants expressed feelings of being secure in the knowledge that the child was in no danger. Signed consent was secured.

The risk of breach of confidentiality was addressed by not collecting any personally identifiable data or clinical data, and by attributing a study number to each participant. Data was stored securely on a password-protected computer, and hard copy files were stored in locked filing cabinet with access restricted to the researchers (Johnson & Long, 2010). A register of participants (with corresponding study number) was made but retained by the NHS trust R&D department for destruction as soon as possible under GDPR guidance. Approval was secured from a university research ethics committee and an NHS research ethics committee. No unexpected ethical issues arose, and there was no breach of the protocol.

Findings

The impact of HCP behaviour on help-seeking behaviour

Parents told Neill et al. (2013) that feeling the need to avoid criticism by medical professionals could cause them to delay a request for medical consultation. It was common in this study for parents to recount unsatisfactory exchanges with HCPs which caused them to perceive criticism and dismissal of their concerns. However, despite feeling that they had been turned away unjustly, they would persist in attempts to access help for the child, sometimes from the same service. They expected the practitioner to engage with their concerns, recognizing the validity of parental knowledge of the individual child. A persisting imbalance in power was identified in the professional-parent relationship. In particular, the relevant perspectives of each party were seen by participants to be in conflict regarding the purpose and reason for access to the health service. Parents sought professional assessment and intervention but reported that professionals indicated or expressed views of inappropriate attendance and needless concern which added to over-taxing of the service. This suggests a perceived lack of unity of vision over the nature of the encounter.

Powerful yet pressured HCPs

Participants acknowledged HCPs as empowered, knowledgeable agents with responsibility to manage access to limited resources, but they were not aware of the impact on practitioners of government-set targets and the wider demand on provision of services established by the rules of the health structure. It was concluded from the analysis that the rules that might fix their position of the HCP as a compassionate, caring agent within the health structure could be reformed when the HCP experienced pressure exerted by the boundaries of targets. During a consultation, the *unwritten* modified rules imposed for accessing the service would be put into place by the professional, and the HCPs would expect parents to comply. Participants believed that when they failed to comply with the unknown expectations, the professional would apportion blame to them as the help-seeker and would level criticism, while their own position of power would be reinforced. After digesting this encounter mentally, parents might enter future consultations with trepidation and fear of further criticism.

> Whenever I see the GP with one of the children, I get the feeling they're thinking "she's back again." I find him condescending, that I'm worrying for nothing; wasting his time.

Alternatively, parents could challenge the power of the HCP if they felt that their trust in HCPs had been redefined by a previous encounter. Any disparity in professional knowledge and management meant parents were less likely to conform to the rules of the health structure, or they modified the rules based on their experience. Parents felt enabled to question the HCP's professional judgment, and the power base of the HCP would be weakened.

> They didn't look at her with fresh eyes. They just thought it was the same illness as before. It's only because of my persistence as a mum who knows my child.

> I've not been listened to in the past, and I've been proven right. So now I just keep going back until I know it's sorted.

> Tell me he's ok and I'll go away, but if I'm not convinced, I'll come back.

The impossible complexity of the health system

The complex system of the UK NHS (as with many others in the World) is difficult to navigate. Parents in the study attempted to master this, but found themselves thwarted by conflicting messages, implicit requirements and changing structures. In order to select the most appropriate service to address their child's needs as emphasized by governmental advice, parents had tried in vain to understand the available options. In part, this was due to lack of advice and services specific to children's health problems, and partly to existing systems being ill-equipped to offer helpful pathways to successfully seeking professional help. The same systems multiplied parental concern through adding delay to accessing professional intervention, in the process increasing frustration and stress. Inability to access the suggested appointments, lack of continuity in professional response, and confusion caused by impossible suggestions resulted in confusion and desperation. In this situation, parents resorted to the option that appeared most likely to be safe, competent and available: the ED. Indeed, there were many instances of professionals directing parents to take the child to an ED, leading participants to question the purpose of other services which had, in effect, simply delayed resolution. In this, the structure of the health service as currently configured could be seen to perpetuate the crippling pressure felt on key services; notably, EDs.

> All this could have been prevented. We didn't need a blue light ambulance, only to then be told there was a seven hour wait. We've sat here for another three hours today. All I wanted was the GP to listen to his chest. We didn't need to have all this. They could have done this in a few minutes.

Concern for the child over-rode habits of compliance

Once parents became sufficiently concerned about their child's health, and through increasing experience of the system, they felt able to evaluate the validity of service structures and to disregard the rules (in so far that these could be identified). In effect, they made more or less conscious decisions to circumvent the system. Worry about the child's welfare prompted them to seek help from alternative sources or to return to services previously contacted, relenting only once satisfied that significant attention and effective care were witnessed. In the absence of positive, diligent professional responses, they ignored ineffective signposting and demanded attention in different services until the aim was achieved.

> We weren't messing about. We needed to go the quickest place when he looked so poorly with his temperature. We were very worried. And we've always felt reassured when we've brought

> him to A&E. Feel he always gets fully checked over, and if he needs any investigations or anything, these can be done straight away.

Parents' ideal service

In this study, parents were unable to express what they expected from attending the ED except that there would be a long wait, but a competent professional would assess the child and prescribe treatment if needed. When asked what type of service they would like to access when their child was unwell, it was made clear that they prioritized rapid access to triage or first assessment; a service that was accessed easily; and reassuring care of a high standard that would empower parents to take back care of the child as soon as was appropriate. They expected compassion and kindness from the HCP, together with sufficient time for listening and good communication and for the best needs of the family to be considered in a holistic manner.

> I was worried about him. I don't want to wait when my child is unwell.
>
> I want to get seen quickly. I don't want to have to wait even more than a few hours if he's unwell.
>
> I want her to be seen by someone who's confident, who explains things. This gives me confidence then.
>
> I think good communication instils confidence, a thorough examination, good listening skills, and then information giving.

Persistence of the most common drivers to access the ED

It was notable that the most common signs and symptoms of childhood illness that trigger anxiety and concern about children remained unchanged for more than two decades. Despite efforts to promote parental education and to enhance health literacy (Butun & Hemingway, 2018; Holden et al., 2017; Watson & Blair, 2018), findings from Kai (1996) still apply.

Discussion

Limitations and strengths of the study

The study was limited first by recruitment from a single ED, and further research to include more sites in different cities would be advisable. However, participants were typical in demographic characteristics of the catchment population. Moreover, the onset of the COVID pandemic, with significantly fewer children being taken to EDs internationally, forced reduction of the sample size from 50 to 35. Increasing commonality in what parents reported was found in the latter part of data collection, so this reduction may not have exerted much impact. No notable difference was identified in parents' concerns and help-seeking actions before, during or after the lockdown restrictions.

While the intention had been to elicit what parents had expected from attending the department and then to compare this with their experiences of the encounter, it transpired that few were able to express their expectations other than having to wait (possibly for hours) to have the child assessed by a doctor or a nurse. Despite this, detailed accounts were provided of the logistical route to attendance at the ED, including multiple encounters with HCPs and much frustration at the response.

The study was successful in a number of ways. While previous research has tended to address "inappropriate" attendance at EDs retrospectively and usually remotely, this study was undertaken through contemporaneous interviews "in the moment" and in person in the department. Timing the encounter to occur after triage, with the attendant reassurance that the child was in no danger, enabled meaningful discussion, with parents expressly stating that their anxiety had abated. In only two cases did parents decline to engage in the interview: one father who had to go to work, and a mother who, herself, felt unwell.

Parental views (rather than those of professionals) on the judgment of inappropriate attendance were exposed through exploration of cognitive, behavioral and experiential aspects of decision-making that had led to attendance at the ED. These perceptions were neither embellished not tempered by the passage of time. It was clear that participants were cognizant of the overwhelming demands placed on the health service and the professionals who provided the services, but they prioritized the safety of their child, showing persistence when disappointed by the response, knowingly risking criticism, and learning incrementally from each experience. These perspectives on parental behavior add to the knowledge base in the field.

Increasing pressure on ED services

There can be little doubt that progress has been made, and continues to be made, to achieve the Royal College of Paediatrics and Child Health standards of ED provision for children (Royal College of Paediatrics and Child Health, 2018), though there remains room for improvement (Royal College of Paediatrics and Child Health, 2022). However, comparable guidance for urgent care services offered to children is less well documented. There is no suggested explanation in the NHS Long Term Plan (NHS, 2019) for the continued rate of 25% of ED attendance being by children (whether avoidable or not), nor of alternative means of providing for this need. The document offers a somewhat vague Urgent Treatment Centre model, but this is little more than a listing of alternative sources of support (NHS111, community pharmacies, primary care services, and others), suggesting that these will be more convenient than attendance at the ED. Sadly, these were the services that participants in this study had tried to use unsuccessfully, failing to secure the sought-for reassurance or treatment, and experiencing increasing frustration at the delay in review of the child's condition. The pathways had all led to a visit to the ED, after unnecessary delay, sometimes only to be met with criticism for their action.

Efforts to harmonize the views of service users and service providers has been lacking sometimes at a national policy level. The Kennedy report (Department of Health and Social Care DHSC, 2010) noted that there was little concession to children's needs in the design of health services. This report also acknowledged the inevitability of parents defaulting to ED attendance given the hopeless complexity of other services. More recently, Lord Darzi, in a summary letter to the Secretary of State for Health and Social Care (DHSC, 2024), stated boldly that "the National Health Service is in serious trouble" (Section 1) and that public satisfaction has reached the lowest ever level. Noting that the decline in the nation's health has occurred over 15 years, the report identifies increasing difficulty in accessing GP appointments and other community-based services (mental health services for children and young people being particularly affected). "A&E is in an awful state" declares the report (Section 8), and "The patient voice is not loud enough" (Section 19).

As part of the long-term effort to return the NHS to its former state of functioning, there is an urgent need to reframe the narrative about parental actions when attending the ED with a child suffering non-urgent illness. Rightly, parents prioritize the safety and well-being of their child, combat an ineffective system of alternative provision and a bewildering array of services and contradictory messages, and finally turn in despair to the ED. They have acted as responsible parents. The system has failed them. A different understanding is needed, too, of the performance of ED nurses and doctors and of the services in which they work. Unsustainable pressure of work, striving to meet unattainable targets, and frustration at being unable to offer the service that they wish to provide and of which they are professionally capable provokes stress and fatigue. Lord Darzi expresses this cogently.

> It needs to be stressed that falling productivity doesn't reduce the workload for staff. Rather, it crushes their enjoyment of work. Instead of putting their time and talents into achieving better outcomes, clinicians' efforts are wasted on solving process problems, such as ringing around wards desperately trying to find available beds. (DHSC, 2024, section 13)

Conclusion

To our knowledge, this was the first study that interviewed parents with children suffering non-urgent illness contemporaneously during their visit to the emergency department regarding. Previous studies have collected data retrospectively. This study captured the decisions that parents made at the point of need as a more accurate representation of what they were experiencing. Their concerns, emotions and frustrations were not tempered or embellished following a period of reflection. This approach to further research should elicit more valid data and promote better decision-making on service design.

The findings from this study contradict the culpability of parents for inappropriate access to the ED. Rather, they point to the attitude and actions of HCPs, together with a deeply flawed service model, as a major stimulus to the increasing demand on EDs by parents of children whose clinical need could be met more efficiently and at lower cost by a more appropriate system of support. The over-complicated system of access to services, while designed to direct service users to the most appropriate level of provision, became contradictory and ineffective. For parents, this system appeared as a series of obstacles to securing advice, support, and intervention for their child at a time when they had tried to follow the guidance but were becoming increasingly concerned. They had tried to select the right pathway, but found themselves blamed for making the wrong choice.

Increased understanding of parents' journey to securing review of their child's condition, greater insight into the difficulties experienced by them in attempting to access the intended service, and more empathy with their desperate quest to be reassured that the child was in no danger might improve the overall experience as well as boosting confidence in their own judgment in future. To achieve this, widespread action is necessary in repairing NHS services for children and young people both in the community and in hospital such that nurses and other HCPs are enabled to provide the professional service that they would consider to be of an adequate standard.

Note

1. https://www.datadictionary.nhs.uk/attributes/emergency_care_department_type.html.

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Ethical statement

All participants gave informed consent, and formal ethical approval was secured from the University of Salford (HSR1819-031) and from an NHS Research Ethics Committee (19/NW/0278). Narrative data may be requested from Dr Ruth Berry.

References

Braun, V., & Clarke, V. (2013). *Successful qualitative research* (1st ed.). Sage Publications.

Bryan, M., Evans, Y., Morishita, C., Midamba, N., & Moreno, M. (2020). Parental perceptions of the internet and social media as a source of pediatric health information. *Academic Pediatrics*, *20*(1), 31–38. https://doi.org/10.1016/j.acap.2019.09.009

Butun, A., & Hemingway, P. (2018). A qualitative systematic review of the reasons for parental attendance at the emergency department with children presenting with minor illness. *International Emergency Nursing*, *36*, 56–62. https://doi.org/10.1016/j.ienj.2017.07.002

Canares, T., Brown, L., Slotkin, R., & Garro, A. (2014). Treating children at urgent care centers: A qualitative study to determine how providers perceive managing pediatric patients. *Rhode Island Medical Journal*, *5*(98), 48–53.

Cecil, E., Bottle, A., Sharland, M., & Saxena, S. (2015). Impact of UK primary care policy reforms on short-stay unplanned hospital admissions for children with primary care-sensitive conditions. *Annals of Family Medicine*, *13*(3), 214–220. https://doi.org/10.1370/afm.1786

Conlon, C., McDonnell, T., Barrett, M., Cummins, F., Deasy, C., Hensey, C., McAuliffe, E., & Nicholson, E. (2021). The impact of the COVID-19 pandemic on child health and the provision of care in paediatric emergency departments: A qualitative study of frontline emergency care staff. *BMC Health Services Research*, *21*(1), 279. https://doi.org/10.1186/s12913-021-06284-9

Conlon, C., Nicholson, E., De Brún, A., McDonnell, T., & McAuliffe, E. (2021). *Stuff you think you can handle as a parent and stuff you can't*. Understanding parental health-seeking behaviour when accessing unscheduled care: A qualitative study. *Health Expectations*, *24*(5), 1649–1659. https://doi.org/10.1111/hex.13305

Conlon, C., Nicholson, E., Rodríguez-Martin, B., O'Donovan, R., De Brún, A., McDonnell, T., Bury, G., & McAuliffe, E. (2021). Factors influencing general practitioners decisions to refer paediatric patients to the emergency department: A systematic review and narrative synthesis. *BMC Family Practice*, *21*(1). https://doi.org/10.1186/s12875-020-01277-9

Costet Wong, A., Claudet, I., Sorum, P., & Mullet, E. (2015). Why do parents bring their children to the emergency department? A systematic inventory of motives. *International Journal of Family Medicine*, *2015*, 1–10. https://doi.org/10.1155/2015/978412

Department for Education and Department of Health and Social Care. (2015). *Statutory guidance on promoting the health and well-being of looked after children*. https://www.gov.uk/government/publications/promoting-the-health-and-wellbeing-of-looked-after-children-2

Department of Health. (2009). *Statutory guidance on promoting the health and well-being of looked after children*. https://assets.publishing.service.gov.uk/media/5a7c0121ed915d41476222b1/promoting_health_of_looked_after_children.pdf

Department of Health and Social Care. (2010). *Getting it right for children and young people: Overcoming cultural barriers in the NHS so as to meet their needs. A review by professor sir Lan Kennedy*. https://www.gov.uk/government/publications/getting-it-right-for-children-and-young-people-overcoming-cultural-barriers-in-the-nhs-so-as-to-meet-their-needs

Department of Health and Social Care. (2024). *Independent report. Summary letter from Lord Darzi to the secretary of State for Health and Social Care*. https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england/summary-letter-from-lord-darzi-to-the-secretary-of-state-for-health-and-social-care

Doyle, E. (2013). *Seeking advice about children's health in an online parenting forum*. http://www.medicalsociologyonline.org/resources/Vol7Iss3/MSo_7.3_Seeking-advice-about-childrens-health_Doyle.pdf

Gill, P., Goldacre, M., Mant, D., Heneghan, C., Thomson, A., Seagroatt, V., & Harnden, A. (2013). Increase in emergency admissions to hospital for children aged under 15 in England, 1999–2010. national database analysis. *Archives of Disease in Childhood*, *98*(5), 328–334. https://doi.org/10.1136/archdischild-2012-302383

Gnani, S., Morton, S., Ramzan, F., Davison, M., Ladbrooke, T., Majeed, A., & Saxena, S. (2016). Healthcare use among preschool children attending gp-led urgent care centres: A descriptive, observational study. *BMJ Open*, *6*(6), e010672. https://doi.org/10.1136/bmjopen-2015-010672

Goldman, R. D., Grafstein, E., Barclay, N., Irvine, M. A., & Portales-Casamar, E. (2020). Paediatric patients seen in 18 emergency departments during the COVID-19 pandemic. *Emergency Medicine Journal*, *37*(12), 773–777. https://doi.org/10.1136/emermed-2020-210273

Holden, B., Egan, M., Snijders, V., & Service, S. (2017). *Why do parents bring children with minor illness to emergency and urgent care departments? Literature review and report of fieldwork in North West London [ebook]*. The Behavioural Insights Team. https://www.bi.team/publications/why-do-parents-bring-children-with-minor-illness-to-emergency-and-urgent-care-departments/

Hugenholtz, M., Bröer, C., & van Daalen, R. (2009). Apprehensive parents: A qualitative study of parents seeking immediate primary care for their children. *The British Journal of General Practice: The Journal of the Royal College of General Practitioners*, *59*(560), 173–179. https://doi.org/10.3399/bjgp09X394996

Jarvis, P. (2016). Improving emergency department patient flow. *Clinical and Experimental Emergency Medicine*, *3*(2), 63–68. https://doi.org/10.15441/ceem.16.127

Johnson, M., & Long, T. (2010). Research ethics. In K. Gerrish & A. Lacey (eds.), *The research process in nursing* (6th ed., pp 31–41). Blackwell Publishing.

Kai, J. (1996). Parents' difficulties and information needs in coping with acute illness in preschool children: A qualitative study. *BMJ*, *313*(7063), 987–990. https://doi.org/10.1136/bmj.313.7063.987

The Kings Fund. (2022). *Key facts and figures about the NHS*. Retrieved 23 May, 2022, from https://www.kingsfund.org.uk/audio-video/key-facts-figures-nhs

Kossarova, L., Cheung, R., Hargreaves, D., & Keeble, E. (2017). *Admissions of inequality: Emergency hospital use for children and young people*. https://www.nuffieldtrust.org.uk/sites/default/files/2017-12/nt-admissions-of-inequality-web.pdf

Lazzerini, M., Barbi, E., Apicella, A., Marchetti, F., Cardinale, F., & Trobia, G. (2020). Delayed access or provision of care in Italy resulting from fear of COVID-19. *The Lancet Child & Adolescent Health*, *4*(5), e10–e11. https://doi.org/10.1016/S2352-4642(20)30108-5

Long, T., & Johnson, M. (Eds). (2007). *Research ethics in the real world: Issues and solutions for health and social care*. Elsevier.

Mackway-Jones, K., Marsden, J., & Windle, J. (2013). *Emergency triage: Manchester triage group (advanced life support group)* (3rd ed.). Wiley-Blackwell.

Mason, S., O'Keefe, C., Jacques, R., Rimmer, M., & Ablard, S. (2017). *Perspectives on the reasons for emergency department attendances across Yorkshire and the Humber*. Retrieved May 31, 2022, from https://www.sheffield.ac.uk/media/10306/download

McGovern, M., Kernan, R., & O'Neill, M. (2017). Parental decisions regarding pre-hospital therapy and costing of the emergency department visit. *Irish Medical Journal*, *110*(2), 513. https://imj.ie/parental-decisions-regarding-pre-hospital-therapy-and-costing-of-the-emergency-department-visit/

McLauchlan, K., Ramlakhan, S., & Irving, A. (2020). Why do parents present to the paediatric emergency department with conditions suitable for management in less acute settings? A qualitative study. *European Journal of Emergency Medicine*, *27*(1), 40–45. https://doi.org/10.1097/mej.0000000000000611

Neill, S., Carter, R., Jones, R., Roland, D., Bayes, N., Tavaré, A., Hughes, J., Turner, T., Chynoweth, J., Tan, C., & Moll, H. (2021). Caring for a sick or injured child during the COVID-19 pandemic lockdown in 2020 in the UK: An online survey of parents' experiences. *Health Expectations*, *24*(6), 2036–2046. https://doi.org/10.1111/hex.13347

Neill, S., Cowley, S., & Williams, C. (2013). The role of felt or enacted criticism in understanding parent's help seeking in acute childhood illness at home: A grounded theory study. *International Journal of Nursing Studies*, *50*(6), 757–767. https://doi.org/10.1016/j.ijnurstu.2011.11.007

Neill, S. J., & Coyne, I. (2018). The role of felt or enacted criticism in parents' decision making in differing contexts and communities: Toward a formal grounded theory. *Journal of Family Nursing*, *24*(3), 443–469. https://doi.org/10.1177/1074840718783488

Neill, S., Jones, C., Lakhanpaul, M., Roland, D., & Thompson, M. (2014). Parent's information seeking in acute childhood illness: What helps and what hinders decision making? *Health Expectations*, *18*(6), 3044–3056. https://doi.org/10.1111/hex.12289

NHS Digital. (2024). *Hospital accident and emergency activity, 2022–2023*. https://digital.nhs.uk/data-and-information/publications/statistical/hospital-accident-emergency-activity/2022-23

NHS England. (2019). *The NHS long term plan*. https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan-june-2019.pdf

NHS England. (2023). *Emergency care data set (ECDS) data February 2023 statistical commentary*. Retrieved May 1, 2024, from https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2023/04/ECDS-Supplementary-Analysis-Statistical-commentary-Feb-2023.pdf

Nicholson, E., McDonnell, T., De Brún, A., Barrett, M., Bury, G., Collins, C., Hensey, C., & McAuliffe, E. (2020). Factors that influence family and parental preferences and decision making for unscheduled paediatric healthcare – systematic review. *BMC Health Services Research*, *20*(1). https://doi.org/10.1186/s12913-020-05527-5

O'Cathain, A., Connell, J., Long, J., & Coster, J. (2019). 'Clinically unnecessary' use of emergency and urgent care: A realist review of patients' decision making. *Health Expectations*, *23*(1), 19–40. https://doi.org/10.1111/hex.12995

O'Connor, S., Brenner, M., & Coyne, I. (2019). Family-centred care of children and young people in the acute hospital setting: A concept analysis. *Journal of Clinical Nursing*, *28*(17–18), 3353–3367. https://doi.org/10.1111/jocn.14913

O'Dowd, A. (2015). Doctors increasingly practise "defensive" medicine for fear of litigation, says regulator. *BMJ*, *350*(jan08 6), h87. https://doi.org/10.1136/bmj.h87

Office for Health Improvement & Disparities. (2024). *Child and maternal health: Healthcare use*. Retrieved May 1, 2024, from https://fingertips.phe.org.uk/profile/child-health-profiles/data#page/1/gid/1938133230

Office for National Statistics. (2023). *Inequalities in accident and emergency department attendance, England: March 2021 to March 2022*. Retrieved November 24, 2024, from https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/articles/inequalitiesinaccidentandemergencydepartmentattendanceengland/march2021tomarch2022

Ogilvie, S., Hopgood, K., Higginson, I., Ives, A., & Smith, J. (2016). Why do parents use the emergency department for minor injury and illness? A cross-sectional questionnaire. *JRSM Open*, *7*(3), 205427041562369. https://doi.org/10.1177/2054270415623695

Patton, G., & Thakore, S. (2012). Reducing inappropriate emergency department attendances-a review of ambulance service attendances at a regional teaching hospital in Scotland. *Emergency Medicine Journal*, *30*(6), 459–461. https://doi.org/10.1136/emermed-2012-201116

Prince, M., & Worth, C. (1992). A study of 'inappropriate' attendances to a paediatric accident and emergency department. *Journal of Public Health*, *14*(2), 177–182. https://doi.org/10.1093/oxfordjournals.pubmed.a042718

Roland, D., Harwood, R., Bishop, N., Hargreaves, D., Patel, S., & Sinha, I. (2020). Children's emergency presentations during the COVID-19 pandemic. *Lancet*, *4*. https://doi.org/10.1016/S2352-4642(20)30206-6

Rowe, B., Cook, C., Wootton, R., & Brown, T. (2015). *ED: Studying parental decision making around non-urgent attendance among under 5s*. https://www.revealingreality.co.uk/wp-content/uploads/2017/03/Revealing_Reality_DH_non-urgent_attendance.pdf

Royal College of Paediatrics and Child Health. (2018). *Intercollegiate committee for standards for children and young people in emergency care settings*. Retrieved May 1, 2024, from https://www.rcpch.ac.uk/membership/committees/intercollegiate-committee-standards-children-young-people-emergency-care

Royal College of Paediatrics and Child Health. (2022). *Facing the future: Standards for children and young people in emergency care settings - Audit findings* Retrieved September 25, 2024, from https://www.rcpch.ac.uk/resources/facing-future-standards-children-young-people-emergency-care-settings-audit-findings

Sanders, J. (2001). A review of health professional attitudes and patient perceptions on 'inappropriate' accident and emergency attendances. The implications for current minor injury service provision in England and Wales. *Journal of Advanced Nursing*, *31*(5), 1097–1105. https://doi.org/10.1046/j.1365-2648.2000.01379.x

Simpson, R., O'Keeffe, C., Jacques, R., Stone, T., Hassan, A., & Mason, S. (2022). Non-urgent emergency department attendances in children: A retrospective observational analysis. *Emergency Medicine Journal*, *39*(1), 17–22. https://doi.org/10.1136/emermed-2021-211431

Smith, J., & Firth, J. (2011). Qualitative data analysis: The framework approach. *Nurse Researcher*, *18*(2), 52–62. https://doi.org/10.7748/nr2011.01.18.2.52.c8284

Turbitt, E., & Freed, G. (2016). Paediatric emergency department referrals from primary care. *Australian Health Review*, *40*(6), 691. https://doi.org/10.1071/ah15211

Unwin, M., Kinsman, L., & Rigby, S. (2016). Why are we waiting? Patients' perspectives for accessing emergency department services with non-urgent complaints. *International Emergency Nursing*, *29*, 3–8. https://doi.org/10.1016/j.ienj.2016.09.003

Watson, M., & Blair, M. (2018). Emergency departments and minor illness: Some behavioural insights. *Archives of Disease in Childhood*, *103*(4), 309–310. https://doi.org/10.1136/archdischild-2017-314057

Woolfenden, S., Ritchie, J., Hanson, R., & Nossar, V. (2000). Parental use of a paediatric emergency department as an ambulatory care service. *Australian and New Zealand Journal of Public Health*, *24*(2), 204–206. https://doi.org/10.1111/j.1467-842x.2000.tb00144.x