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Submission to the Urgent and Emergency Care Review in England

This note supplements our response made via the online questionnaire. The shortcomings of that process must be pointed out. It is questionable how some of the response categories, viz "mostly", "partly", will be interpreted. It allowed very little scope for comment outside a rigidly controlled process of agreement or disagreement with set-piece evidence reviews. On such an important subject, it is sad that the online questionnaire was not more carefully designed.

Considering the review's terms of reference, it is necessary to point out that it overlooks two key dimensions to understanding what the present problems are with the public's relationship to urgent and emergency care. First there is no qualitative or quantitative content reflecting what users, carers and the public think about current arrangements and no insight into their behaviour in response to messages about how to use services. That needs to be addressed by appropriate user engagement processes at local level. As an example of what should happen, we designed an engagement process for 111 and Out of Hours Services which could address that need.[1] So far we have seen no evidence that this sort of activity has been implemented anywhere, so the lack of user-led intelligence will persist.

Second, the language of emergency and urgent care is itself subjective and ambiguous to the public (and we suspect, to many health professionals if they would admit that). This must be addressed in terms of what these words mean to everyday people and how they impact on behaviour, especially in times of stress and anxiety. The remainder of this note focuses on the language and behaviour issues and explains our solution.

Words matter, so why keep ignoring that time and again?

MAC partners have many years experience of working up close with the NHS in different lay roles. We have seen clinicians, managers, policy wonks and pundits decry the collective "failure" of patients to use emergency services "appropriately". We have witnessed campaign upon campaign to try to get patients to change what is seen as nativist behaviour and to be more

[1] www.publicinvolvement.org.uk/2012/10/111-user-engagement-doing-the-right-thing-right/

"responsible". It is no surprise that these campaigns fail and that the NHS is bewildered and often resentful about that. But what can they expect when their exhortations use ambiguous, subjective and value-saturated language? "Urgent" and "non-emergency" are some of the most subjective words – like "fairness" – ever encountered. We suggest later in this note a way to overcome this ambiguity by building on the NHS's most successful brand recognition.

Differences in understanding influenced by culture, gender, age, geographical implications – and in most urban areas these are very marked - are all forgotten when the NHS talks about "emergency" and "urgent care". The most ludicrous (though doubtless well-intentioned) example of this failure to communicate was the campaign "Notalwaysaande" which ran in East London earlier this year. [2]

What it said was *Injured or unwell? Don't just go to A&E if it's not a serious emergency.* But what that actually meant to the average reader in multi-ethnic East London is unknown. Double negatives are hard to get your head around and invite confusion about what action to take. This is a classic case of "swamp words" – you think you know what they mean, but when you press them a bit they give way into mush.

Sloppy communications carry a big price of incomprehension

It is only too easy to do the right thing wrong. Communications about NHS 111 are a case in point. Our local announcement in Wandsworth said

You should call 111 if:
- *it's not a 999 emergency*
- *you think you need to go to A&E or another NHS urgent care service*
- *you don't think it can wait for an appointment with your GP, or*
- *you don't know who to call for medical help*

For more routine health needs, you should still contact your GP or dentist in the usual way, and for immediate, life-threatening emergencies, continue to call 999.

Take the first two bullet points: they are clearly contradictory. The first says use 111 if it isn't a 999 emergency; the second says use it if you think you do need to go to A&E. The subtle distinction – if there is one – between these will be lost on 99.9% of people. For the public 999, A&E, and ambulance are essentially synonyms. And they always will be.

And then there is the phrase "NHS urgent care service". As a PEC lay member, I asked for years - since I first got involved in 2009 locally with re-specifying and procuring a new out of hours service – what "urgent care" actually meant. I never had a direct answer that made much sense. There still isn't one for the public. And the way it is written in this announcement, it

[2] www.publicinvolvement.org.uk/2013/02/notalwaysaande-get-it/

implies that A&E and “urgent care” are in the same group of services. Clearly they aren’t.

“Non emergency” (another negative definition of course) might have been used instead, but really that and “urgent care” are terms with little meaning for the public – *how urgent is urgent?* It is entirely subjective to a non-clinician. Someone who is distressed and frightened especially at night or with a small child or elderly relative who is ill is not going to rationally assess things. They are going to go where they know they will eventually be seen and where everything that could be needed is available – and that will always be the nearest A&E department. *“Am I bleeding enough for 999?”* is not a question I want to ask myself before deciding whether to blue light it to A&E or have a nice chat to the new 111 health advisor operative instead.

Stop fighting patient behaviour and learn from it

The message the NHS in England needs to gain from this exercise is simple: Stop fighting the patients by trying to change their behaviour towards what the experts believe it should be. Instead, learn from the behaviour of service users and shape the services around that accordingly.

A colleague, herself a very experienced community nurse, described the problem in these words, bearing in mind particularly the situation of people with limited English and perhaps little understanding of how the NHS is supposed to function (but then on the latter point most home grown citizens could also be included in our experience).

Most members of the human race do better with a simple approach to dealing with challenge. Experiencing sudden onset of confusing symptoms requires the most simple of actions if anxiety is to be avoided. Anxiety is a major issue when coping with the unexpected and trying to do the right thing creates more anxiety which renders us less intelligent and therefore more challenging for the professionals who strive to do the right thing for their patients.

Effective solutions to dealing with A& E contacts will only be achieved if anxiety is diminished, they work at 2am, anxious mothers of babies and young children are considered and binge drinkers and domestic violence are taken into account. I would challenge anyone to ‘do the right thing’ when the advice given is complex and creates yet more anxiety for people who are struggling with the ‘unknown’ and human suffering in the early hours of a cold morning.

That is the reality for many potential A&E and urgent care users. So our recommendation is that everyone be directed to take one simple step -

Just follow the big flashing red arrow to get help

The way to fix the A&E “problem” is to stop seeing it as a problem, but as the tremendous success it really is. The NHS should build on A&E’s great success and universal brand recognition. Key to that is beefing up primary care to a 24/7 accessible service in the following way.

- Keep it simple.
- Locate 24hr primary care in emergency departments
- Make out of hours primary care available on a walk in basis.
- Keep some morning slots at surgeries open so that out of hours demand can be deferred.
- Monitor this and adjust accordingly.
- Emergency staff should rotate through general practice and vice versa.

The rest of the fix is simple too:

- Follow what the users do already.
- Implement engagement systems to produce user-led intelligence about accessing and experiencing the service
- Make the service happen where they want to go to get it.
- Don't berate them for going to the "wrong" place. Wherever they go, makes it "right" for them.

To emphasise all of that, there needs to be a big flashing red arrow over every A&E with the words "come in here and we will sort you out". It would be a bit like the Tardis on the inside with something for everyone – even the drunks.

This may seem counter intuitive to most health care professionals, but it is common sense to the public. It can work because it's what the public wants to do anyway. So why not make it the natural solution instead of repeatedly struggling to make people behave differently? Everybody wins and no one gets blamed for acting "inappropriately" and clogging up A&E. That's because it's where they are supposed to be when they need urgent help.

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