Cutting A&E use and health inequalities

In this article...
- Why patients choose A&E over GP practices
- Steps taken to reduce A&E attendance
- Evaluation of the A&E attendance-reduction programme

Keywords: Diversity/Migrant/Ethnic minority/A&E

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In south west London, nurses, community workers, GPs and others have worked together to develop a programme that supports migrant communities, resulting in a reduction in their use of accident and emergency services. The programme included setting up community education sessions, six-week courses, and bilingual advocacy and interpretation services. Its success relied heavily on the team getting to know local communities, working in partnership and making time to develop trust. The lessons learnt from establishing these services are discussed to help readers improve their equality and diversity practice.

Merton is a leafy borough in south west London, perhaps best known for housing Wimbledon. It may be surprising to learn that 27% of Merton’s population is from minority ethnic groups (Office for National Statistics, 2011). Like many areas, the population in Merton is increasing and getting older, while health and social care resources are limited and a large proportion of the health workforce is heading towards retirement (Merton Council, 2007). People from migrant communities are often not registered with a GP or tend to visit accident and emergency departments rather than using primary care.

Given resource and staffing constraints, it is not sustainable for whole groups of the population to bypass primary care. By not attending GP clinics, this group is also missing out on essential preventive services and support - often coping with progressively deteriorating conditions until they reach crisis point.

Throughout the UK, there is a strong link between deprivation and health inequalities, with the most deprived areas generally having the lowest life expectancy (Randhawa, 2007). These areas also tend to have a higher prevalence of smoking, obesity, unhealthy eating and risky drinking behaviour (Johnson, 2006). This is of particular significance in Merton, where it is not uncommon for a third of geographic wards to be made up mainly of those from minority ethnic populations, including people from eastern Europe and South East Asia.

We audited local data and found 43% of A&E attendance occurred on weekdays, in working hours. GP practices with the highest number of weekday A&E users were in areas of socioeconomic deprivation and high multi-ethnicity.

Aims of the programme
In 2010, we met with nurses, doctors, community groups and commissioners to address how to reduce the high rates of A&E use. We aimed to target migrant communities with education and support. Government policies highlight the need to support diverse groups (Department of Health, 2010; Home Office, 2010) and health and social services are required by law to undertake equality and diversity assessments and implement diversity plans (University of Stirling, 2009). We took a

5 key points
1. People in the most deprived areas generally have the lowest life expectancy
2. There are growing pressures on accident and emergency departments across the UK
3. Health and social services are required by law to undertake equality and diversity assessments and implement diversity plans
4. By choosing to attend A&E rather than go to a GP, individuals are missing out on vital preventive services and support
5. Working in partnership with community groups and charities can help health professionals access hard-to-reach groups

A&E services are overburdened

Many people are increasingly going to accident and emergency departments when they could visit a GP. One scheme aimed to improve education and cut attendances.
The broad aims of the programme were to:

- more sustainable use of health services.
- ultimately lead to healthier behaviour and
- with community groups to support a
- more proactive approach, with nurses and other professionals working side by side with community groups to support a change in mindset in the hope that changing how people think and feel would ultimately lead to healthier behaviour and more sustainable use of health services. The broad aims of the programme were to:

Setting up the programme

Over the past two years, the Government Office for London funded Merton Health-care (now part of Merton Clinical Commissioning Group) to provide targeted support for migrant communities. This work is being expanded into neighbouring areas with funding from NHS South West London Public Health.

Our programme involved three key strategies:

- A bilingual advocacy service was set up to signpost people to NHS services, run education workshops, identify ambassadors in the community and provide interpreting and translating services in GP practices and at home visits. Bilingual health advocates were able to help health professionals provide more responsive services because they understood the community and cultural influences on health, such as fasting or the use of alternative remedies.

- A six-week education programme was developed and run by a multidisciplinary team, including nurses, health coaches, paramedics, pharmacists, midwives, nutritionists and falls specialists. The programme helped participants set their own health goals and become mentors in their communities to share what they learnt.

- Large-scale educational open days were run in community venues to create a friendly environment where local people could meet professionals and ask for advice.

Outcomes of the programme

The programme has had a marked effect on how organisations work together, migrant people’s health behaviours and the use of hospital services. Some of the programme outcomes are listed below:

- Audits have helped to enhance our understanding of the demographics of the area so services can be targeted appropriately;
- A health diversity framework has been developed based on feedback from local people;
- More patients from migrant groups are registering at GP practices and a new migrant registration policy has been developed;
- Data about ethnicity and language preferences is being collected more routinely and more effectively at GP practices;
- Migrant communities report feeling more educated and empowered to use GP and pharmacy services, rather than always relying on A&E (Box 1);
- Colleges, health fairs, the YMCA, homeless charities and the heads of education are rolling out education strategies to help younger migrants, who are less likely to register with a GP, understand how to access services;
- Partnerships have been developed with many stakeholders including patient representative groups, community groups, GPs, ambulance, pharmacy, midwifery and nutrition services, Live Well projects, local authorities, libraries, children’s centres, schools and charities;
- A dedicated team has been set up to promote diversity;
- A bilingual health advocacy service has been set up to provide translators and undertake health promotion. Materials have been translated into languages such as Tamil, Polish, Urdu and Somali and there are plans to run antenatal classes in Tamil and Polish;
- The education model for smoking cessation has been reviewed and a new GP practice-based model has been launched in the Tamil and Polish languages;
- Over a two-year period, 22 six-week Help Yourself to Health education programmes have been run in schools, community centres, temples, mosques and other community venues, with 332 participants. Sessions focus on self-care, first aid at home and understanding how to access GPs, community pharmacists, A&E and other health services;
- Four Stop the Clock information days have been held in community venues to provide advice about diabetes, smoking, heart disease and weight management. In total, 160 people attended a day about diabetes, 156 attended a Happy Heart event, 156 attended a Breathe Easy event and 36 NHS champions, patients, charity leads and council leads shared learning at a stakeholder event;
- Smoking and weight-management clinics have been run at GP practices and community centres;
- Flu vaccination clinics for homeless people have been promoted in collaboration with community pharmacists and a local charity. Over a one-year period, 40 homeless people received flu vaccinations and 33 received health checks;
- Cultural awareness training has been delivered to 50 service providers including nurses, teachers, social workers, health visitors, children’s centre workers and physiotherapists. This includes a discussion of the education, health and insurance services in other countries and how this might impact on migrants’ expectations of the NHS.

**BOX 1. FEEDBACK**

“The [service] has helped my family to get fitter, healthier and...” (Homeless person)

“Now that I am registered with a GP...I can get some help at last for my drinking problems...” (Person from Sri Lanka)

“The...[sic]...has helped my family to [service]...” (Homeless person)

“Now that I am registered with a GP, I would not know how to access services; I just asked for advice.” (Homeless person)

“[sic]...has helped my family to [service]...” (Homeless person)

“[sic]...has helped my family to [service]...” (Homeless person)

“Now that I am registered with a GP, I have renewed confidence to try different things and have managed to stop smoking too.” (Person)

“[sic]...has helped my family to [service]...” (Homeless person)

“[sic]...has helped my family to [service]...” (Homeless person)

“A bilingual advocacy service was set up to...” (Homeless person)

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**TABLE 1. MERTON A&E ATTENDANCE RATES**

<table>
<thead>
<tr>
<th>Year</th>
<th>Attendances</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001/02</td>
<td>56,506</td>
</tr>
<tr>
<td>2003/04</td>
<td>72,635</td>
</tr>
<tr>
<td>2004/05</td>
<td>79,881</td>
</tr>
<tr>
<td>2005/06</td>
<td>82,302</td>
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<tr>
<td>2006/07</td>
<td>83,259</td>
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<tr>
<td>2007/08</td>
<td>84,537</td>
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<tr>
<td>2008/09</td>
<td>72,011</td>
</tr>
<tr>
<td>2009/10</td>
<td>74,023</td>
</tr>
<tr>
<td>2010/11</td>
<td>73,826</td>
</tr>
<tr>
<td>2011/12</td>
<td>71,374</td>
</tr>
</tbody>
</table>
It is important to note that there is a trend towards reducing the tidal wave of unnecessary A&E attendances in Merton. Since 2002, attendances at A&E departments across England have risen sharply. In 2009-10, over 20.5 million people attended A&E – an increase of almost 5% from the previous year (DH, 2012). This increase is thought to be due to confusion over GP out-of-hours services and a rise in migrant populations, members of whom are less likely to register with a GP and, therefore more likely to use A&E services.

In Merton, increases were also apparent (Table 1), but the health diversity initiative is helping to address this trend. Since the programme began in 2010, overall A&E usage rates have declined by 3%. This reduction is even more marked in the five practices serving the most deprived areas, which have received targeted support. Here, there have been reductions in A&E usage of around 10% (Table 2). There remains work to do, but the trends are positive.

**Implications for practice**

The lessons learnt in Merton are applicable to many other areas; Box 2 outlines how to set up user-friendly services for minority ethnic groups.

The issue tackled here is pertinent throughout the UK – birth rates are rising and people are living longer, while there are increasingly diverse groups of people from different cultures, religions and demographic groups. Finances are becoming scarcer so commissioners, nurses and others at the frontline need to focus on preventive services and early interventions and to target people with higher levels of need.

**References**

<table>
<thead>
<tr>
<th>Year</th>
<th>Merton Clinical Commissioning Group</th>
<th>Five practices serving most deprived areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008/09</td>
<td>346</td>
<td>430</td>
</tr>
<tr>
<td>2009/10</td>
<td>353</td>
<td>482</td>
</tr>
<tr>
<td>2010/11</td>
<td>353</td>
<td>482</td>
</tr>
<tr>
<td>2011/12</td>
<td>333</td>
<td>437</td>
</tr>
</tbody>
</table>

**Box 2. DEVELOPING USER-FRIENDLY SERVICES FOR MINORITY ETHNIC GROUPS**

1. Get to know your local communities

Minority communities generally have a much younger age profile but the population is ageing overall. This has direct implications for the services nurses provide: there will be a continuing need for sensitivity to cultural diversity and services may need to be tailored to meet the needs of certain groups.

Services can take some time to establish, so thinking about this now will help in the future. In Merton, an important first step was to run workshops asking Tamil, Urdu and Polish populations what would support their health needs. People said they wanted informal education sessions to help improve their families’ health and to learn what NHS services were available.

Getting feedback from people early on helped to ensure the services were created jointly.

2. Work with others

Efforts need to be spread proportionally by need across many social groups, not just targeted to a single group or geographical area. Partnerships need to be developed that focus on supporting people of all ages across all communities to make healthy life choices.

Social services and community groups can raise awareness about being healthy, local businesses can help improve access to affordable healthy food and gyms, and schools and community centres can improve the uptake of physical activity. Charities and community groups can provide invaluable skills and knowledge, as well as a “way in” to hard-to-reach communities.

3. Build in time to develop trust

Minority communities may have very different beliefs and expectations about wellbeing and health services. Some people may have lived in countries in which they had to pay for everything including their healthcare; others may consider it a sign of weakness to admit that they are unwell or may be anxious about seeing a nurse or doctor, or be embarrassed or worried about communication difficulties. It takes time to help people understand that health services are there to serve them and to meet their needs.

When setting up new services, running education sessions or meeting community leaders, it is important to be realistic about what you can achieve.

4. Spread your knowledge

Often people think or act in a particular way because they do not know about the range of services or support available. In Merton, it became apparent that people were using A&E services because they did not know what else was available. An audit surveying 200 local people found 51% were not aware of emergency out-of-hours services. Explaining primary care, pharmacy and out-of-hours services at every contact and in translated posters and leaflets helped people to understand how to use services more appropriately.

5. Consider quick wins

In Merton, services aimed at preventing the major killers, such as heart disease and cancer, in the over-50s may have the greatest short-term impact. Looking at the demographics and needs of your area can identify how to make progress quickly. Demonstrating how you are making a difference to attitudes and behaviours can keep stakeholders motivated to take part, keep funders interested and build momentum. Celebrating successes and promoting what is being achieved is important for sustainability.