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# A&E: Studying parental decision making around non-urgent attendance among under 5s

A report prepared for the Department of Health

Cover photo: Andy Smith/ ESRO Research

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# 1 Executive Summary

There is currently a high demand for A&E services, putting pressure on NHS trusts and staff, and contributing to increased costs, waiting times and over stretched resourcing. Estimates quantifying the size of non-urgent A&E demand vary from 15% to 40% of all attendances<sup>1</sup>. An important subgroup of non-urgent attenders are young children presenting with symptoms of minor illness.

In order to deepen understanding of the factors influencing non-urgent demand, the Department of Health commissioned ESRO, an agency specialising in behavioural research, to conduct qualitative research with parents of young children who have taken their child to A&E in a non-urgent situation in the past 6 months. This report presents findings from the research.

The objectives of this research were twofold:

- Identify the behavioural factors that influence the decision making process of parents of young children who attend A&E in non-urgent situations
- Identify potential opportunity areas in which behavioural science approaches could be applied to decrease non-urgent A&E demand

The research methodology involved three components:

- A knowledge audit involving desk research into the current literature on paediatric non-urgent A&E demand and eight expert interviews
- 35 qualitative depth interviews with parents of young children who had recently attended A&E in a non-urgent situation across seven locations in England
- Local service mapping in five locations to provide contextual information on the healthcare services available to parents

## FINDINGS

The majority of parents interviewed in this research understood that A&E is for emergencies and agreed that people should only attend in urgent situations. However, all parents included in the research had taken their child to A&E in a non-urgent situation.

While many of the parents in the research described experiencing moments of uncertainty about their decision to go to A&E at some point before, during or after their attendance, this uncertainty was overridden by a desire to act cautiously. Going to A&E to 'just be on the safe side' outweighed the risks of not going. Some parents sought validation from others that their decision to go to A&E was correct and A&E staff would often provide that reassurance.

Parents' perceptions of what is available to them, and how 'appropriate' these services are perceived to be for their child's situation, is a key influencer in their decision to go to A&E. Local services have different 'pull and push' factors that increase (pull) or decrease (push) the attractiveness of services, influencing parents' motivations to use a particular service.

Parental perceptions of what counted as an 'emergency' were influenced by a number of medical and non-medical factors – which also meant that, for many of the parents participating in this research, A&E had become a 'default option'<sup>2</sup>. A&E was often perceived by parents as not only a simple service to understand, but also one that was appropriate to their circumstances.

1 Wide ranging figures for non-urgent demand are abundant, although the research underpinning them is frequently elusive. For example, a 2013 NAO report quantifies 20% of A&E attendances as being appropriate for primary, community or social care, based on analysis of Hospital Episode Statistics (HES) data; NHS England's Phase I *Urgent and Emergency Care Report* suggested that 25-40% of A&E attendances could have been managed by a GP or other primary care service where they are discharged without treatment; a report for the Royal College of Emergency Medicine suggests that no more than 15% of attendances are 'inappropriate'.

2 'Default option' refers to the tendency to opt for the default supplied to us, despite other choices being available.

Seven broad opportunity areas emerged from analysis of the research findings, each with a number of more granular opportunities for behavioural insight interventions to be developed in the future. The focus on identifying interventions to influence parent behaviour means that system level changes have been consciously avoided.



**Opportunity 1: Enhancing Specialism**

Some of the reasons that parents are attracted to A&E relate to the perceived specialisms within the healthcare services on offer within the department and in the wider hospital. Increasing the perceived specialism of other non-A&E healthcare services could help to address this, so that when their child is ill the parent is primed to think of these services as appropriate for their child.

Areas for interventions could include:

- Designing physical environments of non-A&E services to reflect the actual (and perceived) clinical expertise, knowledge, technology and equipment on offer there
- Increasing the perception of alternative services as ‘gateways’ to specialist services
- Reassuring parents that specialist tools and equipment are available at alternative services where appropriate
- Reframing GP services as more specialist
- Ensuring alternative services feel more ‘child appropriate’



**Opportunity 2: Consistent Offers**

A&E is perceived as having a more stable and enduring ‘brand’ than other services and is consequently more ‘top of mind’ when parents are deciding where to go in a potentially urgent/stressful situation. More consistent service provision and branding at other services may help make these services more top of mind.

Areas for interventions could include:

- Attempting to find some consistency in naming conventions for different healthcare offerings
- Positioning alternative services as NHS (or even A&E) ‘outposts’ – e.g. ‘A&E Local’
- Creating greater certainty of service provision and waiting times in other services
- Finding ways for other services to be available 24/7



**Opportunity 3: Skilling Up Parents**

Parents often doubt their own ability/judgement, and this lack of confidence can prevent them from attempting ‘self-care’. There is an opportunity to increase parents’ knowledge and confidence in their own ability to look after their child, perhaps also decreasing their panic and perception of ‘urgency’.

Areas for interventions could include:

- Demystifying child health
- Boosting parents’ confidence in their abilities
- Helping to promote self-care as a default option
- Learning practical treatment skills under supervision



**Opportunity 4: Providing Reassurance**

Parents in a heightened state of anxiety may behave in a less rational manner – often describing feelings of anxiety and panic. Finding ways to reassure parents can help to de-escalate situations and enable more reasoned decision making.

Areas for interventions could include:

- Reassuring and supporting parents at night time
- Improving the language used by other services to help parents make better distinctions between different conditions and avoid vague instructions that can promote uncertainty (e.g. if you are still worried in an hour then you probably should go to A&E)
- Encouraging parents to undertake small tasks related to the care of their child which help them to keep busy – helping them to feel more useful and hopefully reducing anxiety



### Opportunity 5: Timely Information

There is an opportunity to make information about child health more relevant to parents and to deliver it at the time when it will be most impactful and via the channel easiest to access.

Areas for interventions could include:

- Ways to ensure NHS information feels more 'fresh' and up-to-date
- Personalising information
- Opening up different channels of communication (e.g. incorporating live chat/video messaging into existing service offers)
- Enabling parents to communicate visually and share images to help overcome the challenge of articulating problems over the phone



### Opportunity 6: Emergency Environments

For parents, the communication relating to A&E (e.g. A&E won't kiss it better) runs counter to their perception of what it is like to visit an emergency department.

Areas for interventions could include:

- Tailoring the experience at A&E so parents know their attendance is deemed non-urgent
- Not providing medication and other 'free stuff' at A&E (e.g. Calpol and ibuprofen) which can legitimise the appropriateness of attendance – i.e. 'they wouldn't have given it to me if I wasn't here for a good reason'
- Creating spaces that feel more like they are designed for emergencies and for dealing with serious illness



### Opportunity 7: Navigating Choice

When parents feel that they are in an urgent situation, they seek out short-cuts to treatment and choose the path of least resistance. There is an opportunity to shorten the path to other services and help parents feel they are being 'fast-tracked'.

Areas for interventions could include:

- Ensuring parents feel or perceive that they are being prioritised and fast-tracked at alternative services
- Simplifying the actual (or perceived) number of steps involved in accessing alternative services (e.g. number of times you need to phone, number of different providers you need to phone etc). NB. Respondents reported that this is perceived to happen during some calls to NHS 111

## CONCLUSIONS

The issue of non-urgent attendance in A&E is complex with no immediately obvious or straightforward solutions. Behavioural science often presumes the way people behave is 'irrational' or the result of poor logic. However, for many of those included in this research the decision to attend A&E was, to a greater or lesser extent, carefully considered – with A&E often being deemed the best option out of a range of alternatives. One of the biggest challenges to addressing this issue is the complexity and changing nature of the healthcare ecosystem – with parents struggling to keep up with information in a sea of change. Therefore, those services that remain constant, which provide consistent quality and are easy to understand (like A&E), will remain top of mind at the point of need.

Given the number of factors that 'push' parents towards choosing A&E, shifting parental decision making towards other options may require bold interventions if they are to make any significant dent in the current numbers. Three main routes to change seem to exist: making A&E a much less attractive place to go (clearly not a preferred route by many healthcare experts or professionals, although a viable behavioural intervention nonetheless), making other healthcare choices more attractive, and helping parents to develop the confidence and skills around 'self-care'.

The seven opportunity areas identified in this report cover each of these potential routes for behaviour change – some more feasible than others. These opportunities will be considered by the Department of Health and other stakeholders as appropriate.

## 2 Introduction

**This report presents findings from qualitative research with parents who have taken their children into A&E in a non-urgent situation. It aims to provide a deeper understanding of the decisions leading to A&E attendance where an alternative service could have been used.**

There is currently a high demand for A&E services with 18.3 million accident and emergency attendances recorded in 2013-14<sup>3</sup>. This demand is putting pressure on NHS trusts and staff, and contributing to increased costs, waiting times and over stretched resourcing.

Of those who attend A&E there is variation in the urgency of the treatment they require, with some service users needing non-urgent care which could have been provided at an alternative service. Of the 18.3 million A&E attendances, 8.6 million (47%) left A&E without medical treatment and under the code 'GP follow-up required' or 'no follow-up required'<sup>4</sup>. While this does not mean that all these patients were attending unnecessarily, it does suggest the possibility of significant non-urgent demand.

In order to deepen understanding of the factors influencing non-urgent demand, the Department of Health commissioned ESRO, an agency specialising in behavioural research, to conduct qualitative research with parents of young children who have taken their child to A&E in a non-urgent situation in the past 6 months. This research explored the decision-making processes leading to A&E attendance, and focused on parents of young children under 5 years of age as a population subgroup more likely to attend A&E<sup>5</sup>.

What counts as non-urgent demand from the research perspective is A&E attendance by service users who could have used a different care provider such as an urgent care centre, minor injury unit, walk-in centre, primary care service or self-care. Parents use a variety of different terms when referring to their own situation and use the terms 'emergency' and 'urgency' to refer to a range of conditions and situations. Cases and situations mentioned throughout the report refer to those which the researchers would have classified as 'non-urgent'. Use of the words 'urgent' and 'emergency' in inverted commas refers to this disparity between the research definition and the wider perception.

### BACKGROUND: NON-URGENT DEMAND

#### SCALE

Understanding the scale of the problem of non-urgent A&E demand is made difficult due to contested and overlapping definitions, with the phenomenon referred to by a number of terms such as 'inappropriate' or 'unnecessary' demand<sup>6</sup>. As a result, analyses which seek to quantify non-urgent A&E attendance have produced varied estimates of the scale of the problem nationwide: the NHS England's Urgent and Emergency Care Report<sup>7</sup> states that 40% of patients attending A&E are discharged requiring no treatment at all and a National Audit Office report<sup>8</sup> states that approximately 20% of admissions are for known conditions which could be managed effectively by primary, community or social care services. However, a College of Emergency Medicine's study suggests that only 15% of A&E attendees could have been seen by a GP in the community without the need for attending A&E<sup>9</sup>.

#### CAUSES

In addition to uncertainties around the scale of non-urgent A&E attendance, the underlying reasons people attend A&E in non-urgent situations are varied and complex. The academic literature identifies a number of reasons why individuals may make this decision. These include: confusion around what constitutes an emergency<sup>10</sup>; elevated anxiety levels<sup>11</sup>; encouragement from a social network to attend

3 HSCIC 2013/2014

4 HSCIC 2013/2014

5 <http://www.hscic.gov.uk/catalogue/PUB13040/acci-emer-focu-on-2013-rep-V2.pdf>

6 For example, 'inappropriate' attendance has been defined as self-referral, not attending a follow up, received no investigation, no treatment and/or advice only, and discharged with no follow up care (McHale et al, 2013).

7 Transforming urgent and emergency care services in England. Urgent and Emergency Care review. End of Phase I Report. (2013).

8 HSCIC (2013)

9 <http://www.hsj.co.uk/Journals/2014/05/21/fi/fi/Analysis-of-accident-and-emergency-attendances.pdf>

10 McGuigan and Watson (2010); Nelson (2011)

11 Adamson et al (2009); O'Cathian et al (2008)

A&E<sup>12</sup>; perceived and actual lack of access to primary care services<sup>13</sup>; and referrals from less traditional urgent care providers such as out-of-hours or telephone triage services<sup>14</sup>.

The literature suggests that the causes of non-urgent attendance at A&E are a complex mix of systemic and behavioural factors. This creates deep-seated challenges associated with reducing non-urgent A&E attendance.

## PREVIOUS WORK FOCUSING ON THIS ISSUE

Previous policy interventions around this issue have focused on structural change at a systemic level and communication campaigns at an individual level.

Over the years new services such as walk-in centres, urgent care centres and minor injury units have been introduced with the intention of reducing the pressure on A&E<sup>15</sup>. More recently the Urgent and Emergency Care Review in 2013 laid out recommendations for further system-wide transformations<sup>16</sup>. In addition, there have been a number of public education initiatives, most recently the NHS 'Choose Well' communications campaign which has been rolled out across the country<sup>17</sup>.

In addition to structural reform and communication campaigns designed to decrease non-urgent A&E demand, there may be potential for behavioural-based interventions. To date there have been relatively few interventions aimed at reducing non-urgent A&E demand which draw on approaches from behavioural science, despite a growing number of successful behavioural insight interventions in other aspects of public healthcare<sup>18</sup>.

## RESEARCH AIMS & OBJECTIVES

The research aimed to understand the behavioural factors associated with parents' decision to attend A&E in non-urgent situations. This included what factors trigger concern over their child's health, what advice and help is sought and from whom, and what role is played by services other than A&E. The findings are intended to support the generation of evidence-based interventions, informed by behavioural science, to ease the demands on A&E.

The objectives of this research were, therefore, to:

- Identify the behavioural factors that influence the decision making process of parents of young children who attend A&E in non-urgent situations
- Identify potential 'opportunity areas' in which behavioural science approaches could be applied to decrease non-urgent A&E demand.

The first objective (to identify behavioural factors that influence parent decision making) refers to building on what is already known through previous research. This was achieved by going beyond 'what people say' about why they attend by mapping out their decision making processes and surrounding behaviours in detail (albeit still reliant on self-reported data)<sup>19</sup>. In addition, while the research to date has identified a range of contextual factors influencing attendance, there is a lack of evidence exploring the behaviour from the perspective of patient journeys or decision-making processes. This includes a limited understanding of the specific decision-making processes of parents on behalf of their children.

The research intends to help fill this knowledge gap by exploring the behavioural drivers (e.g. social networks and past experiences) and decision-making processes that influence individuals and by identifying the specific points at which these influences occur and decisions are made.

The second objective (to identify opportunity areas for the application of behavioural science) focuses specifically on potential interventions to address this behaviour and which could be low cost, pragmatic, scalable and testable. Opportunities for larger behaviour change (such as service redesign) or large scale structural reform are beyond the scope of this particular research. Although, there is inevitably cross-over between the two approaches.

12 Leaman et al (2006); O'Cathain et al (2008); McGuigan and Watson (2010)

13 Byrne et al (2003); Martin et al (2002); Patton and Thakore (2012); Rajpur et al (2000); Ahmed et al (2007)

14 Cook et al (2010); Purc-Stephenson and Thrasher (2012)

15 Kings Fund (2015)

16 Transforming urgent and emergency care services in England. Urgent and Emergency Care review. End of Phase I Report. (2013).

17 <http://www.choosewellmanchester.org.uk/>

18 Behavioural science is the study of behaviour through controlled and naturalistic observation and disciplined scientific experimentation, drawing on the disciplines of anthropology, psychology and sociology

19 Behavioural Insights Team/Cabinet Office (2010), Applying Behavioural Insight to Health

Given the complexity of the influencing factors causing non-urgent demand, it was decided to focus the research on the experiences of one patient subgroup to enable deeper exploration.

Young children are a population group more likely to attend A&E. Hospital Episode Statistics (HES) data shows that children from birth to four years old are amongst some of the most common A&E attenders<sup>20 21</sup>. In its study of HES data, the College of Emergency Medicine found that, of the 15% of people attending A&E who could be seen by a GP the following day, the largest subgroup were young children presenting with symptoms of minor illness<sup>22</sup>.

Unlike other population groups who are also high A&E service users, such as young adults and over 65 year olds, young children and their parents have more regular and routine points of contact with the health system. This group therefore provides opportunities for the development and testing of behavioural interventions using already established touch-points between parents and the health system.

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20 This in the total number of attendances, not only non-urgent attendances.

21 HSCIC 2013-14.

22 <http://www.hsj.co.uk/Journals/2014/05/21/fi/fi/Analysis-of-accident-and-emergency-attendances.pdf>

# 3 Methodology

## Multi-method behavioural insight research

To meet the aims and objectives of this study, the research involved three components: a knowledge audit involving desk research and expert interviews; in-home qualitative depth interviews with parents of young children who had recently attended A&E in a non-urgent situation, and local service mapping to understand the healthcare services available to parents.

### KNOWLEDGE AUDIT

The first phase of this research aimed to consolidate existing knowledge around paediatric non-urgent A&E demand and inform subsequent phases, ensuring the research did not 'reinvent the wheel' and instead led to new, clear and effective opportunities for interventions. The knowledge audit involved conducting desk research and expert interviews.

### DESK RESEARCH

In addition to the work the Department of Health team had already completed to formulate the research brief for this project, the ESRO research team conducted an element of desk research to identify key themes and hypotheses about this issue. This was not a formal literature review, but encompassed published and web-based materials over the period 2009 to 2014 including government reports, journal articles, book chapters and 'grey literature' (e.g. blog posts and newspaper articles).

A list of materials provided by the Department of Health as background reading and additional sources identified by ESRO are included in Annex A.

### EXPERT INTERVIEWS

Eight in-depth interviews were conducted with leading academics, clinicians and experts in paediatric emergency medicine and child health services. Seven of these interviews were conducted over the phone and one was face-to-face. Interviews generally lasted between 40 and 60 minutes. The interviews focused on the experts' understanding of the problem and causes of non-urgent paediatric A&E attendance and observations from previous interventions addressing the issue. Findings from the expert interviews influenced the design of the qualitative interview discussion guide.

In addition to these telephone interviews, informal conversations were carried out with frontline staff during the service mapping research – either by telephone or face-to-face. Roles included A&E consultants, doctors, nurses and receptionists, GPs and GP receptionists, community pharmacists and out of hours service providers.

### QUALITATIVE INTERVIEWS WITH PARENTS

The second phase involved conducting 35 depth interviews with parents of children under 5 who had taken their child to A&E in a non-urgent situation within the past 6 months.

Interviews were conducted in the following areas: London, Essex, Manchester, Leeds, Southampton and Grimsby between February and March 2015. Areas were selected to provide a range of different geographical and socio-demographic challenges – including urban/rural split and affluence. Ultimate decision was made on which areas to select based on the speed with which recruitment was able to take place in those areas.

Parents were recruited using free-find recruitment, snowballing from early years providers and an online panel.

The research team relied on parental self-assessment of 'non-urgency', using questions to understand the route to A&E (e.g. if they were referred by a GP they were excluded) and the type of treatment they were provided with (e.g. if they only received advice or information of what to do if symptoms got worse they were included). Screener questions can be found in Annex B.

The aim of these interviews was to elicit rich, detailed data on the decision-making processes of parents from their own perspective and the factors that influenced their decision to go to A&E.

All interviews were conducted face-to-face with the majority taking place in the respondents' home. Interviews lasted between 2 and 2.5 hours and were digitally recorded for analysis purposes, with quotes transcribed verbatim.

Interviews were semi-structured and covered parent behaviours and attitudes around parenting styles; child health management and sources of advice; perceptions of different healthcare providers, and A&E attendance 'journeys'. Parents were asked to recount their experiences of going to A&E and to 'walk' through the decision-making processes they went through before, during and after going to A&E. In recognition of the fact that the research would be reliant on recall (as direct observation was not possible), the team designed a number of interviewing techniques to help improve the accuracy of recall:

- **Dynamic timeline:** during the interviews, researchers mapped the events onto a printed timeline using post-it notes, encouraging respondents to reflect on the order of events and fill in gaps that they could see when all the events were more clearly outlined in front of them
- **Photographic 'service mapping' stimulus:** researchers arrived at the interviews prepared with photographs and maps of local healthcare treatment centres. These were designed as an aid to recall and to help respondents articulate their experience (especially as they may not know the names for specific treatment centres)
- **Action replay:** researchers encouraged respondents to 'replay' specific events in their treatment journey during the interview. For example, if the respondent had mentioned an internet search prior to seeking treatment, the researcher encouraged the respondent to repeat this behaviour, recalling search terms and exploring the sites and information that they may have accessed

Throughout the report, verbatim quotes from the depth interviews have been included to illustrate certain viewpoints, particularly where there was broad agreement about an issue. It is important to remember that the views expressed do not always represent those of all participants.

All fieldwork complied with the Market Research Society Code of Conduct (2014). Ethical approval for this project was not required in line with the Health Research Authority guidelines<sup>23</sup> as the participants were not randomised and there was no intervention which changed patient treatment or care pathways. See Annex C for full details of our ethical considerations and measures in relation to this research.

## RECRUITMENT AND SAMPLE DESIGN

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The majority of parents (n=30) were recruited via a recruitment agency using a short screener questionnaire (Annex B). Five were recruited through children's centres in Waterloo, London and Grimsby. Respondents were paid an incentive to take part in the research to compensate them for their time. To meet the sampling criteria, parents had to:

- Be a parent of a child aged 0 to 4 years old
- Have taken their child to A&E in a non-urgent situation within the last 6 months
- Not been directly referred to A&E by another healthcare service

'Non-urgent attendance' at A&E was identified in the screener questionnaire using treatment outcome as a proxy for assessing the status of the 'urgency' of attendance: parents were only included if their child had received no treatment, advice only, or antibiotics to be taken at a later date if the illness got worse. Parents whose child had a serious illness or accident that had needed specialist treatment and care at any time since they were born were excluded.

The parents included in this research presented their children to A&E with a diverse range of symptoms. Most common were high temperatures, rashes, bumps to the head from falls, foreign objects stuck in nasal passages, vomiting, dehydration following refusal of liquids, difficulty breathing and ear infections.

A number of recruitment specification criteria were set to ensure a broad range of views and experiences in the sample. The table below outlines these criteria against the achieved sample.

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23 <http://www.hra-decisiontools.org.uk/research/>

**Table 1:  
Sample criteria vs achieved sample**

<b>Age of child</b>	0 – 12 months: n=15	2 – 4 years: n=20	
<b>Family size</b>	1 child: n=17	2+ children: n=18	
<b>Parent ethnicity</b>	White: n=30	BME: n=5	
<b>Parent social &amp; economic classification (SEC)</b>	ABC1: n=19	C2DE: n=16	
<b>Marital status</b>	Single: n=7	Co-habiting: n=12	Married: n=16

## LOCAL SERVICE MAPPING

The final phase of the research was local service mapping in five of the locations in which parent interviews were conducted. These locations were: Tooting (London), Southampton, Leeds, Manchester and Harlow. The aim of the service mapping was to provide important contextual information around the services available to parents in their local area.

The researchers visited a wide range of services mentioned by parents in the interviews, as well as services not mentioned or known by the parents. These services were identified via an internet search of NHS Choices and through informal conversations with staff working in the local services visited.

These services included walk-in centres, GP surgeries, A&E, minor injury units, children centres and pharmacies. Researcher observations of potential barriers to using these services were recorded (e.g. clarity of signage, service ambiance etc) and ad-hoc, informal conversations were had with staff members to understand the services that they provide and their perceptions of parents' use of healthcare services.

### Limitations of the study

The research was designed to be exploratory and to surface opportunities for potential interventions around non-urgent attendance. There are a number of limitations to the way the research was designed and conducted:

- Interviews and observation in A&E departments was not possible at the time of commissioning for a range of reasons
- Expert interviews did not include GPs or out-of-hours staff
- Whilst the team put in a lot of effort to minimise recall bias, much of the parental testimony was still reliant on recall
- It was decided, given budgetary restraints, to focus this research entirely on those parents who had visited A&E in the last 6 months. Therefore there is no comparison with parents who took children to other services for similar problems

## 4 Context of parent decision-making

### New parents can feel under pressure, under supported and lacking confidence in their abilities.

A number of contextual factors that had a broad impact on parental decision-making emerged from the parent interviews. These factors were:

- Erosion of traditional support networks
- Pressure from online social media
- Lower levels of confidence
- Changing sources of advice and information

#### EROSION OF TRADITIONAL SUPPORT NETWORKS

Increasingly complex family structures<sup>24</sup> and the geographical dispersal of families means that parents may have less access to the expertise of grandparents than previous generations. This was a theme that came out strongly in the expert interviews, and was substantiated by interviews with parents.

*“Parents’ are increasingly atomised as a result of changing family structures and eroding support networks – this makes them more risk averse” (Expert interview)*

In the interviews with parents there appeared to be a difference between parents who felt that they had a strong support network available to them, and those who had a smaller network or who felt less supported. Those with large support networks of families and friends often expressed greater confidence around managing their child’s health. This was because they had more people to turn to for advice, as well as greater exposure to other children.

*“I have a large family and grew up surrounded by children. All my brothers and sisters now have children, and so do most of my friends... I knew what to expect when I had my own.” (Mother, Manchester, 3 children aged 2, 3 and 7 years old)*

The research found that younger and older parents can face similar issues in terms of having less support available to them. Younger parents may have support from their family but do not always have friends of a similar age who also have children, as described by one young mother (in her 20s) who lived with her daughter at her parents’ house:

*“It is hard sometimes that none of my friends have children. It can feel lonely, I used to be able to go to them for advice about anything but it doesn’t feel like that anymore.” (Mother, Manchester, first time parent, child 2 years old)*

Several older parents in the research were dealing with the declining health of their own parents. This was found to not only be an additional source of stress but also lessened the support and advice they might have otherwise received. For example, an older mother in her 40s with two young children described feeling enormous amounts of pressure as a result of both caring for her elderly mother, who had recently been diagnosed with dementia, and caring for her children.

Respondents without large support networks often actively sought out alternative sources of support. These parents highlighted the importance of playgroups and antenatal classes as an opportunity to meet other parents going through a similar situation.

*“Antenatal classes were a lifesaver. Not because of what I learnt but because it helped me meet other mums. We gave each other support.” (Mother, Harlow, 2 children aged 3 and 5 years old)*

While family support networks do relieve some of the pressure parents of young children face, they can also be a source of pressure. A number of parents in the research described the difficulty of ‘living up’ to family expectations, particularly the expectations of in-laws. Several respondents recounted instances where the advice they sometimes received from other family members about their child’s health conflicted with their own instincts as to what they should do.

24 Office for National Statistics (2011). Report. Households and families, Social Trends 41

## PRESSURE FROM ONLINE SOCIAL MEDIA

The research found evidence of online social networks creating new sources of pressure on parents, a finding that supports previous research<sup>25</sup>. The majority of parents interviewed used online social networks, and many described enjoying sharing images of their children online and updating friends with news about their child.

However, social networks were found to play a role in increasing parental anxiety. Many respondents described finding themselves comparing the development of their child with other children, noting that this was something they felt online social networks made easier. In addition, some respondents felt there was a bias towards presenting positive experiences online which did not always match their own experiences of feeling stressed and disorganised as a parent. The apparent disjuncture between their own experiences and the experiences of other parents shared online led to low levels of constant anxiety.

*"I can't help myself sometimes going on to look at other parents' photos and always end up feeling a bit worried. It can feel very competitive." (Father, Leeds, 2 children aged 2 and 3 years old)*

The public nature of social networks means that parents were wary about using these sites as a source of advice and information about child health. This wariness often stemmed from a desire to protect the child's privacy, but also due to a disinclination to post 'negative' updates or photos. One young mother described once posting a photo of her child's rash to see whether anyone had experienced something similar but quickly deleting it after receiving a few replies as she did not think it was appropriate to have images like that on her page.

While the public nature of online profiles meant that the parents in this research generally hesitated seeking healthcare advice on social media sites, some parents in the research had found a way around this by setting up private groups which allowed them to share things with selected other parents. One mother described how her antenatal class had set up their own private group two years ago and still regularly used it to post pictures of different health concerns and ask for advice.

## LOWER LEVELS OF CONFIDENCE

Many of the parents interviewed used words such as 'terrifying', 'scary' and 'overwhelming' to describe the experience of becoming a parent for the first time, in addition to words such as 'amazing' and 'mind blowing'. The anxiety these parents experienced was often attributed by them to the sense of responsibility that comes from being the protector of a young life.

*"It's scary – literally every aspect is petrifying, from feeding and holding them to changing nappies, it's terrifying because you're in charge." (Father, Leeds, three children aged 12 months, 4 and 10 years old)*

The research found considerable variation in the experiences reported by parents who had more than one child. Some parents described feeling more confident and relaxed on the birth of their second child due to the experience they had gained looking after their first child. However, other parents felt that it was just as difficult the second, and even third, time. This was often because they did not go to antenatal classes the second time round and missed the support of other parents, or because the second child had illnesses that they had not experienced with the first.

A small number of parents with more than one child felt that there was an expectation from healthcare professionals that they should be more confident, which made it more difficult for these parents to ask for help.

Some parents described feeling that neither they nor their peers had the same level of practical skills that their own parents had. They attributed this to a growing reliance on child health specialists, whom their parents simply had less access to, and a growing concern as to whether or not they are 'doing the right thing'.

## CHANGING SOURCES OF INFORMATION AND ADVICE

The parents participating in this research used a variety of sources of information and advice to help them manage the health of their children and rarely relied on one source alone. These sources included information received from healthcare professionals such as GPs, midwives and health visitors, as well as non-healthcare professionals including family and friends. A small number of the parents interviewed had

a family member with a healthcare background. All of these parents described this family member as their first port of call.

Almost all the respondents actively sought out information about child health and specific illnesses and symptoms online. However, some respondents reported feeling confused by advice posted on online forums like Mumsnet which sometimes conflicted with “official” websites such as NHS Choices.

While parents often sought information from specific sites, many also reported searching Google and clicking through the sites that appeared at the top of the search results. Parents had mixed opinions about using Google to research symptoms and noted that it can lead to confusion through exposure to conflicting information and heightened anxiety. Parents also described difficulties navigating online information, a finding that supports previous research<sup>26</sup>.

*“Google is very useful sometimes but it can also be dangerous – you put in a symptom and it tells you that your child has meningitis” (Mother, Manchester, 2 children aged 4 and 13 years old)*

A significant number (approximate 1/3 of those in our sample) of parents receive information from brands such as Pampers and Aptimel. Several parents had signed up to receive Pampers email alerts, having signed up to get access to coupons received in the Bounty Pack they had received after giving birth. A couple of parents even recounted using live chat services on Aptimel’s website to get advice, such as what infant milk formula to use for their child and for how long.

## SUMMARY

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The research identified a number of broad contextual factors around the changing nature of support networks and sources of advice and information that appear to influence parents’ decision-making. These contextual factors influence decision-making as they impact on the confidence of parents and their levels of anxiety, which can increase the pressure felt by parents. The support and informational resources available to parents are an important context for understanding how parents behave and make decisions around child health management.

## 5 Perceptions of healthcare services

### A fragmented and frequently changing landscape of healthcare services has left parents confused and looking for dependability.

This research finds that parents' perceptions of what is available to them, and how appropriate these services are for their child's situation, is a key influencer in their decision to go to A&E. Parents perceive services to have different 'pull and push' factors<sup>27</sup> that increase or decrease the attractiveness of services, influencing their motivations to use a particular service. The healthcare services examined in this section are:

- GPs
- Out-of-hours GP services
- NHS 111
- Minor injury units
- Walk-in centres
- Pharmacies

Before exploring parents' perceptions of individual healthcare service options, it is worth considering their perception of the overall service mix available to them. The fragmentation of healthcare services has been reported in previous studies as being linked to increased A&E attendance<sup>28</sup>. This is supported to an extent by this research. Changes to healthcare provision and services available locally make it difficult for parents to navigate the range of options available to them. Many respondents lacked awareness of all the healthcare options available to them in their local area.

*"I don't really know how I'd go about finding out about the options if I moved somewhere new"*  
(Mother, Manchester, first time parent of a 1 year old child)

Some respondents felt confused by changes to services in their local area. Several respondents described walk-in centres closing down and opening somewhere else under a different name, and confusion as to who could be treated there. By comparison, A&E was often perceived to be a more stable and 'dependable' service offer.

In addition to the healthcare services provided by the NHS, the research found a small number of parents using information and advice services provided by consumer brands. This suggests that brands are playing a substantial role in the range of service offers perceived by some parents. Brands such as Pampers and Aptimel are increasingly offering parents child health information services as part of their larger efforts to drive customer loyalty and closer relationships with parents. Services offered include online baby clubs and parent community forums, live chat services to get information and advice, and tailored content that parents can sign up to receive.

#### GENERAL PRACTITIONERS

The parents in the sample had variable perceptions of GPs. This variability is key to understanding why parents do not always consider their GP when deciding where to go when their child becomes ill or injured.

#### GP 'PUSH' FACTORS

- **Variation in the perceived accessibility of GPs:** There was considerable variation in access to GPs across the sample in terms of access to appointments. A number of parents reported difficulties getting a same-day appointment with their GP, often describing the considerable lengths they went to get an appointment – such as setting their phones on constant redial 10 minutes before their GP surgery opened in order to try and "beat" the queue.
- **Lacking specialism:** Parents often reported trusting their GP as they knew many of them had years of experience, and in some cases had built a personal relationship with specific GPs over the years. However, when it came to seeking medical attention for their children, some parents felt that GPs may lack the kind of specialist paediatric knowledge needed to be able to diagnose and treat their child appropriately.

27 'Pull' factors are positive aspects that increase a service's attractiveness and motivate a patient to use that service, whereas 'push' factors are negative aspects that decrease a service's attractiveness and discourage a patient from using that service.

28 High quality care for all, now and for future generations: Transforming urgent and emergency care services in England (2013)

*“They’d done everything they could. But it wasn’t enough. They’re not paediatricians, they’re not experts on babies. They’re general practitioners, they can only cover the basics.”*  
(Mother, Harlow, 2 children aged 18 months and 4 years)

The perception that GPs lack paediatric specialism resulted in parents bypassing them because they anticipated the GP would refer them to hospital anyway, and so it represented an unnecessary step which increased the time taken to gain treatment.

- **Inconsistent advice:** Few parents in the research regularly saw the same GP at their surgery, particularly when making a same-day emergency appointment. This meant they were exposed to variation in opinion depending upon which individual GP was seen. This led to a perception that going to the GP in an urgent situation can be ‘luck of the draw’. In contrast, because most parents go to A&E less frequently than to GPs, they have less exposure to variation between individual A&E staff. This contributes to making the A&E experience feel more consistent and trustworthy as a result.

*“It all depends on which GP you see, they are so different - some are great, some are awful. Every time I’ve been to A&E they’ve been brilliant, they’re more consistent than GPs”*  
(Mother, Waterloo, first time parent, 18 months)

- **Less visible consultation with colleagues:** Several parents said that they had noticed never seeing a GP consult colleagues, which was felt to increase the risk that the GP may have ‘missed something’. These parents described noticing how at A&E doctors more visibly consulted one another, which increased their trust in the diagnosis given to their child.

*“You see doctors at A&E talking to their colleagues to get a second opinion, you don’t see GPs talking to other GPs.”* (Mother, Leeds, first time parent of a 2 year old child)

- **Less thorough:** The time constraints on the length of GP appointments, often restricted to 10 minutes, led parents to describe feeling that their child was on a ‘conveyor belt’ at the GP surgery. Parents generally wanted their child to be physically examined by the GP and often described leaving the surgery feeling that the examination had not been thorough enough.

In addition, parents felt that the information about their child’s symptoms provided by GPs was often generic and lacked detail – particularly when compared to the experience at A&E, where doctors explained more thoroughly the cause of the symptoms.

*“The doctors at A&E were brilliant. They gave me more detail about croup than the GP did and explained what croup is and how it often gets worse at night.”*  
(Mother, Peterborough, first time parent, 14 month old child)

- **Out of date information:** Linked to the perception that GPs may lack paediatric speciality was a concern amongst some that the advice given to them by GPs about child illnesses and injuries is out of date or ‘old fashioned’. This is felt to be particularly true in contrast to the advice given by doctors at A&E who are perceived as having greater familiarity with the latest medical information.

For example, one parent described taking her two year old son to the GP because he was displaying the symptoms of croup<sup>29</sup>. The GP advised steam therapy, which immediately concerned her as she had read online that this was outdated advice – the online advice was to take the child outside to expose them to cold air instead. A couple of days later she took her son to A&E as he was still ill with croup and the doctor at A&E advised cold air rather than steaming. This reinforced her perception of GPs as out of date compared to A&E.

- **Diagnoses influenced by an ‘agenda’:** GPs are understood by parents as being concerned with all aspects of the child’s health, including longer term and ‘lifestyle’ behaviours such as diet and exercise. However, this contributed to a perception among some parents that GPs were not ‘appropriate’ for more urgent, immediate health concerns. In addition, a small minority of parents reported feeling that the advice given to them by their GP was influenced by a wider political agenda of cost-cutting or by their own personal beliefs.

*“I feel like GPs have their own beliefs and it’s more likely to shape how they treat you. They push their own agenda on you. A&E doctors seem more conscious that it’s your baby, and your care... they just do the medicine and don’t let their own beliefs come into it”*  
(Mother, Manchester, first time parent, 1 year old child)

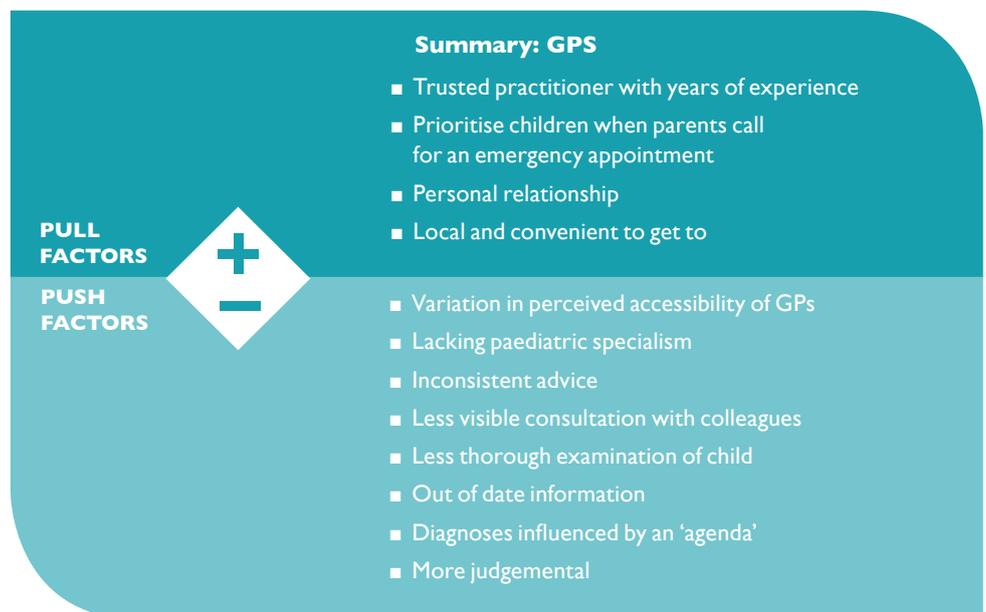
- **More judgemental:** Parents, particularly the younger parents participating in this research, expressed concern that they were treated differently by their GPs because of their age. This can impact on the

29 Croup is a childhood condition that affects the windpipe (trachea), airways to the lungs and the voice box (larynx).

interaction parents have with GPs. For example, one young mother described a reluctance to ask her GP questions about her child's health as she worried that it might make her look like she did not know what she was doing as a parent.

## GP 'PULL' FACTORS

- **Trusted practitioners:** Parents generally reported high levels of trust in their GP, particularly those who had seen the same GP for a period of time. While recognising that GPs were not paediatric specialists, many parents acknowledged that GPs often had years of experience and had seen many children during their career.
- **Prioritise children:** While many parents voiced frustration over securing appointments, there was a general perception that the GP surgery would prioritise them if they told the receptionist they had an ill child and that it was an emergency.
- **Personal relationship:** Although the majority of parents did not frequently see the same GP, several respondents noted that the fact that they had been taking their child to the same GP practice since their birth meant that there was a more personal relationship with the service, particularly compared to other services such as walk-in centres.
- **Local and convenient:** While not true in all cases, many of the parents in this research were registered at GPs relatively close to their homes. This was particularly important for parents who did not own a car, although it was noted by one parent without a car that for her A&E was actually more convenient as there was a bus that went directly to the hospital.



## OUT OF HOURS GP SERVICES

The perception of out of hours GP services<sup>30</sup> is broadly similar to that of GPs, although with lower levels of awareness as to the existence of the service and how to access it.

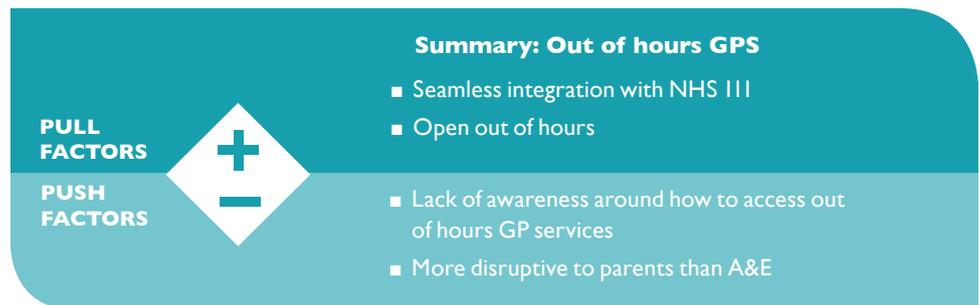
## OUT OF HOURS GP 'PUSH' FACTORS

- **Lack of awareness around how to access the service:** While the majority of parents participating in this research reported knowing about out of hours GP services, fewer knew how to access the service. For example, parents reported turning up at the out of hours GP and being bemused when told to call a number in order to make an appointment, even though they were standing in front of the receptionist.
- **More disruptive than A&E:** GP out of hours services are also perceived to be disruptive to parents, as a result of perceptions around the total length of time required for a visit. This perception that visiting an out of hours GP could take longer than A&E stemmed from parents 'counting' the number of steps involved in accessing the service.

*"I went to A&E because I knew it would take 4 hours whereas the out-of-hours GP would be 5.5 hours including making the call." (Mother, Leeds, two children aged 3 and 7 years old)*

## OUT OF HOURS GP 'PULL' FACTORS

- **Seamless integration with NHS 111:** Parents in some locations, such as Harlow in Essex, reported being able to use NHS 111 to book appointments at out-of-hours GP services. This service was appreciated as it meant that they did not need to research where the out of hours GP service was or make a separate call to make an appointment, as this was all done by NHS 111.
- **Open out of hours:** An obvious but important benefit of out of hours GP services for parents was their accessibility during evening and weekends when their GP surgery had closed.



30 The out of hours period is usually from 6.30pm to 8am on weekdays and all day at weekends and on bank holidays.

The parents in this research reported mixed perceptions about NHS 111. The majority of the sample had used it at least once. Some found it useful and reassuring, while others felt there was little point calling as it took up valuable time.

## NHS 111 'PUSH' FACTORS

- **Not useful in urgent situations:** There was confusion among respondents as to the purpose of NHS 111, with some parents viewing its role primarily to determine whether or not the situation should be treated as an emergency. For these parents, NHS 111 is deemed less appropriate when they are certain that their child's illness or injury is urgent. In these circumstances, parents described looking for advice about what to do immediately, not whether it is an emergency. They did not think NHS 111 would be able to give them that information.
- **Dependency on verbal communication:** In some situations parents struggled to articulate verbally the problems experienced by their child. For example, in one case a parent was unable to describe what had happened when her daughter's upper lip frenulum became stuck between her teeth. In these situations, where the description of the illness or injury is difficult to articulate, NHS 111 is limited by the constraints of being a phone based channel. These parents stated without prompting that being able to communicate visually, through photos or video, would have been of value to them in these situations.

*"I wished I'd been able to text a photo of my daughter's lip to NHS 111, it would have saved me the trouble of going to A&E to physically show it to someone"*  
(Mother, Leeds, 2 children aged 3 and 7 years old)

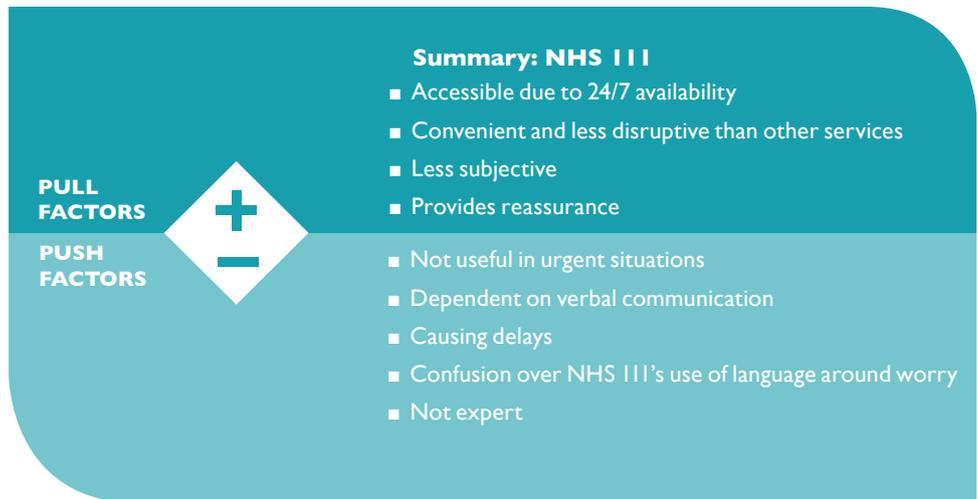
- **Causing delays:** Many respondents perceived NHS 111 to be an 'unnecessary' step that could be easily bypassed. This was based on a belief that NHS 111 was over cautious and would simply refer them to A&E. This belief was formed from previous experience of calling NHS 111 as well as from stories that they heard via the media or from other parents.

*"My advice to other parents would be to skip NHS 111 as it's a waste of time, they'll just tell you to go to A&E and you'll have wasted 30 minutes going through all their questions"*  
(Mother, Waterloo, first time parent of a 2 year old child)

- **Confused by NHS 111's language around worry:** The research found that the language used by NHS 111 may in some instances be unintentionally causing parents to go to A&E. Several parents described how operators had told them to go to A&E if they were 'still feeling worried'. This was interpreted as being a 'green light' to go to A&E as they were indeed feeling worried about the child.
- **Not expert:** A number of parents perceived NHS 111 operators to be untrained and acting as if they were simply 'reading questions off a computer screen'. This perception stemmed from stories parents had heard in the media about the algorithm used by NHS 111.

## NHS 111 'PULL' FACTORS

- **Reassuring:** A number of parents in the research reported finding NHS 111 reassuring. This was a result of being able to speak to someone quickly while still at home, and through being helped by operators to plan their next steps.
- **Accessible:** Many of the parents who had used NHS 111 found the service's 24/7 availability to be helpful when other services had closed.
- **Convenient:** An important benefit described by parents in this research was that using NHS 111 meant they did not have to leave the house and arrange childcare for other children. This meant that the service was perceived to be less disruptive than other services that had to be visited physically.
- **Less subjective:** Although NHS 111's algorithm caused some parents to distrust the service, other parents viewed it positively as it meant that the service was not dependent on the opinion of one individual, and they presumed that paediatric specialists would have been involved in the development of the algorithm.



## MINOR INJURY UNITS

Minor Injury Units are among the more under-utilised services in this research, suffering from a general lack of awareness as to where they are located, who is eligible to use them and what these units specialise in. The parents who had used Minor Injury Units often described them as “hidden gems” due to their convenience, shorter waiting times and professional expertise.

### MINOR INJURY UNIT ‘PUSH’ FACTORS

- Lack of awareness:** Many parents participating in this research were unclear what Minor Injury Units were, the services they offered or where they were located. An exception was in Leeds, where almost all of the parents interviewed had used the Minor Injury Unit at the Wharfedale Hospital in Otley. This appeared to be because the Unit had previously been an A&E and so was well known in the local area.
- Not appropriate for urgent situations:** Among the parents in Leeds, who had higher usage of the local Minor Injury Units compared to parents in other locations included in this research, the decision to go to A&E rather than the Minor Injury Unit was due the perception that Minor Injury Units were better suited to more ‘routine’ injuries.

Parents in all locations described feeling confused by the naming of Minor Injury Units, as it was not clear what ‘minor’ injuries were being referred to. In addition, the name was perceived by some parents to suggest minor injuries such as small cuts and bruises.

### MINOR INJURY UNIT ‘PULL’ FACTORS

- Good service:** The parents in this research who had used Minor Injury Units described experiencing shorter waiting times compared to A&E, and that this contributed to a favourable impression of the service.

*“The Minor Injury Unit is friendly, quiet, the staff have more time for you, it’s much better than A&E.” (Father, Leeds, 3 children aged 12 months, 4 and 10 years old)*



## WALK-IN CENTRES

While the majority of parents in this research were aware of walk-in centres<sup>31</sup> and most had used the service on occasion for themselves, only a minority had considered taking their child to a walk-in centre during the episode of illness or injury that had resulted in attendance at A&E.

### WALK-IN CENTRE 'PUSH' FACTORS

- **Not appropriate in urgent situations:** Walk-in centres are viewed as places to go for health problems that can be serious, but are not urgent. As a result, this does not match with parents' own perceptions about the urgency of their situation.

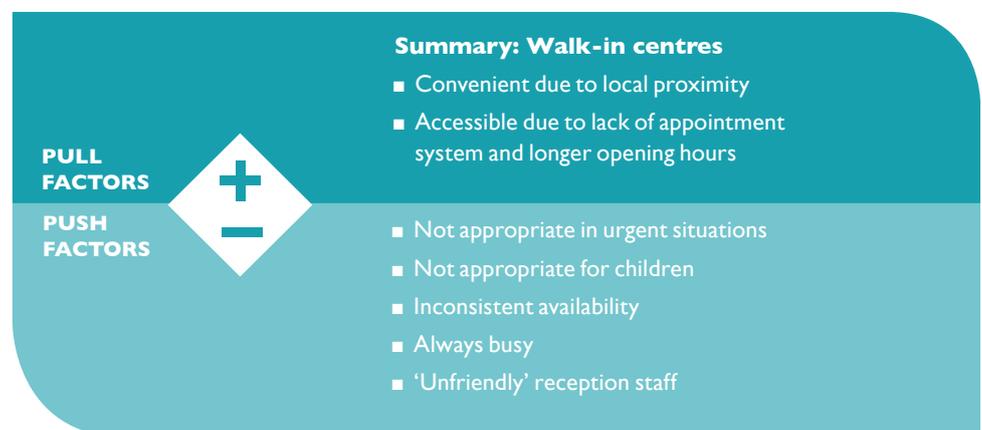
*"Walk-in centres are for those 'middle ground' problems, but with babies it never seems to be in that middle ground. With babies, it's always more urgent" (Mother, Manchester, first time parent of a child aged 11 months)*

- **Not appropriate for children:** Compared to other healthcare services, walk-in centres were more likely to be perceived by parents as inappropriate for children. As part of the local service mapping phase of this research, visits by researchers to walk-in centres found fewer toys at walk-in centres compared to other services. In addition, the researcher noticed that some walk-in centres advertised sexual health services. These factors could potentially lead parents to assume that walk-in centres are less appropriate services for children.
- **Inconsistent availability:** Several respondents described walk-in centres closing down and opening somewhere else under a different name. For example, one respondent in Waterloo, London described how she had frequently used a local walk-in centre that was within walking distance to her house. The service, however, closed last year and this had reduced the options perceived to be available to her.
- **Always busy:** Many parents in this research had noticed that walk-in centres were often busy – usually when visiting for a health reason of their own. Several respondents went on to say that this meant they would hesitate taking their child there as it might result in a long wait with no guarantee that their child would be able to be treated there. A&E, in contrast, was perceived by these parents to be a 'safer bet'.
- **Unfriendly receptionists:** A small number of respondents reported observing 'unfriendly' reception staff at walk-in centres, attributing this unfriendliness to being busy. These same respondents felt A&E receptionists to be friendlier, despite also being busy.

*"The scornful looks you get from the battleaxe receptionist at the walk-in centre would deter you to go next time." (Father, Leeds, 2 children aged 2 and 3 years old)*

### WALK-IN CENTRE 'PULL' FACTORS

- **Convenient:** Perceptions of convenience were dependent to some extent on the geographical proximity of the walk-in service to the respondent's house. However, respondents generally perceived walk-in centres to be easily accessible, although not always as well sign-posted as other services.
- **Accessible:** Being able to walk-in off the street without a prior appointment meant parents generally perceived walk-in centres to be accessible, particularly compared to GPs. Longer opening hours than GPs also contributed to this perception.



<sup>31</sup> Walk-in centres are usually nurse-led and do not require appointments to be made. Many centres are open 365 days a year and outside office hours.

## PHARMACIES

Along with Minor Injury Units, pharmacies appear to be underutilised by parents. This is despite the convenience of many pharmacies and the availability of 24/7 services in some locations.

### PHARMACY 'PUSH' FACTORS

- **Variability of service:** The parents in this research perceived the service 'landscape' of pharmacies to be variable, from supermarket pharmacies through to small independent neighbourhood pharmacies.
- **Cost of prescriptions:** The cost of prescriptions can be significant and off-putting to parents as a result – particularly when medicines such as Calpol are available for free at A&E.
- **Lack of paediatric expertise:** Pharmacists are not always perceived by parents as expert in children. Several parents described being told by pharmacists that they were unable to prescribe medication for children.
- **Less medical environments:** Visits made by researchers to small neighbourhood pharmacists as part of the local service mapping found a variety of goods on offer, including distinctly non-medical products such as wigs and washing up liquid. This potentially detracts from their image as a place of medical expertise.
- **Not appropriate for non-routine child illness:** The majority of parents in this research perceived pharmacies as good places to go when their child has an everyday illness like a chesty cough or a cold. This led to pharmacies having a close association with 'normal' and 'everyday' conditions in parents' minds.

### PHARMACY 'PULL' FACTORS

- **Convenient:** Many parents perceived pharmacies to be convenient due to their locations on high streets and positioning in local communities.
- **Accessible:** Not needing to make an appointment enhanced parents' perceptions of pharmacies as accessible services.
- **Longer opening hours:** A small number of parents reported taking advantage of late night pharmacies in their local area. However, many parents in the research did not know where their nearest late night pharmacy was, or that these services existed.
- **Part of parents' shopping routines:** Supermarket pharmacies were perceived by parents to be particularly convenient as visits can be combined with everyday shopping routines. Supermarket pharmacies were described as being extremely convenient, enabling parents to drop in while doing their shop and show their child physically to the pharmacist in order to get small, non-urgent symptoms checked out.
- **Trustworthy established brands:** Big brands, such as Boots and the supermarket pharmacies, were perceived to be reliable and trustworthy due to their established brand names. Customer service was perceived to be good as a result of the parent feeling like they were being treated as a valued customer rather than as an unwanted patient.



## 6 Exploring paediatric attendance at A&E

Whilst parents express doubt about the appropriateness of A&E, they often decide that it is the best option.

The majority of parents interviewed in this research understood that A&E is for emergencies, and agreed that people should only attend in urgent situations. However, all parents included in the research had taken their child to A&E in a non-urgent situation. This suggests that a gap exists between what parents say and their actual behaviours. The next section of the report explores the causes of this ‘gap’ in further detail.

### DECISION UNCERTAINTY

A number of healthcare professionals remarked in conversations during the visits to local services that it is easier to identify a non-urgency with the benefit of hindsight. However, many of the parents in this research described experiencing moments of uncertainty at some point before, during or after attending A&E. This uncertainty centred on whether or not they needed to go to A&E.

*“I did have a nagging feeling in my head that it wasn’t an emergency, but in the middle of the night you feel desperate” (Mother, Harlow, 2 children, 4 and 6 years old)*

However, uncertainty about going to A&E was generally discounted by the fact that parents rationalised the decision as being the best they could have made at the time. This is generally because they felt that acting cautiously and going to A&E to ‘just be on the safe side’ outweighed the risks of not going.

*“I’m willing to take a chance on myself [of not going to A&E] but it would be stupid to do that with a child” (Father, Tooting, first time parent of a 2 year old child)*

Several parents recounted being aware they might be labelled as “neurotic” or as a “worrier” for taking their child into A&E. However, these parents described consciously deciding that they would ignore this potential labelling as their child’s safety should be their biggest priority, not their own embarrassment.

*“You think ‘was I a bit neurotic, a nutty mother for taking her in?’ But if you have to take them in, you can’t worry about what other people think. If they laugh then that’s fine.” (Mother, Harlow, 2 children 3 and 5 years old)*

Other parents sought validation from others that their decision to go to A&E was correct. Fortunately for these parents, A&E staff would themselves often provide that reassurance. A number of parents described how staff would go to some lengths to reassure them that they had done the right thing.

*“They always agree that it’s best to get checked out. A nurse in A&E once said to me ‘your children are precious, it’s human nature that you’re anxious.’” (Mother, Southampton, first time parent to an 18 month year old)*

*“When you go into A&E you think ‘am I worrying about nothing?’ but they always reassure you – they tell you that you’ve done the right thing and that you’re not wasting their time. They don’t treat you like you’re just ‘another overprotective parent.’” (Mother, Grimsby, 2 children aged 3 and 6 years old)*

A small minority of parents interviewed reported knowing whilst at A&E that they should not have taken their child in. Several parents were explicitly told by a doctor or nurse at the end of their consultation that they should not have come in. This was generally just before the parents were about to leave, which made them feel they could not have a conversation about it. The other respondents were not explicitly told, but were instead redirected to alternative services located near the hospital. The explanation given to them was that the wait at these services would be shorter, not that they had come to the wrong place.

There were instances recounted in the research of A&E staff initiating ‘subtle signals’, such as asking parents things like “have you tried Calpol?”. Questions like this acted as seeds of doubt in the parent’s mind that maybe they did not need to be there. However, these subtle signals were often overshadowed

by the wealth of other reassurance that the parent had done the right thing (e.g. a warm welcome, a reassuring atmosphere, feeling calmer, courteous services from staff, and an absence of any indication that they were in the wrong place).

## TRIGGERS INFLUENCING PERCEPTIONS OF “EMERGENCY”

When deciding whether or not to go to A&E, any reservations about attending were typically overridden by the perception that their child’s health situation was an emergency for them. Not necessarily life threatening, but urgent and having some of the characteristics of emergency nonetheless.

The perception that their situation was indeed ‘urgent’ meant that the majority of parents in this research genuinely felt that going to A&E was the right thing to do in their particular situation. In most situations, this was because the service offer at A&E was in line with their need for ‘urgent’ treatment, rather than because they believed themselves to be genuine emergencies.

For parents, these ‘emergencies’ could involve different kinds of situations – ranging from things that were stressful and unpredictable, anything that was ‘high priority’, right through to things that were ‘very serious’ (e.g. a parent could consider not being able to pick their child up from nursery on time ‘an emergency’, simply because it is high priority and causes distress). While the display of physical symptoms was the primary trigger for parents to seek medical attention, it was not necessarily the only factor leading to the parent making the decision that their child needed ‘emergency’ treatment. Non-medical triggers such as time of day, reluctance to disturb their child’s routine, pressure from significant others, not feeling able to cope and the lack of an action plan all played a role in exacerbating parental levels of anxiety.

*“I knew about the Minor Injuries Unit in Otley – but it didn’t cross my mind to take [my child] there, as I was worried that it was an emergency.”  
(Mother, Leeds, 2 children aged 4 and 6 years old)*

## MEDICAL TRIGGERS OF ‘EMERGENCY’

Two medical triggers influencing parents’ perceptions of being in an ‘emergency’ were identified in this research: the perceived seriousness of symptoms and the perceived abnormality of symptoms.

- **Perceived seriousness of symptoms:** Many of the symptoms presented to A&E in this research have high prevalence among young children (e.g. a high temperature). They may be considered fairly ‘ordinary’ illnesses or injuries. However, they often do not feel ‘ordinary’ to the parent of a child experiencing one or more of these symptoms. This is due to the perception of uncertainty surrounding each symptom, with parents quick to articulate that, for example, a rash may be a sign of meningitis or a bump to the head may indicate internal damage. The ‘what ifs’ surrounding the symptoms displayed by their child caused considerable anxiety and, as a result, parents found it difficult to judge how serious the symptom was.

*“When a baby is young you really worry about what is wrong with them, you panic, it’s not just a rash it’s something more serious” (Father, Leeds, 2 children aged 2 and 3 years old)*

For example, several parents recounted doing the ‘glass test’ on their child’s rash and finding that particularities of the situation (such as the exact curvature of the glass or the specific location of the rash) made it difficult to compare to the images they saw on Google image search. As a result, they still felt uncertain whether or not the rash was serious, as they felt like they had nothing to compare it to.

In addition, many of the parents recounted how Googling their child’s symptoms had caused them to feel a lot more anxious than they had been feeling previously.

*“You Google ‘rashes on children’ you read all this stuff about how it might be meningitis. And once that thought gets in your head, it’s very difficult to ignore it.” (Mother, Waterloo, first time parent of a child aged 18 months)*

- **Abnormality of symptoms:** Parents also take into account their perception of the symptom’s ‘abnormality’ when deciding whether a situation is an emergency or not. The parents in this research judged abnormality by comparing to either their child’s usual state or to what other children experience. The research suggests that parents who have had less exposure to other children are particularly likely to use their own individual child as a baseline measure for what is normal or ‘average’.

Parents feel that the advice they receive from healthcare professionals such as GPs or health visitors feels generic, as it is assumed to be based on a population average rather than their child’s personal average. While it

could be assumed that knowing a child's illness is common amongst other children of a similar age would be evidence for there being 'nothing to worry about', some parents do not find this message reassuring as it does not relate to their child's individual circumstances.

## NON-MEDICAL TRIGGERS OF 'EMERGENCY'

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Five non-medical triggers influencing parents' perceptions of being in an 'emergency' were identified in this research: time of day, disruption to child's routines, pressure from significant others, not feeling able to cope and lacking a plan.

- **Time of day:** Previous research has highlighted that out-of-hours attendance at A&E results from perceived and actual limited access to healthcare services at these times<sup>32</sup>, a finding that is substantiated by this research. However, the interviews with parents in this research suggest that attendance at A&E at night time is not just an access problem. The experience of looking after an ill child at night or in the evening can feel qualitatively different, with night time heightening the sense of anxiety parents feel.

*"It feels incredibly isolating when you have a crying baby at night with no-one around to help. The responsibility can be overwhelming." (Mother, Harlow, 2 children aged 3 and 5 years old)*

- **Disruption to child's routines:** Many of the parents in this research were sensitive to disruptions of their child's routines as a result of the importance placed on establishing and maintaining a routine for child development. However, the regularity of routines meant that it could be difficult for the parent to judge whether their child was drowsy because of possible concussion resulting from a bump to the head or simply because it was the child's nap time.

Routines may also heighten the sense of emergency because it creates a 'deadline' in the parent's mind. For example, one parent described feeling that she had to take her child to A&E in the early evening in order to ensure that she could put her child to bed by 9pm.

*"I'd rather go to A&E than wait for a call back from the GP, particularly if it is close to her bedtime" (Mother, Tooting, 2 children aged 2 and 6 years old)*

- **Pressure from significant others:** A minority of parents in the research described family members increasing their perception of an emergency. This was generally due to the other person advising the parent to go to A&E or displaying signs of concern or distress that increased the parent's own distress. Several parents went to A&E even though they personally felt it unnecessary, because they worried about causing relationship tensions if seen to be ignoring their advice.

*"I was at my sister's house when [my child] began wheezing heavily and my sister started freaking out saying that we should go to A&E. I wasn't too concerned when he started wheezing as he had a cold at the time which I thought was causing it. But I felt I should go [to A&E] because my sister was so worried." (Mother, Manchester, first time parent to a 2 year old child)*

- **Not feeling able to cope:** Looking after an ill child can be deeply distressing due to the perceived vulnerability of the child and a fear of loss that can be overwhelming. Parents in the research often described sitting up all night to watch over their ill child. This often led to them feeling fatigued, not only physically but also mentally. In this state, parents worried that they may not be capable of looking after their child and this considerably increased their perception of being in an emergency situation.

In addition, some parents felt that they were failing to manage their other responsibilities, often a combination of work commitments, looking after other children and housework. Parents may struggle balancing these commitments at the best of times, and when a child becomes ill that fragile balance may be disturbed.

*"Sometimes you need reassurance that you are doing all right because as a mum it's difficult, there are times when your housework isn't done, lots of things aren't done, you feel like you're sinking." (Mother, Harlow, 3 children aged 10 months, 3 and 6 years old)*

- **Lacking a plan:** The research found that parents, particularly those with less experience of parenting, often felt that they are encountering symptoms for the very first time. This may be because their child (or any previous children) has never had that particular illness before, or because the symptoms are worse than any other previous occurrence. This made it more difficult for parents to plan out what they should do.

*“If you don’t have a plan, you get lost and that’s when you don’t cope”  
(Mother, Harlow, 3 children aged 10 months, 3 and 6 years old)*

Parents with a plan of next steps were more likely to have mentally ‘rehearsed’ their actions. For example, one mother described using her experience of doing risk assessments as a support worker to help her plan what to do when her children became unexpectedly ill. Other parents described calling NHS 111 and being helped to “figure out” a plan of action in case their child’s condition deteriorated.

*“I’ve had good experiences of using NHS 111. When I’ve called they have reassured me by telling me the range of temperature and what I should do if his temperature reaches that threshold”. (Mother, Leeds, first time parent to 18 month old child)*

## SUMMARY: A&E AS THE ‘DEFAULT OPTION’

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Parents’ perception that their child’s situation was an emergency, even when in reality it would not be triaged as one, meant that A&E became a ‘default option’ for many of the parents participating in this research. A&E was perceived by these parents to be one of the simplest services to access, and also the most appropriate to their situation.

This may explain why alternative services currently intended to be default options – primarily GPs and NHS 111 – are being bypassed by parents: they are not necessarily considered appropriate by parents in a potential emergency situation.

In situations not perceived as an emergency, parents rarely described A&E as their first port of call for seeking medical attention for their child. Instead, GPs, NHS 111 and occasionally minor injury units or walk-in centres were described as their “first port of call”, depending on the type of symptoms displayed.

This suggests that there is opportunity to ‘reset’ parents’ default option to other services and away from A&E, as long as those services can become more closely aligned and associated with situations perceived to be an emergency by parents.

# 7 Applying behavioural theory to the findings of the research

## A wide range of factors shape parental behaviour

<b>Behavioural concepts<sup>33</sup>: Present bias (a form of hyperbolic discounting)</b>	
<b>Description</b>	<b>Findings from this research</b>
<p>People can have excessive urges for immediate gratification, overvaluing the present over the future. This can lead to 'time inconsistent' attitudes and regret of choices made on the spur of the moment.</p>	<p>Attending to their child's immediate health needs often becomes an overriding priority when the child is ill or injured. Parents become more susceptible to making spontaneous decisions as a result.</p> <p>Gaining access to diagnosis and treatment as quickly as possible was a priority for many parents.</p> <p>Parents described finding the advice "wait and see" difficult to follow. Waiting was often a stressful time, particularly when waiting at home (for example, waiting for a call back from NHS 111 or waiting for a GP appointment later in the day).</p> <p>Going to A&amp;E provides immediate gratification when in a heightened state of anxiety, with parents describing a feeling of immediate relief upon arrival at A&amp;E.</p> <p><i>"As soon as I get to A&amp;E I calm down because I know if anything happens it's going to be okay." (Father, London, 1 child, 14 months)</i></p> <p>Only a minority of parents expressed regret about going to A&amp;E, even when the non-urgency of the situation became apparent upon arrival and when the experience involved 'wasting' time as a result of a long wait. This was because of the perceived risks to the child's health of 'taking a chance' by not going to A&amp;E.</p> <p><i>"I do think it was the right decision to come in - her health and wellbeing comes before everything else." (Mother, Southampton, 1 child, 14 months)</i></p>

<b>Behavioural concepts: Reference dependence and loss aversion</b>	
<b>Description</b>	<b>Findings from this research</b>
<p>Consumers may not assess outcomes in their own right, but rather as gains and losses relative to a reference point. Psychologically, losses are felt more than gains of a similar magnitude. As a result consumers underweigh gains and overweigh losses. Where choices are framed according to a reference point, the perception of outcome change can shift if that reference point also moves.</p>	<p>Parents are highly sensitive to any perceived loss in relation to their child. Concern over their child's immediate health generally outweighs any other type of 'loss' affecting either the parent (e.g. waiting time at A&amp;E, disruption of work commitments) or the NHS (e.g. staff time and use of resource).</p> <p>While some parents described feeling guilty about their use of A&amp;E resources when it became clearer that their child's situation was non-urgent, this feeling was often overridden by the sense of duty to protect their child.</p> <p><i>"I've worked bloody hard and pay my taxes - if my child gets ill I'm not going to think twice about taking her to A&amp;E if I think she needs to go." (Mother, London, 1 child, 2 years old)</i></p> <p>Many parents described feeling concerned that they were not doing the 'right thing' when treating their child at home. This led to worry that they might cause damage or harm to their child – a 'loss' that they want to avoid.</p> <p><i>"The doctors at A&amp;E gave me the same cream for the rash that I had already been using so this reassured me that I was doing the right thing by giving her that cream." (Father, London, 1 child, 14 months)</i></p>

34 Table adapted from 'Occasional Paper No. 1: Applying behavioural economics at the Financial Conduct Authority' (2013) – <https://www.fca.org.uk/static/documents/occasional-papers/occasional-paper-1.pdf>

### Behavioural concepts:

#### Emotions or affect

Description	Findings from this research
People may act to avoid ambiguity or stress. Their choices can also be distorted by temporary strong emotions (e.g. fear).	When their child became ill or injured, parents often enter into a 'hot state' of decision-making and display heightened levels of anxiety. Anxiety is exacerbated by a range of non-medical factors including time of day (parents described feeling more fearful and isolated during the night), not feeling able to cope and pressure from significant others.

### Behavioural concepts:

#### Over-extrapolation

Description	Findings from this research
People often make predictions on the basis of only a few observations, when these observations are not representative. .	Parents with smaller social networks or with geographically dispersed families described having less exposure to other children. This meant that when their child became ill or injured, they were often less able to draw upon other parents' decisions and experiences in similar situations.  The majority of parents in this research had visited primary care services much more often than they had visited A&E. For parents with negative experiences of primary care services, this meant that A&E appeared to be a better alternative.  Several parents described observing instances of A&E clinical staff consulting with each other, something they had not observed with their GPs. The consultation between colleagues at A&E was inferred by these parents to mean that the diagnosis received at A&E was more robust

### Behavioural concepts:

#### Framing, salience and limited attention

Description	Findings from this research
The framing effect is an example of cognitive bias, in which people react to a particular choice in different ways depending on how it is presented e.g. as a loss or as a gain <sup>34</sup> .  Even when the benefits of particular choices are identical in two situations, consumers may make different choices depending on how the decision problem is framed i.e. what it draws attention to. What makes a particular frame or interpretation lead to a particular choice depends on the bias triggering the reaction.	Very few parents in this research had a complete understanding of the different healthcare service options available to them (e.g. not aware of walk-in centres or minor injury units in the local area).  The perception of their child being in need of urgent attention, even when presenting non-urgent symptoms, meant that other services were often discounted as being unsuitable due to their lack of association with 'urgency'.  <i>"I knew about the Minor Injuries Unit– but it didn't cross my mind to take her there, as I was worried that it was an emergency." (Father, Leeds, 3 children aged 1, 4 and 10 years old)</i>  Parents often justified their decision to go to A&E in non-urgent situations with secondary service features (e.g. convenience, friendlier and more reassuring staff, availability of free Calpol and ibuprofen).

33 Table adapted from 'Occasional Paper No. 1: Applying behavioural economics at the Financial Conduct Authority' (2013) - <https://www.fca.org.uk/static/documents/occasional-papers/occasional-paper-1.pdf>

**Behavioural concepts:**  
**Heuristics or decision making ‘rules of thumb’**

Description	Findings from this research
<p>A heuristic is any approach to problem solving, learning or discovery that employs a practical methodology not guaranteed to be optimal or perfect but sufficient for the immediate goals<sup>35</sup>.</p> <p>People simplify complex decision problems by adopting specific rules of thumb (heuristics). Mostly these rules of thumb operate unconsciously. When choosing from a wide range of options, people may choose the most familiar, avoid the ambiguous or uncertain, or pick the first option on a list.</p>	<p>The parents in this research often discounted other healthcare services from their decision-making processes (either consciously or unconsciously). This was in part the result of access or perceived access to other services. A lack of knowledge about the full range of out-of-hour services available led to several parents describing A&amp;E as the out-of-hours alternative to GPs.</p> <p><i>“If it’s before 6pm I go to my GP. If it’s after hours then I go to A&amp;E.” (Father, London, 1 child, 14 months)</i></p> <p>For other parents who were aware of alternative services, A&amp;E was perceived to be a simpler choice involving fewer steps (e.g. compared to out of hours GP services).</p> <p>A&amp;E was perceived to be more stable and consistent than other services as a result of it being open 24/7, easier to find due to its location in hospitals and with a known service ‘offer’.</p> <p>While GPs are often the service most familiar to parents, GPs can be bypassed by parents due to a perception that they will refer the child to hospital/A&amp;E due to a lack of specialist equipment at the GP surgery or a lack of paediatric expertise.</p> <p>While the majority of parents knew about and had used NHS 111, they bypassed it on occasion due to the perception that their child’s situation was definitely an emergency or that they would be told to go to A&amp;E.</p>

**Behavioural concepts:**  
**Persuasion and social influence**

Description	Findings from this research
<p>Persuasion is the process of guiding oneself or another toward the adoption of some attitude by some rational or symbolic means. Robert Cialdini defined six “weapons of influence”: reciprocity, commitment, social proof, authority, liking, and scarcity. These “weapons of influence” attempt to bring about conformity by directed means. Persuasion can occur through appeals to reason or appeals to emotion<sup>36</sup></p>	<p>Pressure from significant others to go to A&amp;E influenced several parents’ attendance, even when their instinct told them that it was not an urgent situation.</p> <p>A small minority of parents described pressure from online social networks. For example, one mother who had taken her child to A&amp;E after a fall caused a head bump described a posting on Mumsnet telling another parent in a similar situation that she should go to A&amp;E.</p>

34 Plous, S. (1993). The psychology of judgment and decision making. New York

**Behavioural concepts:  
Cool and hot decision making states<sup>37</sup>**

Description	Findings from this research
<p>A hot-cold empathy gap is a cognitive bias in which a person underestimates the influences of visceral drives, and instead attributes behaviour primarily to other, non-visceral factors.</p> <p>The crux of this idea is that human understanding is "state dependent". For example, when one is angry, it is difficult to understand what it is like for one to be happy, and vice versa</p> <p>In cool states, people are more likely to make rational long-term decisions, whereas in hot states people give in to 'immediate gratification'.</p>	<p>When in a situation perceived to be an emergency, parents make decisions in an emotional state, as they often feel anxiety, fear, and empathy with their child's pain and discomfort. These anxieties are compounded by other concerns that cause stress, such as having to juggle work commitments or getting childcare arranged quickly for other children.</p> <p>The high levels of emotion experienced by parents in these situations can impact the rational process of making a decision</p> <p>Discrepancy between parents who are in a 'hot' state and healthcare professionals who are in a 'cool' state (e.g. they see these problems every day) has been described as an 'interpersonal empathy gap'. This may, for example, cause parents to perceive healthcare professionals as lacking empathy or not having their child's best interests at heart. This can lead to parents feeling particularly sensitive and protective of their children.</p>

35 Daniel Kahneman, Amos Tversky, and Paul Slovic, eds. (1982) Judgment under Uncertainty: Heuristics & Biases.

36 Cialdini, Robert B. (2001). "Influence: Science and practice (4th ed.)

# 8 Opportunity Areas

## Seven behavioural intervention platforms to encourage parents to use a range of healthcare services in non-urgent situations

**This section outlines the opportunity areas that have emerged from this research for behavioural interventions to encourage the use of a range of healthcare options and help to shift the default away from A&E.**

There are seven broad opportunity areas identified:

- Enhancing specialism
- Consistent offers
- Skilling up parents
- Providing reassurance
- Timely information
- Emergency environments
- Navigating choice

Within each opportunity area a number of more granular illustrative ideas are described which are intended to help stimulate the generation of further ideas. Some of these ideas were spontaneously suggested by the parents themselves, others were identified by researchers during the research process (including the local area service audits), and others were extrapolated from the research findings and behavioural theory during analysis. At this early point in the process, opportunities have been included that may be impractical or contradict with other healthcare priorities, and as such are unlikely to ever be implemented. However, including them is important as it may help to trigger further ideas or opportunities— or indeed, they may become more practical at some point in the future.

It should be highlighted that the purpose of this project was not to generate specific ideas or recommendations. Any ideas mentioned have been included to help with the communication of an opportunity area.

Finally, the focus throughout the research was on identifying interventions to influence or ‘nudge’ parent behaviour rather than generating ideas for system level changes. However, across the seven platforms there is some potential overlap between two.



### OPPORTUNITY 1: ENHANCING SPECIALISM

**Parents can mentally bypass alternative services as it is assumed they do not have specialism in dealing with childhood healthcare problems and medical needs (for example, paediatrics, ear, nose and throat or skin). This opportunity area focuses on ways to change parental perception of other healthcare services by enhancing their perceived specialism (e.g. if parents believe that another service can offer the specialist care they feel they need then they are more likely to choose it).**

#### I. REFRAMING GENERALISTS

Parents can be quite literal in how they develop their understanding of what a service is for. As a result, perceptions can be shaped significantly by how the service has been named or labelled. For example, if something is wrong with their child’s ear they assume they need to see someone who is a specialist in ears. Alternatively, they only feel they can go to a ‘minor injury unit’ for an ‘injury’ (the definition of which can be quite narrow in the parents’ minds). The very name of GPs as ‘general practitioners’ limits what parents expect them to be able to do and contributes to a perception that GPs may not be an appropriate first port of call in a situation that requires a specialist.

37 Lowenstein, George (2005). “Hot-cold empathy gaps and medical decision making.” *Journal of Health Psychology*

Reframing ideas include:

- Including more specific references to specialisms in the names of other services
- Renaming and rebranding ‘general’ practitioners (e.g. ‘family health experts’ or ‘everyday illnesses specialists’)
- Highlighting the qualifications, training and experience of healthcare providers (e.g. on name labels or door signs – ‘qualified since 2001’ or ‘Senior Pharmacist’)
- Promoting experience or expertise with children (e.g. Early Years Pharmacy or Paediatric Specialist GP Service)

## 2. CLINICAL & ‘EXPERT’ ENVIRONMENTS

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Parents ‘read’ the physical environments of healthcare environments for signs that they are at a place that has experience and expertise in dealing with medical needs. Less clinical looking environments can be off putting as they suggest that the service may not be appropriate. For example, community pharmacists sometimes stock non-medical items including laundry detergent, make-up, sweets, and mobility devices (indeed, one of the pharmacies encountered in the research had a large and prominent display of wigs). The presence of these items may confuse parents about the clinical experience the pharmacist has, reducing their perceived expertise. Another example could be GP surgeries that have very homely interiors may struggle to convey ‘specialism’ or ‘expertise’ in the same way as A&E departments or hospitals do.

Clinical cues could include:

- Cleanliness or hospital like furniture or other stimulus (e.g. smell)
- Presence of hi-tech equipment
- Uniforms and scrubs

## 3. GATEWAY TO SPECIALISM

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Parents can be attracted to A&E because it is perceived to have a paediatric specialism and be the gateway to many other specialisms (e.g. by being located in a hospital environment and parents seeing the signage to other departments). This reassures parents that their child can be looked at by the right kind of specialist.

Gateway cues can include:

- Visible signposting and clear links to other specialist services (e.g. mentioning that a pharmacy is part of a hospital trust and supplies different specialist departments)
- Promoting and flagging staff areas of expertise (e.g. using certificates or labels)

## 4. PERCEIVED NEED FOR SPECIALIST TOOLS AND EQUIPMENT

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Parents sometimes bypass alternative services because they assume that their child’s illness or injury requires specialist equipment that can only be found in hospitals. While this can apply to large and expensive technology such as X-ray machines, it also applies to smaller tools perceived as necessary to deal with non-urgent ailments, such as removing foreign objects. Many parents assume that these kinds of medical tools and equipment may not be present within more generalist healthcare environments. As a result, the healthcare professionals working in those places may not be perceived to have access to those tools or have the required skills to be able to use them effectively. Furthermore, when attending A&E parents often receive more tests and diagnostic measures than they may get at a GP – furthering their perceived need for more specialist tools.

Specialist equipment cues include:

- Visible display of equipment
- Live ‘demonstrations’ of staff using the tools (e.g. in A&E the tools are much more ‘public’)
- Use of less technical equipment in A&E where appropriate to decrease perceptions that specialist tools are always needed (e.g. if a simpler tool will do the same job – such as using domestic tweezers rather than surgical ones to remove a splinter)



## OPPORTUNITY 2: CONSISTENT OFFERS

Parents perceive other health services to be less consistent compared to A&E, creating uncertainty around what the parent can expect from them. This erodes parents' confidence in making a good decision and affects their trust in other services. A&E is perceived as being a more stable 'brand' and consequently parents can feel more confident going there, even if they do not think their child's condition is 100% appropriate. More consistent or clearer branding of other services may help increase confidence in selecting other healthcare options.

### 1. CONSISTENT SERVICE

Parents valued consistent service and saw A&E as one of the most consistent 'brands' and providers of healthcare services in a local area, perceiving the service as high quality and reliable. This strong brand can overcome challenges about inconsistent staffing, for example, the A&E brand and service offer reassures parents that no matter who they see, the quality of service will not be affected. When contrasted with their experience of GPs, parents feel that the quality of service may lie more with an individual GP – resulting in a more variable and subjective experience (and introducing an element of risk or chance to the experience). Where parents cannot guarantee an individual and consistent relationship with an individual clinician, a positive alternative is to default to a strong brand with a clear and consistent service ethos.

Some anecdotal evidence here was that parents feel more comfortable asking for ad-hoc advice from big-brand pharmacies (e.g. supermarket or high street brands) as they feel the advice is more likely to be up-to-date and the staff more consistently trained.

Cues for consistency include:

- Strong healthcare brands
- Customer service charters and quality guarantees
- Customer service focus
- Consistent staff training and roles
- Less subjectivity in service delivery

### 2. NHS/A&E 'FAMILY' OF SERVICES

There is often confusion about different services on offer in a local area and the quality of treatment they offer. Walk-in centres, minor injury units, GPs and A&Es are all NHS organisations but they do not always appear to belong to the same 'family'. While parents may know rationally that alternative services are NHS run, the services do not necessarily feel equal.

In part, this sense of the NHS 'family of services' was addressed by the 'Choose Well' campaign. However, significant confusion still remains.

Creating a 'family of services' could include:

- More visible NHS branding
- More consistent branding across the healthcare portfolio
- Other services using A&E branding or other connections to borrow credibility and help reassure parents that services are similar to those provided in A&E (e.g. Community A&E, GP A&E Service, A&E Local)

### 3. AUTHORITATIVE AND EXPERT ADVICE

Parents seek reassurance that the advice they are being provided is expert and authoritative. This stems from concerns that there may be considerable variation between individuals and that advice might be highly subjective. Visual cues and other forms of reassurance that the professional is knowledgeable and take their situation seriously are much appreciated. For example, parents highlighted negative experiences of GPs 'Googling' their symptoms which undermined credibility. Conversely, seeing doctors in A&E consulting with others was sometimes perceived as getting a second opinion – which made parents feel important or valued.

Signs of being authoritative and expert include:

- Clear signs of seniority and experience
- Getting second opinions or having advice validated by another professional
- Providing references or citing past experience
- Professionalism

#### 4. CERTAINTY OF SERVICE & GUARANTEES

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A&E comes with perceived 'guarantees' of service that are often lacking in other services, for example, a 'guaranteed waiting time' of 4 hours and a promise that they will be seen no matter what. By contrast, even though the waiting time at alternative services may be shorter, it can feel like a more uncertain experience.

Potential guarantees could include:

- Waiting times
- Appointments
- Service promises
- Complaints and customer service

#### 5. 24/7 AVAILABILITY

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A&E is attractive because it is always open and available at all times of day. This not only means that parents can fit going to A&E easily around their schedules, but also that they do not have to worry about whether the service is going to be open (increasing confidence in their choice, reducing the overall amount of time involved in accessing healthcare, reducing stress and worry, and increasing certainty about being seen). In contrast, the limited opening/closing times of alternative services may mean that parents struggle to access these services if they cannot take time off work or balance their other responsibilities.

Illustrative ideas around increased availability:

- Better promotion of other out of hours services
- Lengthening opening times of other services
- Simplifying the 'out-of-hours' offer (e.g. NHS 111 for all out of hours requests)
- More seamless integration with other out-of-hours services
- Live status updates of how busy different services are
- Out of hours 'chat' services



### OPPORTUNITY AREA 3: SKILLING UP PARENTS

**Many parents lack the practical skills and confidence to treat their children themselves. This can lead them to seeking medical attention outside of the home for minor illnesses and injuries that they could treat themselves. There is an opportunity to increase parents' knowledge and confidence in their own ability to look after their child, which may reduce the likelihood of parents perceiving their situation to be urgent.**

#### I. DEMYSTIFYING CHILD HEALTH

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Parents often have limited understanding of child health and childhood illnesses. This can lead to parents feeling unable to treat their children for fear of doing damage or getting it wrong. It can also lead to healthcare professionals seeming like the only ones able to provide treatment.

Opportunities for demystifying child health include:

- Using less jargon or medical names for symptoms (making healthcare feel more accessible and non-specialist)
- Explanation of how the body works to demystify illness
- Openness and transparency about the simplicity of some of the tools and techniques used by clinicians

## 2. BOOSTING CONFIDENCE

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Parents can lack confidence in their own capabilities around managing child health and seek medical attention as a result of feeling that their child will be in more capable hands. Parents' confidence levels may be eroded by family and friends who put pressure on them or question their parenting skills.

Suggestions for boosting confidence include:

- Being told that they are doing a good job
- Not comparing themselves with other parents
- Showing how they have made progress

## 3. PARENTAL INSTINCT

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Parents use instinct to help them make decisions, particularly when facing conflicting information or uncertainty as to what the correct course of action should be. In some cases, this is also used as a justification to go directly to A&E, with parents sometimes advising each other to go to A&E if that is what their instinct is telling them to do.

Opportunities for re-anchoring instinct include:

- Listening to the 'other' instinct – the instinct that says the child is okay
- Using the language of instinct in relation to other services
- Fostering instinct of knowing 'what to do'

## 4. LEARN BY DOING

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Parents described that one of the most useful things health visitors do is show them how to do practical things such as breastfeed under their supervision. Learning a practical skill under supervision can build the confidence of parents when on their own at home, particularly when using tools given to them by healthcare professionals such as syringes to give their child fluids.

Potential pathways to learning include:

- Stories about what other parents have done themselves
- 'How to' videos and demonstrations
- Clinicians physically showing parents how to do something
- Creation of medical 'rituals' that are easy for parent to do e.g. glass test for meningitis



### OPPORTUNITY 4: PROVIDING REASSURANCE

**Parents in a heightened state of anxiety do not always feel able to cope. Providing reassurance to parents when in a state of heightened anxiety may reduce their perception of the situation's urgency.**

#### 1. NIGHT TIME

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Attendance at A&E during the evenings and at night time does not appear to be an issue limited only to the availability of and access to out-of-hours services. Parents describe how it can feel isolating and scary when their child gets ill or injured at night, causing emotional distress that exacerbates the perception of being in an emergency situation.

Ideas for learning include:

- More explicit use of "night" language rather than "out-of-hours"
- Video conferencing at night
- Sleep advice
- Brighter lighting at other services

#### 2. KEEPING BUSY

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Time feels longer when parents are anxious about their child's health, with minutes feeling like hours. Parents can, therefore, find it frustrating when told by NHS 111 or by their GP to "wait and see". The experience of waiting at home feels qualitatively different to waiting at A&E because parents feel that at least they have 'done something' by coming to A&E.

Opportunities for keeping busy include:

- Time keeping
- Instructions for small things parents can do to distract from waiting time
- Asking parents to monitor child and write down observations (e.g. regularly taking the child's temperature)

### 3. LANGUAGE OF WORRY

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Although parents might try not to worry, it is a hard thing to do when in a heightened state of anxiety – and, therefore, the advice not to worry may be difficult to follow. Similarly parents describe being told by NHS 111 to go to A&E if they are still feeling worried, which is interpreted as being a green light to go.

Potential suggestions include:

- Cutting out the phrase “if you are still worried”
- Giving more specific signs of deterioration to watch out for



#### OPPORTUNITY 5: TIMELY INFORMATION

**When and where parents receive information influences how they use it. Currently parents can feel that the information received from other health services may not be up to date or is too generic, and they find some channels inconvenient. Parents often want to share visual information with services, as well as receive it.**

**There is an opportunity to make information about child health more relevant to parents, and deliver it at the time when it will be most influential and via the channel easiest to access.**

#### 1. 'FRESH' INFORMATION

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Information has a shelf life and can be perceived by parents as quickly ‘going out of date’. This applies to information received during previous episodes of illness, such as leaflets handed out by GPs, which are often not referred to in future episodes as they are either discarded or are perceived to have lost their currency. When reading information online, parents will check to see when it was last updated. They are generally more suspicious of information that has either not been recently updated or is not clearly ‘time stamped’.

Recommendations for information provision include:

- ‘Live’ updates and ‘breaking news’
- More visible timestamps
- Ordering information
- ‘Sell by dates’ on information

#### 2. PERSONALISED UPDATES

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A number of parents reported valuing the healthcare information they receive from brands such as Pampers, perceiving it as more tailored and less generic than other information. Parents who use it are largely unconcerned about potential bias due to high levels of trust in these brands, and tended to find out about the services via the Bounty Pack. There is low awareness of the Information Service for Parents and no parents in the sample reported using it.

Ideas for updates include:

- Using first names
- Pictures of children on communications
- Personalised Amazon-style recommendations
- Tailoring beyond age and gender

#### 3. DIFFERENT CHANNELS

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A barrier to using NHS 111 can be its reliance on spoken communication, which can be off-putting to parents when they are unable to articulate sufficiently well the illness or injury their child has. Parents may hesitate to call NHS 111 because they do not want to wake their child if they are in the same room or because they are at work.

Suggestions for different channels include:

- Video and live chat

## 5. MONITORING ANXIETY

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Some baby monitoring apps used by parents are beginning to help them anticipate milestones in their child's development and prepare them for future parenting problems that may be on the horizon given the child's age. However, while this has the potential to help parents be more prepared, parents reported becoming more sensitive to possible problems which could have the unintended consequence of increasing rather than reducing anxiety.

Example tools for monitoring could include:

- Child self-monitoring tools that track development
- Anticipating potential problems and advice on how to handle them
- Showing the variability of developmental progress

## 6. MAKING 'ADVICE' STICK

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Parents can find it difficult to remember information provided by healthcare professionals during consultations when they or their child is stressed. Parents like to be given information written down so they can refer to it at home. Making the information given to them during consultations easier to remember may help prevent repeat visits.

Suggestions for impactful advice include:

- Written record of advice given at the end of consultation to take home
- Reminder messages
- Asking parents to repeat key information



### OPPORTUNITY 6: EMERGENCY ENVIRONMENTS

**The physical environments of waiting rooms in children's A&E do not currently communicate that the space is for emergencies, making it easier for parents to validate their decision to use it in non-urgent situations. There is an opportunity to ensure the environment of A&E is more clearly anchored to a consumer sense of what an 'emergency' looks and feels like.**

### 1. VALIDATING ATTENDANCE / 'OUTCOME BIAS'

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Parents attending A&E in non-urgent situations often come away with 'extras' which can validate their decision to go (e.g. Calpol and ibuprofen). Although their decision to go to A&E may not necessarily be motivated by avoiding payment, receiving 'free stuff' increases the strength of 'outcome bias'.

Opportunities for reducing the outcome bias include:

- Stop giving out free Calpol/ibuprofen
- Introducing charges or penalties for non-urgent visits
- Communicating the costs of non-urgent A&E visits
- Increasing 'free stuff' provided by other services

### 2. TAILORING SERVICE TO ATTENDANCE

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Parents usually guess that their attendance has been categorised as non-urgent when they realise that they have been waiting longer than other parents, although the sunk costs of waiting can encourage them to carry on. Some A&Es are tailoring the service parents receive according to attendance type, whereby parents attending in a non-urgent situation go through separate processes within 15 minutes such as speaking to 'navigators' who redirect them to other services.

Potential areas of tailoring service include:

- Redirecting parents to other services soon after arrival at A&E
- Stickers indicating triage category
- Communication of non-urgency during triage
- Feedback from clinicians before, during or after care

### 3. 'EMERGENCY APPROPRIATE' SPACES

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The waiting rooms at children's A&E are designed to be comforting and engaging to children, and often have painted murals, toys, TVs and lots of colour. As a result, they can be perceived by parents as being appropriate for all children regardless of the urgency of their attendance.

Suggestions for A&E spaces include:

- Pictures of serious injuries/illnesses on walls
- Ambulances visible from waiting room window
- Sharing of staff's war stories of most serious injuries

### 4. MAKING ALTERNATIVE SERVICES FEEL MORE URGENT

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Parents often bypass alternative services because they are not considered appropriate to take a child to in an emergency. Making alternative services feel more appropriate, or more closely associated with emergency situations, may help parents feel like they have other options.

Potential enhancements of urgency include:

- Renaming (e.g. Minor Injuries Unit to Major Injuries Unit)
- Better labelling of range of symptoms that can be treated
- Stories about the most urgent cases treated at the service



#### OPPORTUNITY 7: NAVIGATING CHOICE

**When parents feel that they are in an urgent situation, they seek out short-cuts to treatment and choose the path of least resistance. Parents will probably always want to take short-cuts when their child is ill or injured. There is an opportunity to shorten the path to other services and help parents feel they are being 'fast tracked'.**

#### 1. FAST TRACK

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When parents feel that they are in an emergency situation, they actively seek out ways to speed up the process. A&E enables parents to bypass additional steps in the process, such as going to the GP, and gain quicker closure as a result. NHS 111 services that book out-of-hours GP appointments are also considered fast track as the booking is made for them.

Fast track ideas include:

- 'Concierge' style services to get appointments booked
- Cues that signal prioritisation
- Suggesting shortcuts to other services

#### 2. ONE STEP NAVIGATION

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A&E is attractive because it offers a simple, one step solution to urgent medical attention, compared to out-of-hours services that typically require two or more steps. However, A&E is not the only service that can be accessed in one step – walk-in centres, pharmacies and minor injury units are also one step services.

Potential navigation recommendations include:

- Emphasising simplicity
- Extending the practice of NHS 111 booking out-of-hours appointments nationally

## 9 Conclusions

The issue of non-urgent attendance in A&E is complex with no immediately obvious or straightforward solutions. Behavioural science often presumes the way people behave is 'irrational' or the result of poor logic. However, for many of those included in this research the decision was, to a greater or lesser extent, carefully considered – with A&E often being deemed the best option out of a range of alternatives. One of the biggest challenges relates to the complexity and changing nature of the healthcare ecosystem – with parents struggling to keep up with information in a sea of change. Therefore, those services that remain constant, provide consistent quality and are easy to understand, like A&E, will remain top of mind at the point of need.

Given the number of factors that 'push' parents towards choosing A&E, shifting parental decision making towards other options may require bold interventions to make any significant dent in the current numbers. Three main routes seem to exist: making A&E a much less attractive place to go (clearly not a preferred route by many healthcare experts or professionals, although a viable behavioural intervention nonetheless), making other healthcare choices more attractive, or helping parents to develop the confidence and skills around 'self-care'.

Using a combination of primary research and behavioural analysis, seven opportunity areas have been identified. These opportunities cover a diverse range of different kinds of interventions– from enhancing the perceived specialism and expertise of non-A&E local healthcare options to promoting the confidence of parents in dealing with everyday ailments and illnesses. These opportunity areas are starting points for innovation and development only – not specific recommendations. It is hoped that, through discussion and debate with practitioners, patients and policy makers, more refined ideas will be identified.

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# 11 Annex B: Screener questions for parents

The following screener was developed by the research team, with advice from a GP and other healthcare professionals.

## RECRUITMENT SCREENER

Instructions to interviewer: We are currently working on a research project related to parent experiences of managing their children's health problems for the Department of Health.

We're looking for some parents to take part in an interview, but we have some questions to ask first, to make sure we can get the right balance of people involved.

Would you mind if I asked you some questions about you and your family, and then I can provide some details on the project?

## SECTION I – CHILD HEALTHCARE DETAILS

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▶ Q1. Are you a parent of a child currently aged between 0 – 4 years old?

ASK ALL RESPONDENTS

Yes

No

\*If No, then thank & close.

---

▶ Q2. How old is your child?

ASK ALL RESPONDENTS

0 – 12 months old

1 year old

2 years old

3 years old

4 years old

\*Spread evenly across age groups

---

▶ Q3. Do you have any other children?

No – this is my first child

Yes – I have other children

\*Spread according to family size quotas

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▶ Q4. Is your child registered with a GP?

Yes

No

\*Record only

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▶ Q5. Thinking about your child/children aged 0–4, how healthy have they been over the last 6 months / (or if child is under 6 months) since they were born?

My child has been well, aside from normal 'coughs and colds'

My child has been quite unwell at some points but nothing too serious

My child has had a serious illness or accident which needed specialist treatment and care

\*If answer is 'My child has had a serious illness or accident', thank & close

- Q6. Thinking about your child/children aged 0–4, which of the following things have you done in the last 6 months on their behalf?

ASK ALL RESPONDENTS

- Taken your child to the dentist
  - Seen a pharmacist about your child
  - Taken your child to a walk-in centre
  - Taken your child to see a GP
  - Called the GP out-of-hours service
  - Called NHS 111 about your child
  - Had your child admitted to hospital
  - Taken your child to A&E
  - Taken your child to see a therapist (e.g. speech and language etc.)
  - Seen a health visitor about your child
  - Taken your child to an Urgent Care Centre or Minor Injuries Unit?
  - Seen another type of healthcare professional, PLEASE SPECIFY
- \*All to have taken their child to A&E – if not, thank & close  
 \* Record all

- Q7. How many times have you done each of these things on behalf of your child within the last 6 months?

ASK ALL RESPONDENTS

ASK FOR EACH ACTION ANSWERED IN Q6

USE FOLLOWING RANGES:

- Once
- 2 – 3 times
- 4+ times

Number of times in last 6 months	
Taken your child to the dentist	
Seen a pharmacist about your child	
Taken your child to a walk-in centre	
Taken your child to see a GP	
Called the GP out of hours service	
Called NHS 111 about your child	
Had your child admitted to hospital	
Taken your child to A&E	
Taken your child to a therapist	
Seen a health visitor	
Taken your child to an Urgent Care Centre or Minor Injuries Unit	

\*Record only

- Q8. When your child has gone to A&E in the last 6 months, who has told you to go there? (Choose all that apply if child has been to A&E more than once)

ASK ALL RESPONDENTS

- GP told you to take child to A&E
- NHS 111 told you to take child to A&E
- Family member/ friend told you to take child to A&E
- No-one told me to take child to A&E
- Other – PLEASE SPECIFY

\*If answer is “GP” or “NHS 111” on all occasions – thank and close

A&E: Studying parental decision making around non-urgent attendance among under 5s

- ▶ Q9. Thinking about your most recent visit or contact with each of the following, which treatments did your child receive on that occasion, (or received a referral for that treatment as a result of their visit)? Choose all that apply.

ASK ALL RESPONDENTS

MUST INCLUDE A&E + 2 OTHER PLACES LISTED IN Q6 (PRIORITISE GP IF APPROPRIATE)

**FOR A&E ONLY: MUST ASK ABOUT TREATMENT RECEIVED FOR EACH VISIT TO A&E WITHIN THE LAST 6 MONTHS (IF VISITED MORE THAN ONCE). RECORD CODES ON ONE COLUMN PER VISIT.**

ALL OTHER SERVICES: ASK ONLY ABOUT MOST RECENT VISIT

	GGP (most recent)	A&E visit 1 (most recent)	A&E visit 2 (if appropriate)	A&E visit 3 (if appropriate)	Choose 1 other from q5 (Most recent)
No treatment					
Advice					
Antibiotics to be taken at a later date if illness got worse					
Antibiotics to be taken immediately					
X-Ray					
Casting for broken bones					
Drip					
Blood test					
Oxygen mask					
Asthma treatment e.g. nebuliser					
Stitches / gluing					
Routine injection					
Admitted to hospital					
Other					

\* Continue if there is at least one A&E visit in the last 6 months where the ONLY CODES MARKED ARE ANY OF THOSE BOXES SHADED IN GREEN (No treatment, Advice and Antibiotics to be taken at a later date if illness got worse). If any of the other codes are marked for each of the A&E visits then do not continue.

## DEMOGRAPHIC DETAILS

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► Q10. Can I ask what age band you fall in to?

ASK ALL RESPONDENTS

Under 16 (end)

16 – 19

20 – 24

25 – 29

30 – 34

35 – 39

40 – 44

45 – 55

55+

\*If under 16, then thank & close

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► Q11. Can I ask who lives in your household, and what their relationship is to you?

ASK ALL RESPONDENTS

Person	Relationship to you

\*Record only

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► Q12. Do you have any children or other dependents that do not live with you?

ASK ALL RESPONDENTS

Yes

No

\*Record only

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► Q13. How would you describe your current marital status?

ASK ALL RESPONDENTS

Single

In a relationship, but not co-habiting

Living with partner

Married / civil partnership

Separated

Divorced

Widowed

Other

\*To include a broad spread of single parent, co-habiting/married, divorced

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► Q14. What is your current employment status?

ASK ALL RESPONDENTS

- Self-employed
- Employed part-time
- Employed full-time
- Unemployed
- Student
- Retired
- Other, PLEASE SPECIFY

\*Broad spread of employment status types

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► Q15. What is the current or most recent job title of the main wage earner in your household?

ASK ALL RESPONDENTS

\*Broad spread of social economic grade A/B/C1/C2/D/E

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► Q16. If this is not you, what is your current or most recent job title?

ASK ALL RESPONDENTS

\*Broad spread of social economic grade A/B/C1/C2/D/E

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► Q17. Which of the following best describes your ethnicity?

ASK ALL RESPONDENTS

- White – British
- White – Irish
- Any other white background
- White and Black Caribbean
- White and Black African
- White and Asian
- Any other mixed background
- Asian – Indian
- Asian – Pakistani
- Asian – Bangladeshi
- Any other Asian background
- Black – Caribbean
- Black – African
- Any other Black background
- Chinese
- Any other, PLEASE SPECIFY

\*Broad spread according to local area – must include 5-7 BME

RECORD GENDER OF RESPONDENT

- Female
- Male



REVEALING REALITY