



## NHS Patient Survey Programme

# 2018 Urgent and Emergency Care Survey

Statistical release

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# Summary of findings

Urgent and emergency care services provide vital care and support to millions of people every year. However, services and their staff have been working under steadily increasing pressure, with the number of attendances rising each year. The sector is also undergoing significant transformation to meet the vision for a simplified and integrated system as set out in the [Five Year Forward View](#) and subsequent policy documents, including most recently the [NHS Long Term Plan](#). As a result, changes are being made to the way services are organised over recent years, to try to reduce pressures and demands on major (Type 1) accident and emergency (A&E) departments by providing care through alternative services, where possible.

This survey looked at people's experiences of using Type 1 (major A&E) and Type 3 (urgent care centres, minor injury units, urgent treatment centres) urgent and emergency care services, from decision to attend to leaving. Understanding their experiences is essential to improving services and delivering high-quality care, as well as being an essential quality indicator for the work of organisations including the Care Quality Commission (CQC) and NHS England and NHS Improvement.

One hundred and thirty two trusts took part in the survey, of which 63 trusts had both a Type 1 and a Type 3 department, and 69 trusts had only a Type 1 A&E. The survey only includes Type 3 departments that are run directly by acute trusts, and not those run in collaboration with, or exclusively by others.

As with the previous survey carried out in 2016, this report shows that the majority of people were positive about most aspects of the urgent or emergency care they received in 2018. Despite widely recognised pressures and challenges on these services, most results have not significantly changed between 2016 and 2018.<sup>a</sup> Areas where results were less positive point to pressures on staff time or flag persistent issues with leaving hospital or the urgent care centre (also found in other [NHS Patient Surveys](#)). For example, within the Type 3 survey results, fewer patients this year said that if they had any anxieties or fears about their condition or treatment, a health professional 'completely' discussed this with them, and just over two fifths of people who took part in the Type 1 survey could not always get medical or nursing attention if they needed it. Where people spent longer than four hours in A&E or urgent care departments, they reported universally poorer experiences.

## Positive results

Very few questions showed a statistically significant improvement between 2018, and the last time the survey was carried out in 2016.

Of those using Type 1 services, the proportion of people to say they 'definitely' had enough time to discuss their condition with the doctor or nurse has improved from 73% in 2016 to 75% in 2018. Fifty-nine per cent in 2018 said that they were

<sup>a</sup> A statistically significant difference means it is very unlikely we would have obtained this result by chance alone if there was no real difference.

able to get suitable food and drink while they were in A&E if they wanted to compared with 56% in 2016.

The results for Type 3 departments were generally positive across most areas. There have been improvements in questions asking about privacy; the proportion of respondents to say that they were 'definitely' given enough privacy when discussing their condition with the receptionist has improved from 51% in 2016 to 57% in 2018, and the proportion of respondents to say that they were 'definitely' given enough privacy when being examined or treated has improved from 88% in 2016 to 90% in 2018.

Within both the Type 1 and the Type 3 results there has been an increase in the proportion of respondents to rate their overall experience with the top score of '10'. Within the Type 1 data this increased from 27% in 2016 to 29% in 2018. Within the Type 3 data this increased from 33% in 2016 to 37% in 2018.

While few questions had improved, there are several questions that continue to have very positive results, with some of the best results seen for questions asking about interactions with staff. For example, 78% of Type 1 respondents and 85% of Type 3 respondents felt that the staff they saw 'definitely' listened to what they had to say. Seventy-six per cent of Type 1 respondents and 81% of Type 3 respondents 'definitely' had confidence and trust in staff examining and treating them. The majority of respondents (79% for Type 1 and 86% for Type 3) said that they were treated with respect and dignity 'all of the time'. Staff are also generally providing clear explanations to most people about their treatment, for example, of those who had tests, 76% of respondents to the Type 1 survey and 85% of respondents to the Type 3 said that staff 'completely' explained why they needed these tests in a way they could understand. Of the Type 1 respondents who received test results before they left, 78% said staff 'definitely' explained the results to them in a way they could understand. Positive results for questions about how patients are treated by staff are also seen across other surveys in the NHS Patient Survey programme such as the [2018 maternity survey](#) and the [2018 inpatient survey](#).

Other areas where results are positive include cleanliness, where across both surveys the majority of respondents described the A&E or urgent care centre as 'very clean' or 'fairly clean' (95% for Type 1 and 97% for Type 3).

### **Areas for improvement**

Within the Type 1 results, the only question to show a decline in patient experience was the total length of time spent in A&E (which is discussed below).

Within the Type 3 results, results deteriorated for the proportion of respondents to say that health professionals 'definitely' talked to each other about them as if they were not there. This is still low but has increased from 4% in 2016 to 6% in 2018. There has also been a decrease in the proportion of respondents to say that if they had any anxieties or fears about their condition or treatment, a health professional 'completely' discussed this with them. This moved from 67% in 2016 to 63% in 2018. Though unchanged between years within the Type 1 survey, this question showed room for improvement with 57% saying that if they had any

anxieties or fears about their condition or treatment, a health professional 'completely' discussed this with them.

While there are very few questions that show a decline across Type 1 and Type 3 services, the results do suggest some areas for improvement particularly for waiting times, provision of effective pain relief, information about eating and experiences when leaving the A&E or urgent care centre.

### Waiting times

Results also show that patients are seen quicker and their visit is shorter at urgent care centres. This is as expected, as Type 3 services see patients who are less seriously unwell or injured, and who are therefore able to be treated more quickly.

The majority of respondents are waiting longer than 15 minutes for an initial assessment; 68% of Type 1 respondents waited more than 15 minutes before they first spoke to a nurse or doctor.<sup>b</sup> The majority of Type 3 respondents are also waiting longer than recommended with 57% of respondents who had attended with a pre-booked appointment and 65% of respondents who did not have an appointment waiting more than 15 minutes before they first spoke to a health professional.

The operational standard is that 95% of people should spend four hours or less in the urgent and emergency care department.<sup>c</sup> Just over two fifths of Type 1 respondents (41% in 2018, an increase from 40% in 2016) said that overall, their visit to A&E lasted for more than four hours. For Type 3 departments this is much lower at 12%, improved from 15% in 2016.

### Pain relief

Sixty-seven per cent of respondents who attended a Type 1 department (65% in 2016) and 64% of respondents who attended a Type 3 department said that they were in pain when they visited the A&E or urgent care centre. Just over half (55% of Type 1 respondents and 56% of Type 3 respondents) felt that staff 'definitely' did everything they could to help control their pain.

### Information about eating

It is important that patients have access to suitable food and drink, particularly if there is a long wait to be seen. However, in both the Type 1 and Type 3 results 10% (down from 11% in 2016 for Type 1 services) of respondents who wanted something to eat or drink, did not know if this was allowed. This suggests information provision around eating and drinking while waiting could be improved.

<sup>b</sup> As set by the Royal College of Emergency Medicine in its guidelines on the [Initial Assessment of Emergency Department Patients](#) and in [principles and standards for Urgent Care Centres](#).

<sup>c</sup> As set out in the [NHS Mandate for 2018-19](#) and in [principles and standards for Urgent Care Centres](#). At the time of writing this report the standard was being reviewed, please see policy section for further information.

## Going home

Research suggests that patients' experiences of leaving hospital can be poor, and there is also evidence of this in other NHS patient surveys such as the [2018 Adult Inpatients Survey](#). Results from the 2018 urgent and emergency care survey suggest that people's experiences of receiving information when leaving were not as positive as other areas of their care. For example, of the Type 1 respondents prescribed new medication, less than half (44%) said that they were 'completely' told about any side effects.<sup>d</sup>

Information provision to enable people to look after themselves at home could be improved. For example, less than half (45%) of respondents who visited a Type 1 service and needed this information said that a member of staff 'definitely' told them when they could resume their usual activities, such as when to go back to work or drive a car. For respondents who visited a Type 3 service this proportion was 54%. Some people who need greater support are also not receiving this; 39% of respondents who visited a Type 1 service, said that a member of staff 'completely' took their family or home situation into account when they left A&E, if this was necessary.<sup>e</sup>

## How experiences varies by department type

Results for Type 1 and Type 3 departments are detailed separately in this report as due to operational differences and differences in patient case-mix it is not appropriate to compare questions across services. While it is not appropriate to compare the detailed question level results, when looking more broadly across the results as a whole, respondents who visited a Type 3 department were more positive about all aspects of their care compared with respondents who visited a Type 1 department.

## How experience varies for different groups of patients

We also analysed the results to check for variation in experience between different groups of patients.

For users of Type 1 services, the analysis showed that, generally, older patients (66+) report experiences that are more positive. Conversely, younger respondents (16 to 35) report more negative experiences.

Where people spent longer than 4 hours in A&E or urgent care departments, they reported universally poorer experience: within the Type 1 results, respondents who said that their visit to A&E lasted for more than four hours had a worse than average experience for **all** patient experience themes covered by the survey. Within the Type 3 data, respondents who said that their visit to the urgent care centre lasted for more than four hours had a worse than average experience for four out of eight themes.

<sup>d</sup> While this question was also asked in the Type 3 questionnaire, results are not able to be reported due to many trusts having less than 30 respondents

<sup>e</sup> While this question was also asked in the Type 3 questionnaire, results are not able to be reported due to many trusts having less than 30 respondents

The analysis also shows that Type 1 respondents who said that they had been to the same A&E about the same condition or something related to it within the past week report have a poorer than average experience across four out of nine themes: respect and dignity, involvement and decision making, confidence and trust, and their overall experience. Type 1 respondents who have a mental health condition had a worse than average experience for three out of nine themes: respect and dignity, involvement and decision making and information.

Within the Type 3 analysis fewer differences were found which may be due to the lower sample size and therefore lower number of respondents in each sub group, which created wider confidence intervals.



# Introduction

## Urgent and emergency care services

Urgent and emergency care services can be accessed by people, without an appointment or referral, when they are experiencing an urgent health problem.

Urgent and emergency care is a complex system with a number of services. Departments are divided into four types that each provide different levels of care:<sup>1</sup>

**Type 1: A major, consultant-led A&E department with full resuscitation facilities operating 24 hours a day, seven days a week.**

**Type 2: Consultant-led single speciality services, for example, ophthalmology or dentistry.**

**Type 3: Other A&E/minor injuries unit/urgent care centre treating minor injuries and illnesses. Can be doctor or nurse-led and accessed without appointment.**

**Type 4: An NHS walk-in centre.**

Type 1 urgent and emergency care services include accident and emergency departments, which are also known as A&E, casualty or emergency departments. Acute trusts may also have other Type 1 services such as an ambulatory care unit, which may also be known as [same day emergency care](#). These are services where people can be rapidly assessed and diagnosed without admission to hospital. Type 3 service terminology also varies and these services may be known as urgent care centres, urgent treatment centres and minor injury units. However, [under plans from NHS England](#) to standardise these to make them less confusing to patients, all services should be transitioning to become known as urgent treatment centres. Other sources of urgent care and advice include primary and community services such as walk in centres, out-of-hours GP services, community pharmacies, mental health crisis care and NHS 111 services. The aim of these urgent care services is to reduce pressure on main hospital A&E departments by providing alternatives for less serious accidents, illness and injuries.

Emergency care is a key area of focus for the NHS and issues around waiting times in A&E and overcrowding have always attracted media attention, particularly in peak times such as the winter months. The 2013 review of the NHS urgent and emergency care system in England recognised the need to fundamentally transform services to address these issues. Progress towards achieving this was set out in subsequent policy documents. These changes are

taking place within a context of financial and system wide pressures. For more detail please see the [policy context](#).

This survey looked at people's experiences of using Type 1 and Type 3 urgent and emergency care services from decision to attend to leaving the department. Understanding their experiences is essential to improving services and delivering high-quality care. Data from the survey is used by CQC as part of its regulation, monitoring and inspection of NHS acute trusts in England. It is also used by NHS England to check progress and improvement against the objectives set out in the NHS mandate. For more information on how data from the survey is used please see [appendix E](#).

## Terminology used in this report

There are many different terms used to describe urgent and emergency care services, which can contribute to confusion around the appropriate services to use (see '[navigating the urgent care system](#)' section). In this report, we use the following terminology based on information from [NHS Choices](#).

**Accident & Emergency department (A&E)** - may also be known as 'emergency department' or 'casualty.' This refers to Type 1 (and 2) services and should deal with serious and life threatening emergencies.

**Urgent care service** - refers to Type 3 (and 4 services) and includes urgent treatment centres, urgent care centres and minor injuries units. They should deal with illness and injuries that are not life-threatening.

**Urgent and emergency care service** - refers to all four types of service.

## About this report

The data used in this report is based on a postal survey of people aged 16 and over who attended a Type 1 or Type 3 urgent and emergency care service provided by an acute trust between 1 and 30 September 2018.<sup>f</sup> Trusts that had an eligible Type 3 service and could not achieve the required sample size in September could also sample back to August. Fieldwork (the time during which questionnaires are sent out and returned) took place between October 2018 and March 2019.

One hundred and thirty two trusts took part of which 63 trusts had both a Type 1 and a Type 3 department, and 69 trusts had only a Type 1 A&E. Two questionnaires were used tailored to each service type. Results can be used to understand patient experience at England and trust level.<sup>g</sup>

<sup>f</sup> Moorfields Eye Hospital NHS Foundation Trust has been treated as a Type 1 department within all analysis as it was the only trust included in the survey with a Type 2 department.

<sup>g</sup> Trust level results are published on the [CQC](#) and [NHS Surveys](#) websites

For Type 1 services, we received responses from more than 42,700 people, a response rate of 30%, which is up from 28% in 2016. For Type 3 services, we received responses from more than 7,400 people, a response rate of 29%, which is up from 25% in 2016.<sup>h</sup>

For more information on the respondents to the survey, please see [Appendix B](#).

Due to substantive redevelopment ahead of the 2016 survey, results are **not comparable** with surveys carried out before this time. For more information about this and the survey methodology for 2018 please see [Appendix A](#).

It is important to note that the survey only includes Type 3 departments that are **run directly by acute trusts**, and not those run in collaboration with, or exclusively by others. This means we only have a partial picture of people's experiences of Type 3 departments in England. It is difficult to determine the exact number of providers of Type 3 services, and therefore the proportion included in the survey. However, based on the monthly figures for September 2018 (the sample month for the survey) from NHS England for [A&E attendances and emergency admissions in NHS and independent sector organisations in England](#) (which also include Type 4 services under Type 3), we estimate there to be around 200 Type 3 and 4 urgent care services combined.

It is also important to note that local provision will affect the type of patients and the severity of illness or injury ('case-mix') seen at a Type 1 department. While 69 trusts provided a Type 1 sample only, this does not necessarily mean that there are no other alternative services available locally. For example, there may be services outside of the scope of the survey, such as walk-in centres, an urgent treatment centre run by another provider, or an out-of-hours GP service. This would affect the case-mix seen at the Type 1 department; if a trust does not have any alternative services available locally, it will see a mixture of major and minor cases. However, a trust that has other alternatives available locally (whether available directly through the trust or another provider) would likely see a higher proportion of more seriously ill or injured patients in its Type 1 department and have fewer minor cases. Although this should have little impact on the results for England (based on the amalgamated results for all trusts), this variation in provision should be considered if comparing the trust level results [published on CQC's website](#).

The urgent and emergency care survey is part of a wider programme of [NHS patient surveys](#), which covers a range of topics including people's experiences of care in adult inpatient, children and young people, maternity, and community mental health services. To find out more about the survey programme and to see the results from previous surveys, please see the further information section ([Appendix G](#)).

<sup>h</sup> The 'adjusted' response rate is reported. The adjusted base is calculated by subtracting the number of questionnaires returned as undeliverable, or if someone had died, from the total number of questionnaires sent out. The adjusted response rate is then calculated by dividing the number of returned useable questionnaires by the adjusted base.

# Policy context

It is important to consider the landscape of urgent and emergency care in England at the time the survey was carried out. This section summarises the main policies, standards and guidelines for this area of healthcare.

## The importance of people's experiences

Alongside clinical effectiveness and safety, a good experience for people is seen as an essential part of an excellent health and social care service. Most recent national policy requires organisations to measure and improve patient experience. People's experiences provide key information about the quality of services, which can be used to encourage improvements both nationally and locally by providers and commissioners of services.

There are a number of documents that set out policy and standards in relation to the delivery and assessment of patient-centred care. This includes the [NHS Constitution for England](#) (2012, updated in 2015), which committed the NHS to encouraging feedback from patients to improve services, and the [NHS Outcomes Framework](#) (first published 2013/14) that sets out high-level national outcomes that the NHS should aim to improve, and that includes the need to make sure that people have a positive experience of care.<sup>2</sup>

The *Five Year Forward View* (2014), committed to personalised care by empowering patients to have greater control of their own care.<sup>3</sup> This continued with the NHS Long Term Plan (2019), which makes the commitment that 'people will get more control over their own health and more personalised care when they need it,' and that staff will be trained and supported to have the right conversations with patients to enable this.<sup>4</sup> The model for implementing this is set out in *Universal Personalised Care: Implementing the Comprehensive Model* (2019).<sup>5</sup> This model is based on six key components: shared decision-making, personalised care and support, enabling choice, social prescribing and community-based support, supported self-management and personal health budgets. The [questionnaires](#) used for the urgent and emergency care survey included a number of questions on issues relating to personalised care.

Policy is supported by guidance about what creates a positive patient experience. The NICE quality standard for patient experience in adult NHS services provides evidence-based guidance and quality standards that help healthcare professionals to implement policy initiatives.<sup>6</sup> The NHS Patient Experience Framework published by the National Quality Board highlights important elements of patient experience.<sup>7</sup> This identified eight key elements including respect and involvement, coordinated and integrated care, information and communication, physical comfort, emotional support and the involvement of family or friends. Again the [questionnaires](#) used for the urgent and emergency care survey included a number of questions relating to these issues.

Research is increasingly highlighting the benefits of involving people in their care, which include better knowledge of, and improved satisfaction with, their care and treatment. Evidence from academic research shows that when people are

involved in their care, decisions are made more effectively, and health outcomes improve.<sup>8</sup> A review of academic research has also confirmed the positive association between patient experience and clinical outcomes.<sup>9</sup>

## Urgent and emergency care

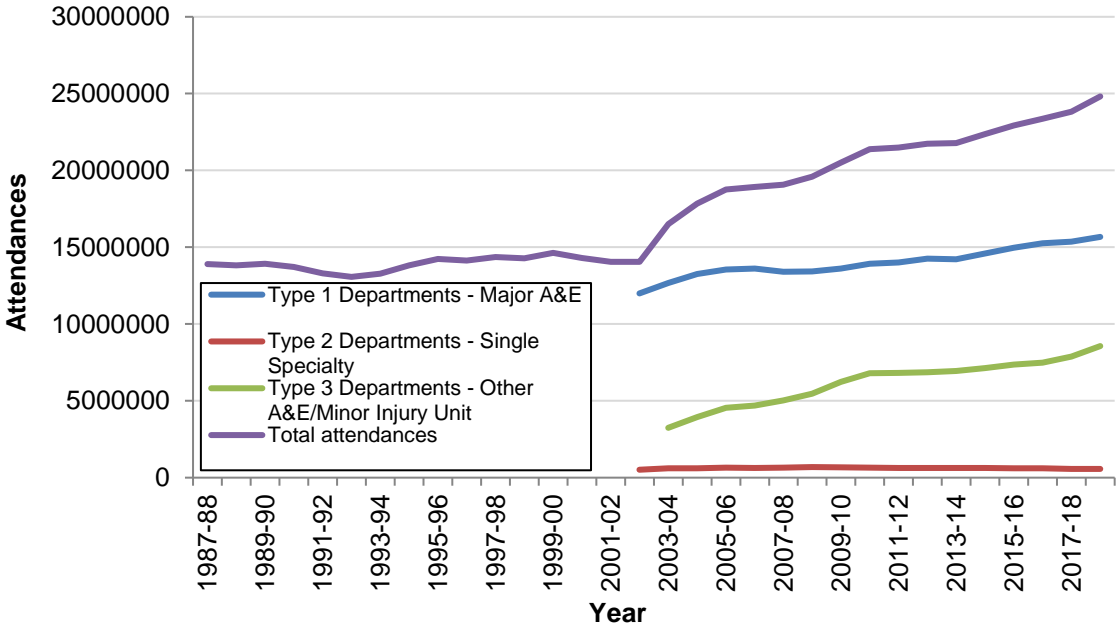
### Increasing demand

It is generally accepted that demands on the healthcare system, and therefore on the staff working within the system, have risen dramatically.

CQC’s *The state of health care and adult social care in England 2018/19* describes how trends in rising attendances at A&E, and acute hospital admissions, have continued since the publication of the last report in 2018.<sup>10</sup> It describes how urgent and emergency services bear the brunt of this demand and struggle to provide high-quality care, with 44% rated as requires improvement and 8% rated as inadequate. Despite this, CQC report that the majority of NHS hospitals have continued to provide good care during 2018/19, with 65% of core service rated as good and 7% of core services rated outstanding. However, safety remains the area of most concern with 39% of services rated as requires improvement or inadequate.

As may be seen in figure 1, attendances to urgent and emergency care services continue to rise each year. Statistics published by NHS Digital and NHS England<sup>11</sup> show that there were 24.8 million total attendances in A&E in 2018/19, an increase of 4% from 2017/18, and an increase of 21% compared with 2009/10. Figures for Type 3 attendances are slowly increasing over time, increasing from 30% in 2009/10 to 35% in 2018/19.

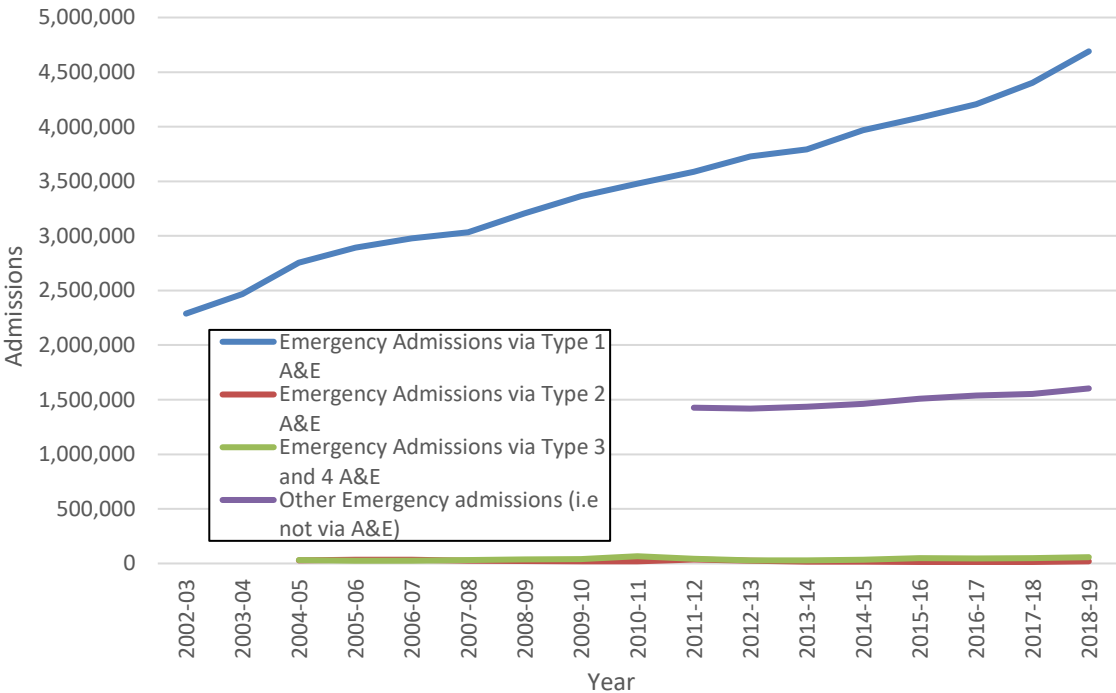
**Figure 1: Attendance at urgent and emergency care services 1987/8 to 2018/19**



Source: NHS England <https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/ae-attendances-and-emergency-admissions-2018-19/>

There has been a corresponding increase in emergency admissions (people admitted as an inpatient following their visit to urgent and emergency care services). The Health Foundation report that this has increased by 42% over the last decade. This trend is driven by increasing numbers of patients attending A&E with multiple and complex health conditions and admissions have particularly increased for older patients aged 85 and over.<sup>12</sup>

**Figure 2: Admissions from urgent and emergency care services 1987/8 to 2018/19**



**Source:** NHS England  
<https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/ae-attendances-and-emergency-admissions-2018-19/>

**Waiting times**

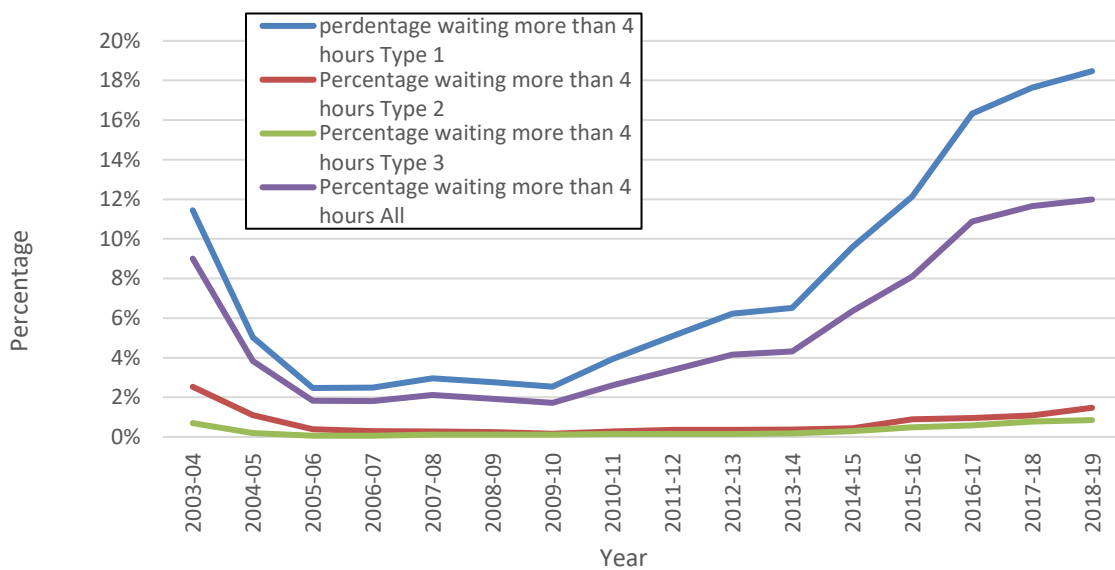
Waiting times can impact on patients’ experiences of care. While some research suggests a link between long waits and lower patient satisfaction, other research suggests that people’s experiences of A&E are not just based on how long they wait, but the quality of care they receive.<sup>13,14</sup> However, longer waiting times can cause overcrowding, which can have a detrimental effect on patient safety. As described by the Royal College of Emergency Medicine (RCEM) overcrowding is associated with poorer outcomes for patients, including increased length of stay (if admitted) and mortality.<sup>15</sup>

The NHS Constitution currently pledges “a maximum four-hour wait in A&E from arrival to admission, transfer or discharge.”<sup>16</sup> This commitment was first introduced in 2004 when 98% of patients were expected to spend no longer than four hours in A&E. This was reduced to 95% in 2011 when the Department of Health replaced the standard with a set of clinical quality indicators.<sup>17</sup> These

measure a range of metrics, including time to initial assessment (ambulance arrivals only), time to treatment, total time in A&E, and unplanned reattendances, allowing for a broader understanding of waiting time issues.

In recent years the NHS has struggled to meet the four-hour target.<sup>18</sup> Figure 3 below shows a drop in the proportion of people waiting more than four hours following the introduction of the standard, but since 2014/15 this has increased substantially again.

**Figure 3: Percentage waiting more than four hours from arrival to discharge or admission 2003/4 to 2018/19**



Source: NHS England

<https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/ae-attendances-and-emergency-admissions-2018-19/>

However, the length of time people spend in urgent and emergency care services depends on the type of service they visit. Quality Watch describe how while Type 2 and Type 3 services usually treat people in less than four hours, major (Type 1) A&E departments who deal with higher numbers of attendees and more serious cases, find it harder.<sup>19</sup>

Recent policy has included milestones to return to achieving the four-hour target. Next Steps on the NHS Five Year Forward View (2017) included three milestones to restore this by 2018, though these were not achieved.<sup>20</sup> The NHS Mandate for 2018/19 put the four-hour waiting time target on hold, stating that the NHS must "deliver aggregate A&E performance in England above 90% in September 2018, with the majority of trusts meeting 95% in March 2019, and aggregate performance in England at 95% within the course of 2019".<sup>21</sup>

It is recognised that the four-hour target is a measure of how well the system is working as a whole. For example, [The Royal College of Emergency Medicine \(RCEM\)](#) and [The King's Fund](#) have stated that waiting times are affected by

pressures in other services such as ambulatory, primary and social care, as well as patient flow through the hospital.<sup>22</sup>

A recent review into NHS access standards by NHS England's National Medical Director has recognised the limitations of the current four-hour standard.<sup>23</sup> For example, limitations of the target include that it does not measure total waiting times, it does not differentiate between severity of condition, it does not recognise the complex pathways of the modern urgent and emergency care system, it is misunderstood by the public, and hospital staff are driven by processes and targets rather than clinical judgement. The report sets out plans to test four new access standards:

1. Time to initial clinical assessment in emergency departments and urgent treatment centres (type 1 and 3 A&E departments).
2. Time to emergency treatment for critically ill and injured patients
3. Time in A&E
4. Utilisation of same day emergency care.

The new standards will be tested across [14 pilot sites](#) before recommendations are rolled out nationally, currently expected from Spring 2020.

## Integrated care

### What is integrated care?

Based on information from [NHS England](#) integrated care includes the following principles:

- Different health and social care services are able to work together in a joined-up way to deliver the best care for their local communities.
- Care must be 'personalised' meaning it is tailored to the needs and preferences of the patient and family or carers, where involved.

Integrated care is seen as key to reducing demand on acute services for conditions that could be better managed in other primary or community settings. Recent policy has recognised the need to improve how different services and systems work together to manage pressures and improve patient experience of care. [The Five Year Forward View](#) describes the need to change the structure of the NHS to dissolve traditional boundaries between primary care, community services and hospitals to better meet the needs of patients. Most recently this continues within the [NHS Long Term Plan](#), which commits that every area will be served by [an integrated care system](#) by 2021.

However, as highlighted in *Under pressure: safely managing increased demand in emergency departments*, the problems in urgent and emergency care are a symptom of a much wider capacity problem across the whole health and social



care system, with health and social care systems not working together effectively.<sup>24</sup>

[The NHS Long Term Plan](#) sets out a 10-year plan for healthcare in England which focuses on preventative health and health inequalities. For urgent and emergency care, it continues to build on the Five Year Forward View which set out new models of care that aimed for better integration between urgent and emergency services to help prevent unnecessary attendance at Type 1 departments. The NHS Long Term Plan will continue to expand and reform urgent and emergency care services to provide people with access to care quickly and relieve pressures from A&E.

Changes to pre-hospital urgent care include improving advice provided to patients and support for staff working in the community by establishing a multidisciplinary Clinical Assessment Service (CAS) as part of NHS 111 from 2019/20; and implementing the recommendations of Lord Carter's report into the operational efficiency of ambulances.<sup>25</sup> This found that pressures on A&E could be reduced by patients being better assessed over the phone and treated at the scene by paramedics. Changes to within hospital care include the introduction of same day emergency care by 2019/20. This means that A&E patients requiring a few hours of care or observation can be diagnosed, treated and discharged on the same day, avoiding and reducing overnight stays.

The questionnaire includes some questions looking at integrated care, including questions asking about the decision to attend the urgent and emergency care department and the information and support people received when leaving.

### **Navigating the urgent and emergency care system**

[Next Steps on the Five Year Forward View](#) estimates that up to three million people attend Type 1 A&E departments unnecessarily for care that could be more appropriately managed elsewhere.

Changes to the provisions of urgent and emergency care services mean that there is currently a great deal of variation in how services are organised and delivered in England. While some acute trusts provide only major (Type 1) A&E departments, others may offer a range of services such as a minor injuries unit and a walk-in centre. Where these are co-located on site, staff can stream patients with less serious illness and injuries to these services. If located off-site, this relies on patients either making the decision to attend an alternative to A&E, or receiving advice, for example through NHS 111.

Depending on local commissioning arrangements, who provides the services varies. While they can be located on an acute trust site, urgent care can be provided by other types of trusts (such as a community trust), by clinical commissioning groups (CCGs) or by independent companies. There can also be partnership or shared arrangements such as where a service is managed by the trust but staffed by another provider.

Research has shown that that this variation makes it more difficult for people to decide which is the most appropriate service to use. [A Healthwatch report](#) looking

at reasons for attending a Type 1 A&E suggests that many people are unaware of alternatives as current NHS marketing campaigns have not sufficiently raised awareness. The report describes how other reasons include not seeking help or guidance from elsewhere to signpost them to the appropriate service, A&E being the most convenient option, or that they feel A&E to be the best course of action and prefer this to alternatives.

A study by the National Institute for Health Research (NIHR) found that adults aged 16 to 44 years are more than three times more likely to present for non-urgent reasons than those over 65 years.<sup>26</sup> Non-urgent attendances are also more common during out-of-hours periods, especially at night. The article suggests that this may reflect confusion about how to access the correct care, particularly among young people who want this at a time and place which suits them, for example, around work commitments. It concludes services need to continue to find ways to divert people to more appropriate services to take the pressure off main (Type 1) A&E departments.

This confusion has prompted NHS England to commit to a programme of work to roll out Urgent Treatment Centres (UTC) to replace the current mixture of services. UTCs will provide a more standardised service and are required to meet a core set of standards as set out in published guidance.<sup>27</sup> This includes that they will be GP-led, open 12 hours a day, co-located with other services and should offer both pre-booked and walk-in appointments. To enable effectively integrated services they should also establish strong links with other community services (such as mental health crisis support, pharmacies, dental services). By December 2019 all designated UTCs should be meeting this guidance. NHS England said that they '*...expect reduced attendance at, and conveyance to, A&E as a result of this standardisation and simplified access.*' The [NHS Long Term Plan](#) continued this commitment stating that the UTC model would be fully implemented by autumn 2020.

Key to making sure patients access the correct service for their needs is ensuring they have access to the right information. The [NHS Long Term Plan](#) sets out improvements in how people will be able to seek advice before leaving home to signpost them to the correct service. The telephone and online services provided by [NHS 111](#) services will continue to provide access to the wider NHS by guiding people to the appropriate service. The service will be improved to include increased provision of clinical assessments and immediate advice and/or referrals. Digital technology will provide convenient ways for people to access advice, such as via apps, as well as providing fast access to primary care by online consultations.

## Staffing

Gaps in the workforce affect staff ability to be responsive to the needs of patients, which in turn may impact on patient experience. According to the draft workforce strategy for England, emergency medicine has the highest vacancy rate by speciality, which was 15.6% in March 2016.<sup>28</sup>

The Nuffield Trust has recently set out concerns that the NHS does not have enough staff to meet demand.<sup>29</sup> A joint report from Health Education England

(HEE), NHS England, NHS Improvement and the Royal College of Emergency Medicine (RCEM) on securing the future workforce says that while the numbers of staff working in emergency medicine have increased, the workforce is not able to keep up with the challenges of increased attendances and admissions and increasing complexity of conditions.<sup>30</sup> The report finds that an expansion of medical training posts, more clinical staff, multidisciplinary teams and the development of new roles (such as advanced nurse practitioners) are needed to meet these pressures.

In particular, the RCEM separately reports that the increase in demand in A&E has not been matched by an increase in consultants, who are needed for clinical decision making and supervision of junior staff.<sup>31</sup> The Interim NHS People Plan sets out workforce actions that need to be taken now, to deliver the new models of care set out in the NHS long-term plan.<sup>32</sup> It recognises that many staff are currently overstretched, that there are difficulties in staff recruitment and retention and increasing the workforce needs to be prioritised. It describes how as well as rapidly recruiting staff, particularly nursing staff, the NHS needs to be made a better place to work.

The pressure of working in emergency care can negatively impact on NHS staff. An RCEM report highlights poor working conditions, higher vacancy rates, higher levels of work-related sickness and stress, which in turn impacts on patient care.<sup>33</sup> Culture was raised as a key issue in a workshop held by CQC in 2017 to discuss strategies for positive actions to improve A&E. A supportive culture was felt to be essential for encouraging teamwork, and engaging with and empowering frontline staff is key to establishing this.<sup>34</sup> CQC also went on to note concerns about the wellbeing of staff working under pressure without sufficient consultant support in its [report into winter pressures](#).

# Results from the survey

## Understanding the results

This section presents the key results from the 2018 urgent and emergency care survey and follows people's journeys from decision to attend, to treatment and discharge. Not all findings, and not all response options are reported in all cases, though the full results for all questions can be found in open data format on the [CQC website](#). Please also note that two questionnaires were used, tailored to each service type, and not all questions are used across both questionnaires, and sometimes response options are different.

The results highlight statistically significant differences compared with 2016 (the last time the survey was carried out) where possible for both Type 1 and Type 3 departments.<sup>i</sup> Where 2016 data is not also described there is no statistically significant change. Please note that as there are currently only two data points (2016 and 2018) it is not possible to determine if any changes are the start of a trend or natural fluctuation within the data.

Please also note that due to the smaller sample size for the Type 3 services, larger differences between years are required for changes to be statistically significant. The sample size for Type 3 services was also smaller in 2016 with trusts submitting a sample of 300 patients (increased to 420 in 2018). This means that the number of Type 3 respondents for some 2016 questions is quite low and comparisons between 2016 and 2018 should be made with caution. This has been flagged within this report where appropriate.

As was outlined in the policy context section, urgent and emergency care services are currently in a period of transformation. This means that service provision has changed over time and, as might be expected, more trusts had a Type 3 service included in the survey in 2018 (63) compared with in 2016 (49). Though it should be borne in mind that provision has changed when interpreting the results, the survey sample and analysis methodology are designed to be reflective of the overall picture for England.

Results for Type 1 departments and Type 3 departments are detailed separately. This is because it is not appropriate to compare the experiences of people attending different department types. Type 1 and Type 3 departments may be operationally very different, for example Type 3 departments tend to have a different staff mix (they can be nurse or doctor/GP-led) and are not usually open 24 hours. They will also have a different patient case mix as people attending a Type 3 department are more likely to be less seriously unwell or injured.

While it is not appropriate to compare the detailed question level results for reasons described above, when looking more broadly at the results as a whole,

<sup>i</sup> A statistically significant difference means it is very unlikely we would have obtained this result by chance alone if there was no real difference.

respondents who visited a Type 3 department were more positive about all aspects of their care compared with respondents who visited a Type 1 department.

We have also included analysis that compares how different groups of people rated their experiences. The [NHS Constitution](#) and the [Equality Act 2010](#) both require healthcare providers to give “...equal consideration to the needs, experiences, outcomes and aspirations of people with protected characteristics under equalities law”. These protected characteristics are age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation. The Equality Act provides an important legal framework, which should improve the experience of all patients using NHS services.

The analysis modelled the mean scores of different subgroups (age, gender, religion, sexual orientation, ethnicity, long-term conditions, attendance time, attendance day, length of attendance and whether they have attended the urgent and emergency care department previously) for a set of composites aligned with the [NHS Patient Experience Framework](#). Mean scores were calculated for each subgroup and compared with the overall mean score. In this report, differences that are equivalent to at least 0.1 standard deviations from the overall mean of the target variable are treated as being noteworthy, provided that the confidence interval does not overlap the mean line. For more details on the analysis method please see [Appendix A](#). The charts used for the analysis may be found in [Appendix H](#), published as an [external appendix](#).

We present these findings throughout the report and provide a full summary of results in the [subgroup analysis summary](#) section.

## 1: Arrival

### Deciding to go

Urgent and emergency care services are undergoing significant transformation to meet the vision for a simplified and integrated system as set out in the [Five Year Forward View](#) and subsequent policy documents. As a result, the way services are organised has changed over the recent years to try to reduce pressures and demand on major (Type 1) A&E departments by encouraging non-urgent patients to seek alternative services.

The questionnaires therefore included questions to try to understand whether people sought help from other services before they arrived, and why they then went on to attend the service they did.

Most people said that the A&E or urgent care centre was the first service that they went to, or contacted, for help with their condition. There has been a small increase in the proportion of respondents who visited a Type 1 department to say that it was **not** the first service they went to, or contacted, for help with their condition from 42% in 2016 to 43% in 2018. For Type 3 services this proportion was 37%.

These people were asked where they went to, or contacted, for help with their condition first. For Type 1 services the most common response was their GP practice (29%) followed by NHS 111 telephone or online service (28%) and the 999 emergency service (21%). For Type 3 services, the most common response was their GP practice (40%) followed by an NHS 111 telephone or online service (20%). The main reason they then went on to attend the A&E or urgent care centre was that the service they contacted first referred or took them there (68% Type 1, 60% Type 3) or that their condition became worse (21% Type 1, 18% Type 3).

**Before going to this A&E department / urgent care centre, where did you go to, or contact, for help with your condition?**

Type 1		Type 3	
999 emergency service	21%	999 emergency service	5%
NHS 111 telephone / online service	28%	NHS 111 telephone / online service	20%
A different A&E department	3%	A&E department	11%
Pharmacist	1%	Pharmacist	5%
GP practice	29%	GP practice	40%
GP out-of-hours service	2%	GP out-of-hours service	1%
Urgent Care Centre / Minor Injuries Unit / Walk-in Centre	8%	A different Urgent Care Centre / Minor Injuries Unit / Walk-in Centre	13%
Somewhere else	8%	Somewhere else	6%
Number of respondents	18,110	Number of respondents	2,358

Answered by all who contacted another service first for help with their condition.

**Arriving by ambulance**

Guidance states that patients arriving by ambulance should be seen within 15 minutes of arrival at A&E. Delays in the handover of care between ambulance and hospital can have an impact on care and cause poorer patient experiences<sup>i</sup>.

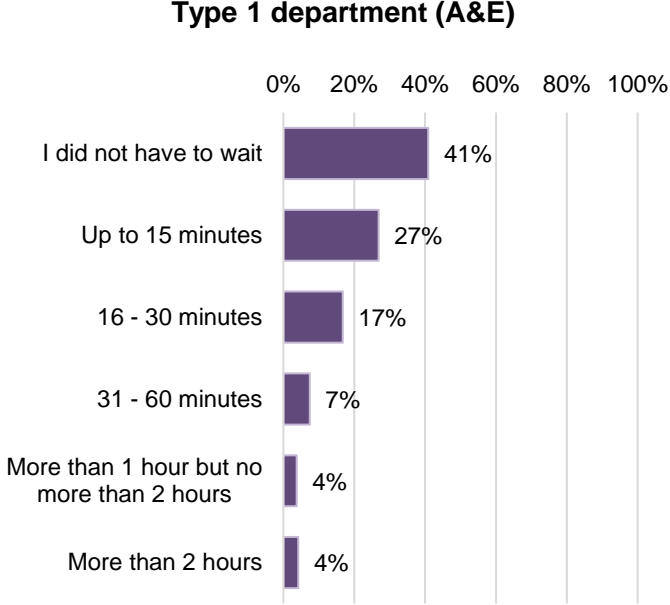
Delays can also be a sign of a system struggling to cope with demand. They are a particular issue during the winter months and are monitored by NHS England during December-February. NHS Improvement state handover delays should be recognised as a system-wide responsibility and has published guidance on how community, primary and acute services can work together to reduce these.<sup>35</sup>

Of those respondents who attended a Type 1 A&E department, almost a third (32%) were taken there by ambulance. Of these people, 41% did not have to wait with the ambulance crew to have their care handed over to A&E staff and 27%

<sup>i</sup> See for example: Care Quality Commission *Under pressure: safely managing increased demand in emergency departments* (2018) [www.cqc.org.uk/publications/themed-work/under-pressure-safely-managing-increased-demand-emergency-departments](http://www.cqc.org.uk/publications/themed-work/under-pressure-safely-managing-increased-demand-emergency-departments) (P9)

waited up to 15 minutes. This leaves just under a third (32%) who waited with the ambulance crew for longer than 15 minutes.

**Once you arrived at A&E, how long did you wait with the ambulance crew before your care was handed over to the A&E staff?**



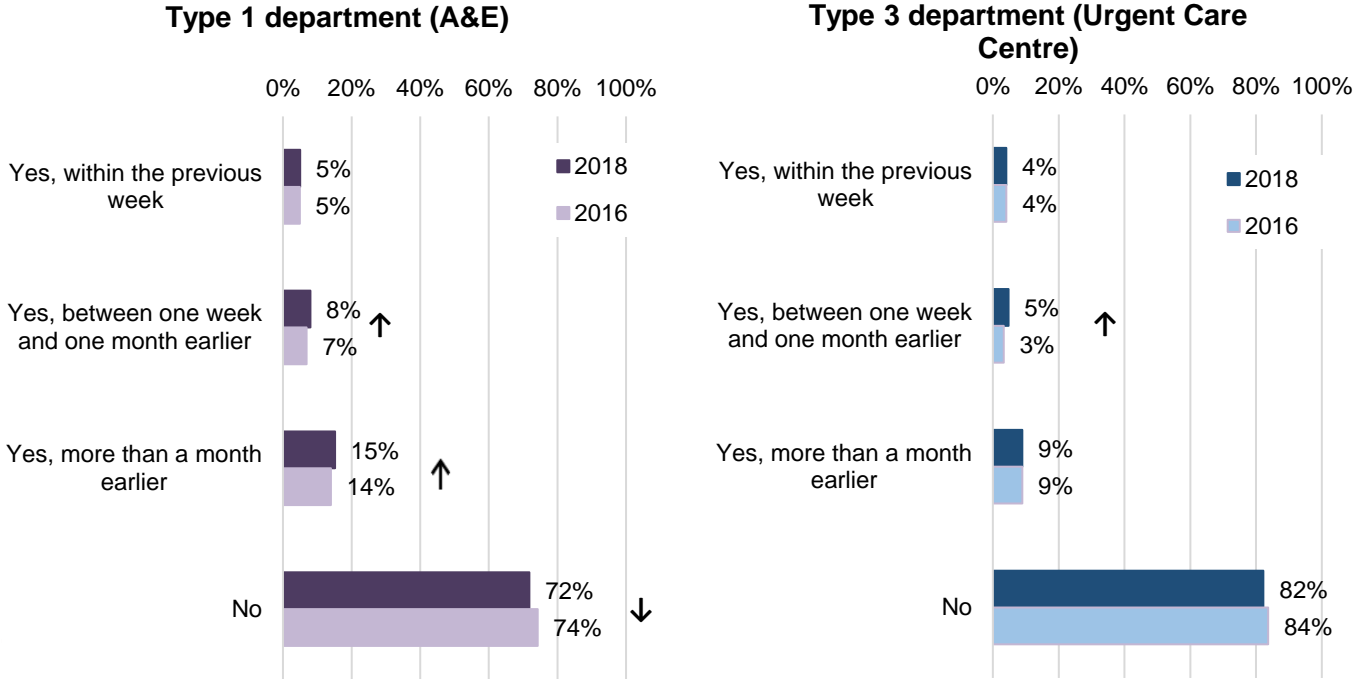
Number of respondents: Type 1 (2018: 12,434)  
 Answered by all who were taken to A&E in an ambulance. Respondents who stated that they didn't know / couldn't remember have been excluded.

**Re-attendance**

The [clinical quality indicator](#) on unplanned re-attendance states that no more than 5% of patients should re-attend within seven days of their first attendance for the same condition. The Royal College of Emergency Medicine (RCEM) describe how reasons for reattendance are complex, for example it can suggest that the patient's needs had not been dealt with appropriately on their first visit, or that their conditions may have suddenly worsened, or it may be another unrelated condition.<sup>36</sup> The RCEM recommends that departments should have a way to identify people who reattend several times, and guidance states that they should be treated with the same care and respect as other patients, and may benefit from a bespoke care plan.<sup>37</sup>

Five per cent of respondents who attended a Type 1 department and 4% of respondents who attended a Type 3 department said that they had been to the same service within the previous week, for the same or a related condition.

**Before your most recent visit to A&E / the urgent care centre, had you previously been to the same A&E / urgent care centre about the same condition or something related to it?**



Number of respondents Type 1 (2016:39,374 2018: 40,272) | Type 3 (2016: 3,414 2018: 6,996)  
 Answered by all.  
 Respondents who stated that they didn't know / couldn't remember have been excluded.  
 Arrows indicate statistically significant increase ↑ or decrease ↓ between 2016 and 2018

**Privacy**

The [NHS Constitution for England](#) states that patients have the right to privacy and confidentiality, and that they can expect the NHS to keep their confidential information safe and secure.

Around half of respondents (51% in 2016 and 52% in 2018) who visited a Type 1 department said that they were 'definitely' given enough privacy when discussing their condition with the receptionist. This leaves 37% who said they were 'to some extent' and a tenth who were not (11% in 2016 and 10% in 2018).

There has been an increase in the proportion of respondents who visited a Type 3 department to say they were 'definitely' given enough privacy when discussing their condition with the receptionist from 51% in 2016 to 57% in 2018. This leaves 36% who said they were 'to some extent' and just under a tenth who were not (10% in 2016 and 8% in 2018).



## 2: Waiting

This section provides relevant policy on waiting times to give context to the survey findings. However, it is important to note that survey results are a different type of data to other published statistics on waiting times, for example those published by [NHS England](#), and therefore are **not directly comparable**. Patients may not have the same definitions as official data, for example, they may not have realised that they have been moved from an A&E to a ward for observation before discharge or admission. The sample for the survey also has certain exclusions, for example, children under the age of 16 were excluded, and they are more likely to be seen quickly. Published statistics also include more organisations than does the survey, for example, they include data for urgent care providers that do not currently fall under the remit of the survey.

[Appendix C](#) provides further information on published statistics on waiting times.

Results show that, as might be expected, patients are seen quicker and their visit is shorter at urgent care centres.

### Waiting for treatment

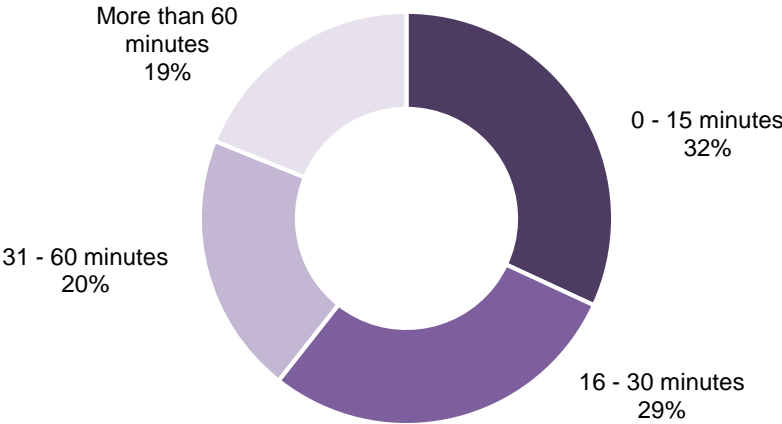
#### Type 1 results

Current standards, as set out by the Royal College of Emergency Medicine in its guidelines on the Initial Assessment of Emergency Department Patients are that patients should have an assessment within 15 minutes of their arrival.<sup>38</sup> This should ensure that patients who are seriously unwell are prioritised. However, the report *Under pressure: safely managing increased demand in emergency departments* describes how [CQC inspections](#) found that for the last three winters, patients in most emergency departments were not receiving this. The report describes this as a risk to patient safety, as delays to initiating treatment can lead to worse outcomes for patients with a deteriorating condition.

Survey results show that the majority of respondents who attended a Type 1 department (68%) are waiting for longer than 15 minutes for an initial assessment. Less than a third (32%) said they first spoke to a doctor or nurse within 15 minutes.

**How long did you wait before you first spoke to a nurse or doctor?**

**Type 1 department (A&E)**



Number of respondents Type 1 (2018: 39,568)  
Answered by all.  
Respondents who stated that they didn't know / couldn't remember have been excluded.

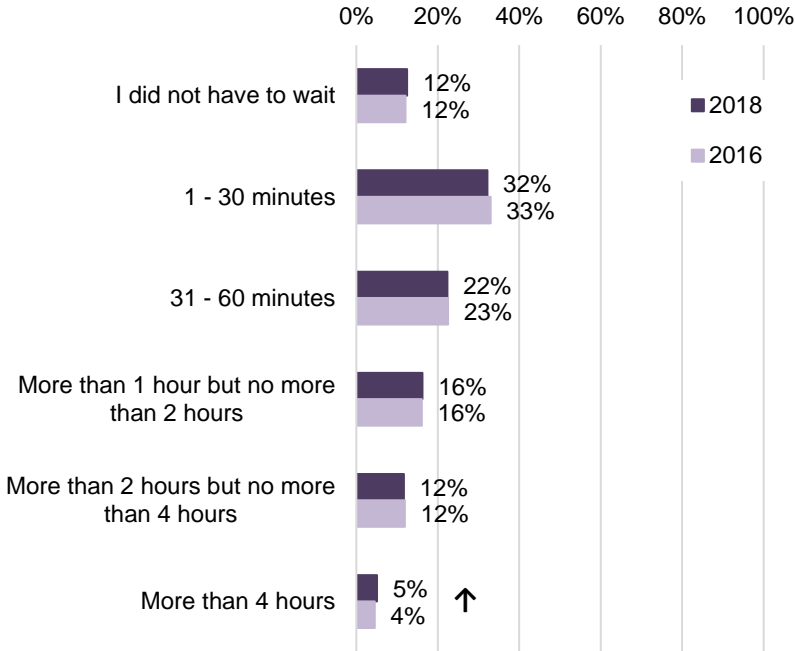
A&E performance is measured by a set of five [clinical quality indicators](#) of which three refer to timeliness of being seen, and include total time in the department, time to initial assessment (for ambulance arrivals only) and time to treatment. For those who do not arrive by ambulance, the time to treatment clinical quality indicator measures the time between arrival and the time when the patient is seen by a clinical decision maker who starts treatment, which should be within 60 minutes.

[NHS Digital](#) report that in September 2018 (the sampling month for the survey) the median average time to treatment for all patients receiving treatment was 61 minutes with 95% of patients receiving treatment within 3 hours 33 minutes.

Survey results show that two thirds of respondents who attended a Type 1 department (67%) waited for 60 minutes or less before being examined or treated, meaning that a third (33%) waited for longer.

**Sometimes, people will first talk to a doctor or nurse and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?**

**Type 1 department (A&E)**



Number of respondents Type 1 (2016:38,927 2018: 39,475)  
 Answered by all.  
 Respondents who stated that they didn't know / couldn't remember have been excluded.  
 Arrows indicate statistically significant increase ↑ or decrease ↓ between 2016 and 2018

**Type 3 results**

There are different expectations around waiting times depending on if a patient attends an urgent care centre with a pre-booked appointment or not. Guidance, as set out in [principles and standards for Urgent Care Centres](#), says that patients who walk-in to an urgent care centre should be clinically assessed within 15 minutes of arrival. Following this assessment, they will be given an appointment slot, which will not be more than two hours after the time of arrival. Patients who have a pre-booked appointment made by NHS 111 should be seen and treated within 30 minutes of their appointment time. However, protocols should be in place to ensure that any more seriously ill or injured patients are seen sooner.

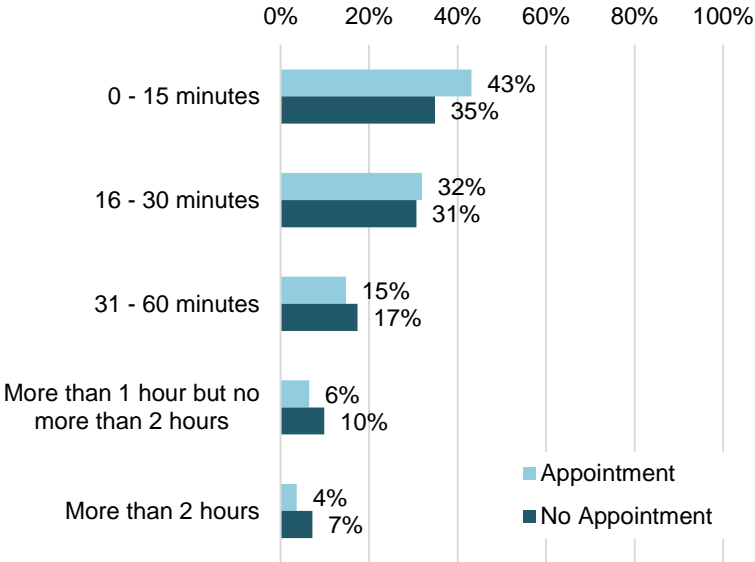
While at the time of the survey a mixture of Type 3 department types took part, we have broken down the results by whether patients had an appointment, as most centres should be transitioning towards offering them. Less than a fifth (17%) of respondents said that they had an appointment on their most recent visit to the urgent care centre.

Survey results show that the majority of respondents are waiting more than 15 minutes for an initial assessment: 57% of respondents who had an appointment and 65% of respondents who did not have an appointment waited longer than 15 minutes before they first spoke to a health professional. As might be expected,

respondents who attended with an appointment first spoke with a health professional quicker.

**How long did you wait before you first spoke to a health professional?**

**Type 3 department (Urgent Care Centre)**

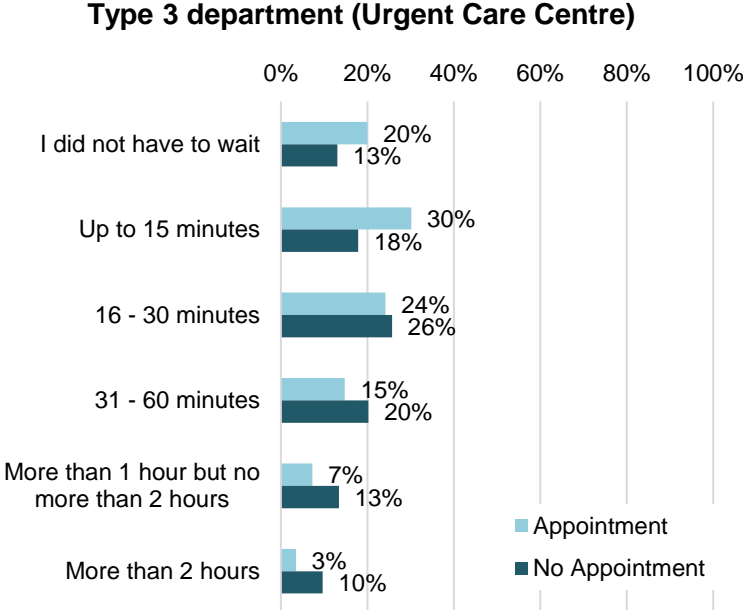


Number of respondents Type 3 (**Appointment:** 1,131 **No appointment** 5,692)  
 Answered by all.

Respondents who stated that they didn't know / couldn't remember have been excluded.

Survey results show that almost three quarters of respondents (74%) who had an appointment for their visit to a Type 3 department waited **30 minutes or less** before being examined. For patients who attended without an appointment, just over three quarters (77%) were examined **within 60 minutes**. As might be expected, respondents who attended with an appointment were seen quicker.

**Sometimes, people will first talk to a health professional and be examined later. From the time you arrived, how long did you wait before being examined?**



Number of respondents Type 3 (**Appointment: 1,123 No appointment 5,660**)  
 Answered by all.  
 Respondents who stated that they didn't know / couldn't remember have been excluded.

**Total length of visit**

Timely access to services is recognised as a critical part of patient experience of care. [The NHS Constitution for England](#) currently pledges “a maximum four-hour wait in A&E from arrival to admission, transfer or discharge”.

[Guidance to trusts](#) on implementing urgent treatment centres states that attendances will count towards the four-hour access and waiting times standard.

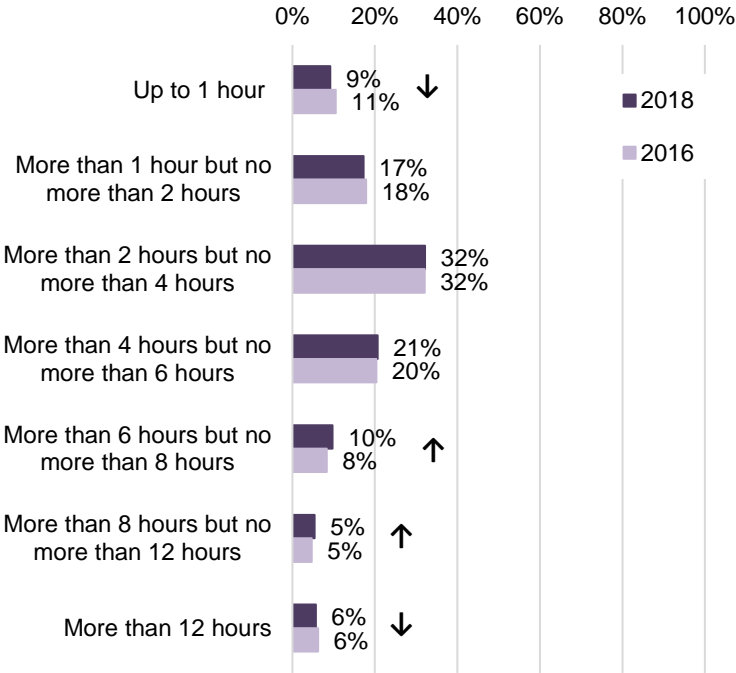
In September 2018 (the sample month for the survey) [NHS England reported](#) that 10% of people spent more than four hours from arrival to admission, transfer or discharge. These figures include all urgent and emergency care types, including services outside of the scope of the survey.

However, the length of time people spend in urgent and emergency care services depends on the type of service they visit. [Quality Watch](#) describe how while Type 2 and Type 3 services usually treat people in less than four hours, major (Type 1) A&E departments who deal with higher numbers of attendees and more serious cases, find it harder.

Results for respondents who attended a Type 1 service are broadly similar compared with 2016. There has been a statistically significant decline in the proportion to say their overall visit lasted for less than an hour, and corresponding statistically significant increases in ‘more than six hours but not more than eight hours’ and ‘more than eight hours but not more than 12 hours’.

**Overall, how long did your visit to A&E last?**

**Type 1 department (A&E)**



Number of respondents Type 1 (2016:39,329 2018: 39,641)

Answered by all.

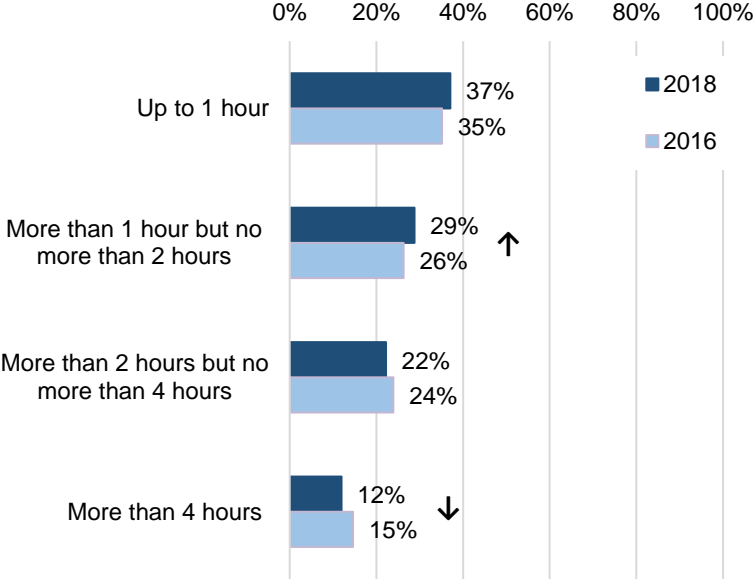
Respondents who stated that they couldn't remember have been excluded.

Arrows indicate statistically significant increase ↑ or decrease ↓ between 2016 and 2018

Results for Type 3 services suggest that respondents reported their visit being shorter in 2018 compared with 2016, with a statistically significant increase in the proportion to respond 'more than one hour but no more than two hours' and a statistically significant decrease in the proportion to respond 'more than four hours'.

**Overall, how long did your visit to the urgent care centre last?**

**Type 3 department (Urgent Care Centre)**



Number of respondents Type 3 (2016:3,441 2018: 7,012)

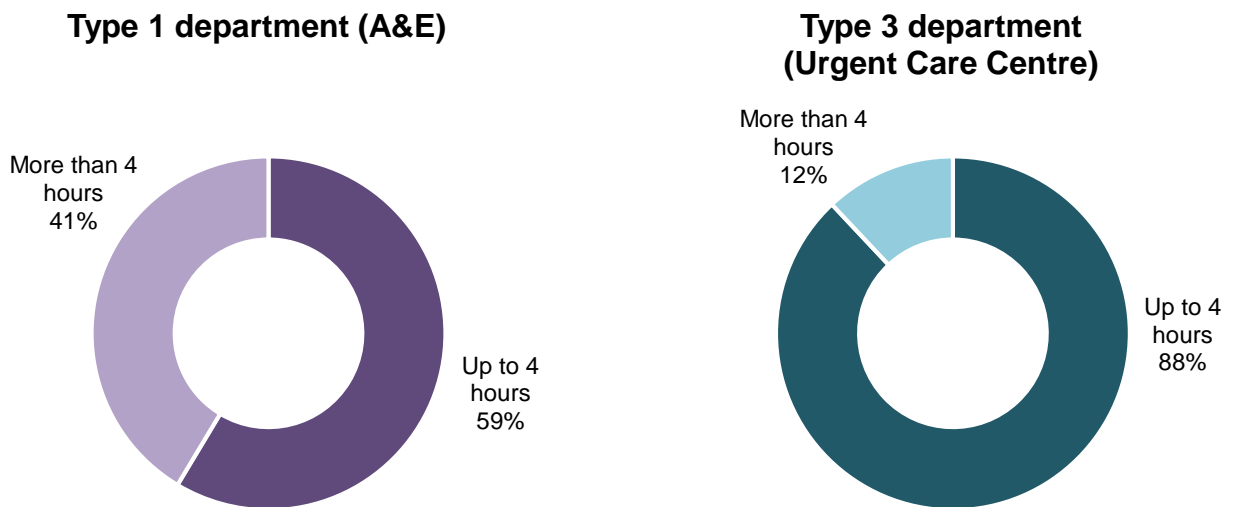
Answered by all.

Respondents who stated that they couldn't remember have been excluded.

Arrows indicate statistically significant increase ↑ or decrease ↓ between 2016 and 2018

When question response categories are amalgamated to four hours or less, or more than four hours, results show that just over two fifths of Type 1 respondents (40% in 2016 and 41% in 2018) said that overall, their visit to A&E lasted for **more than four hours**. For Type 3 departments this is much lower at 12% (improved from 15% in 2016).

## Overall, how long did your visit last?



Number of respondents Type 1 (2018: 39,641) | Type 3 (2018: 7,012)  
Answered by all.  
Respondents who stated that they couldn't remember have been excluded

### Being informed

A [Healthwatch report](#) suggests that how people feel about waiting to be seen may be influenced by a number of factors. Patients feel more positive about waiting if they receive information about how long they may have to wait and are supported by staff (for example, have access to pain relief).

In its best practice guidelines for Emergency Department Care, the Royal College of Emergency Medicine state that waiting areas should provide information regarding updated waiting times (standard 5).<sup>39</sup>

Of those respondents who had to wait to be examined, most said that they were **not** informed how long they would have to wait; 56% of respondents who visited a Type 1 department and 52% of respondents who visited a Type 3 department said 'no, I was not informed'.

Respondents who had to wait to be examined were also asked if while they were waiting, they were able to get help from a member of staff. Of the Type 1 respondents who needed any help, 69% said they were able to get help and 31% that they were not.<sup>k</sup>

## 3: Staff

### Communication and interactions

A good experience of care is dependent on good relationships with staff. Effective communication is essential to help deliver the vision of personalised

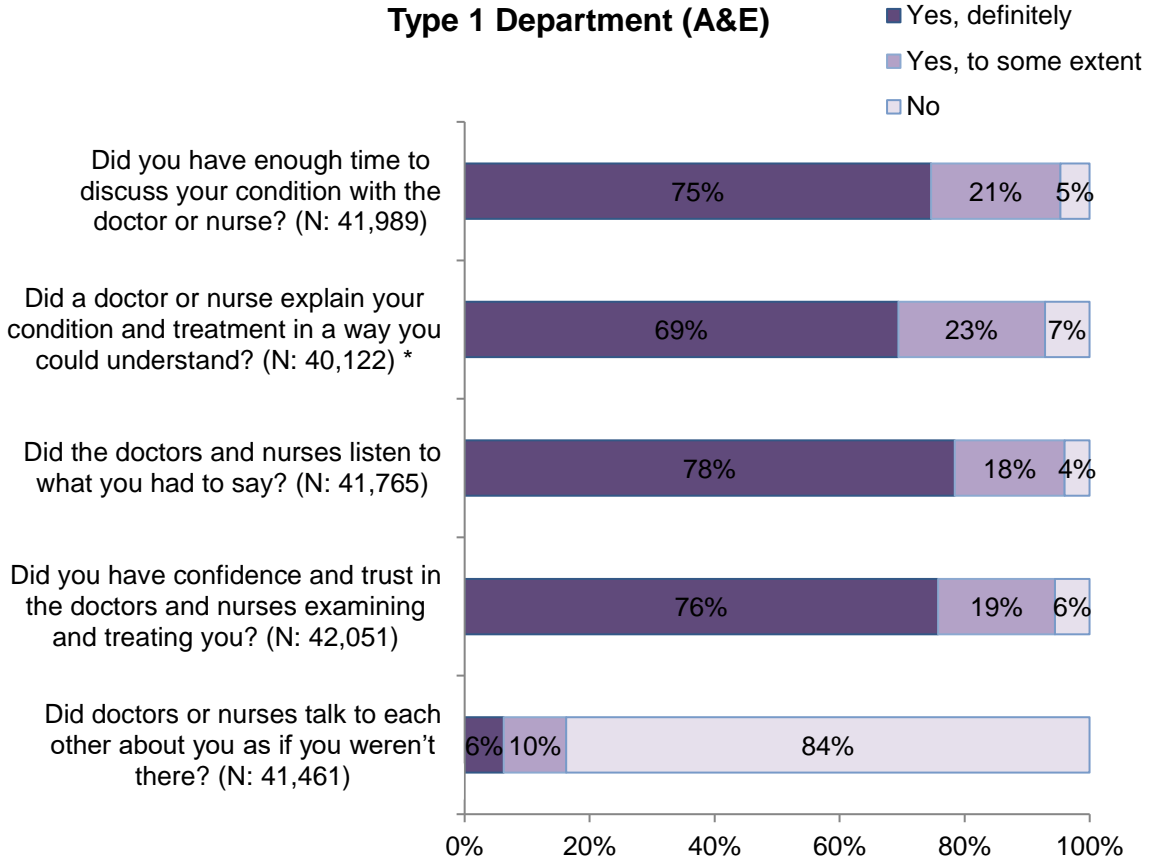
<sup>k</sup> Type 3 results for this question are not able to be reported due to many trusts having less than 30 respondents



care set out in recent policy such as the [NHS Long Term Plan](#), by enabling patients to be actively involved in their care. This is also recognised within the NICE quality statement for [Patient experience in adult NHS services. Quality statement four](#) says that people using adult NHS services should experience care and treatment that is tailored to their needs and preferences. This involves ensuring people have time to discuss their needs and preferences and enabling them to manage their own health. [Quality statement six](#) states that people using adult NHS services should be supported in shared decision making. This includes ensuring that staff have the effective communication skills enabling patients to make informed choices about their treatment.

The survey included a number of questions about interactions and communication with staff. Survey results in this area were generally positive with many reporting good experiences. For example, within the Type 1 results, three quarters or more ‘definitely’ had enough time to discuss their condition with a doctor or nurse (75% in 2018, up from 73% in 2016) and ‘definitely’ had confidence and trust in the doctors and nurses examining and treating them (76% in 2018 and 75% in 2016).

**While you were in A&E...**

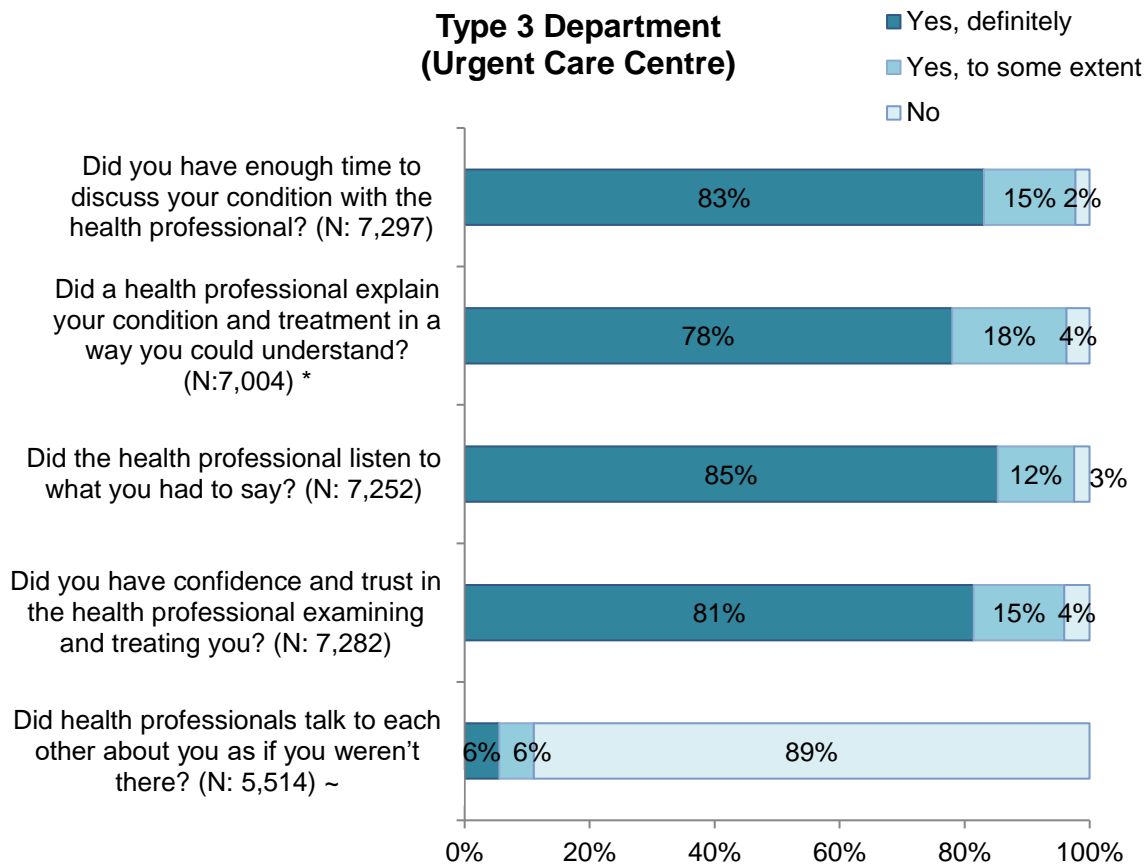


Answered by all.  
 N is the number of respondents for each question  
 \*First response option is ‘Yes, completely’

Similarly positive results were found within the Type 3 data, where, for example, around four fifths or more ‘definitely’ had enough time to discuss their condition

with a doctor or nurse (83%) and 'definitely' had confidence and trust in the doctors and nurses examining and treating them (81%).

**While you were in the Urgent Care Centre...**



Answered by all, except for ~ which excludes respondents who said this was not applicable  
 N is the number of respondents for each question  
 \*First response option is 'Yes, completely'

Positive results for questions asking about staff communication are also seen across other surveys in the NHS Patient Survey programme such as the [2018 maternity survey](#) and the [2018 inpatient survey](#).

We also analysed the results for the question asking about confidence and trust in staff to check for variation in experience between different groups of patients. The analysis showed that within the Type 1 data, poorer than average experiences were reported for: younger patients (aged 16 to 35), people who would prefer not to report their religion, patients whose visit to A&E lasted for more than four hours and people who had visited the same A&E about the same condition or something related to it within the previous week.

Above average experiences were reported within the Type 1 data for older patients aged 66 to 80 and 81+, people who had not previously visited the same

A&E department about the same condition and patients whose visit to A&E lasted for four hours or less.<sup>1</sup>

## Involvement of others

Involving a patient's family (or another person of their choice) is an essential component of providing good care, if the patient wants this. The [NHS Constitution](#) states that "*patients, with their family and carers, where appropriate, will be involved in and consulted on all decisions about their care and treatment.*" [NICE Quality Statement 5](#) says that a patient's preferences about the involvement of others must be respected. [Research from the King's Fund](#) suggests such involvement can increase people's knowledge, confidence and understanding in dealing with health issues.

Sixty-eight per cent of respondents who attended a Type 1 department and 56% of respondents who attended a Type 3 department said that they had a family member, friend or carer with them. Of these people, 68% of respondents who attended a Type 1 department said that if a family member, friend or carer wanted to talk to a doctor, they 'definitely' had enough opportunity to do so; leaving 22% who said they did 'to some extent' and 9% who did not. For Type 3 respondents, 76% said that if a family member, friend or carer wanted to talk to a health professional, they 'definitely' had enough opportunity to do so, leaving 18% who said they did 'to some extent' and 6% who did not.

## 4: Care and treatment

Provision of caring and compassionate care is [a key line of enquiry](#) for CQC in its inspections, and surveys such as this provide valuable information on patient experience.

The survey asked a number of questions to understand people's wider experiences of their care and treatment.

## Involvement in care

Involving people in their care is essential to providing the personalised, person-centred care set out in recent policy such as the [NHS Long Term Plan](#) which made a commitment that '*people will get more control over their own health and more personalised care when they need it*'.

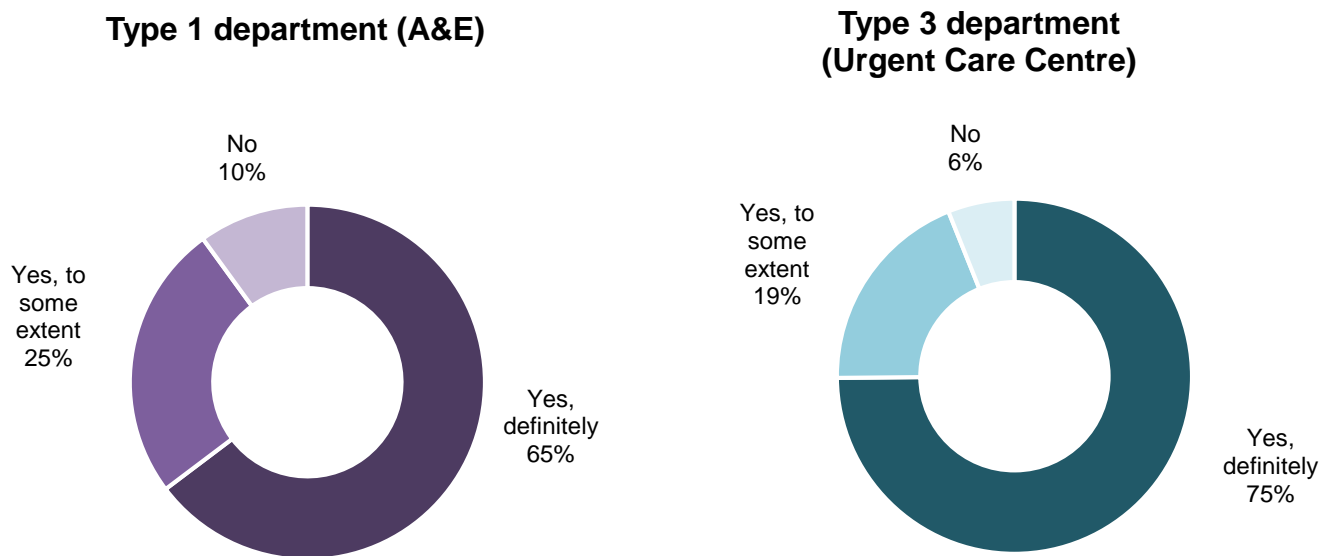
There is strong evidence that supporting patients to be actively involved in their own care and treatment can improve clinical outcomes and experiences of care. A [review of academic research](#) has confirmed the positive association between patient experience and clinical outcomes. [Research from the King's Fund](#) further shows that involving people in their care has many benefits, including improved decision-making and increased knowledge.

<sup>1</sup> There were no noteworthy findings with the Type 3 data for the 'confidence and trust' theme. This may be due to the lower sample size and therefore lower number of respondents in each sub group, which created wider confidence intervals.

However, [a report by CQC](#) looking at patients' involvement in their care over the last 10 years found little change in people's perceptions of how well they are involved in their health or social care, despite the national drive for person-centred care.

Sixty-five per cent of respondents who attended a Type 1 department, and 75% of respondents who attended a Type 3 department, said that they were 'definitely' involved as much as they wanted to be in decisions about their care and treatment.

### Were you involved as much as you wanted to be in decisions about your care and treatment?



Number of respondents Type 1 (2018: 39,506) | Type 3 (2018: 7,091)

Answered by all.

Respondents who stated that they were not well enough to be involved in decisions about their care have been excluded.

We also analysed the results to check for variation in experience between different groups of patients. The analysis of the 'involvement and decision making' questions for Type 1 respondents showed that poorer than average experiences were reported for younger patients (aged 16 to 35), people who would prefer not to report their religion, people who had a mental health condition and people who had visited the same A&E about the same condition or something related to it within the previous week.<sup>m</sup> Patients whose visit to A&E or the urgent care centre lasted for more than four hours also reported poorer than average experiences within both the Type 1 and Type 3 data.

<sup>m</sup> This was a composite theme and included the following questions: Did the doctors and nurses / health professional listen to what you had to say? Were you involved as much as you wanted to be in decisions about your care and treatment?

Above average experiences were reported within the Type 1 data for older patients aged 66 to 80, respondents who described themselves as heterosexual/straight, people who did not have a mental health condition and people who had not previously visited the same A&E department about the same condition. Patients whose visit to A&E or the urgent care centre lasted for four hours or less also reported better than average experiences within both the Type 1 and Type 3 data.

## Information

The [NHS Constitution](#) pledges that people must be offered easily accessible, reliable and relevant information in a form they can understand, and be supported to use it. This will enable them to actively participate in decision-making regarding their care. The [NHS Long Term Plan](#) continues this commitment, describing how patients will be empowered and their experience improved by increased access to trustworthy information.

Guidance published by NHS Improvement on providing patient information describes how providing good quality information in an understandable way helps people to be involved in their care and can improve patient experience.<sup>40</sup>

Best practice guidelines from the Royal College of Emergency Medicine on giving information to patients says that all patients should be given regular verbal advice.<sup>41</sup>

Seventy-seven per cent of respondents who attended a Type 1 department said that they were 'given the 'right amount' of information about their condition or treatment, leaving 15% who were not given enough, 7% who said they were not given any and 1% who were given too much. Eighty-five per cent of respondents who attended a Type 3 department said that they were 'given the 'right amount' of information about their condition or treatment, leaving 11% who were not given enough and 4% who said they were not given any.

We also analysed the results to check for variation in experience between different groups of patients. The analysis of a subset of questions relating to information provision<sup>n</sup> for Type 1 respondents showed that younger patients (aged 16 to 35) and patients with a mental health condition reported poorer than average experiences. Patients whose visit to A&E or the urgent care centre lasted for more than four hours also reported poorer than average experiences within both the Type 1 and Type 3 data.

Above average experiences were found within the Type 1 data for patients who do not have a mental health condition, and patients who had not previously visited the same A&E department about the same condition. Patients whose visit to A&E or the urgent care centre lasted for four hours or less also reported better than average experiences within both the Type 1 and Type 3 data.

<sup>n</sup> This was a composite theme and included the following questions: Did you have enough time to discuss your condition with the doctor or nurse / health professional? While you were in A&E / the urgent care centre, did a doctor or nurse / health professional explain your condition and treatment in a way you could understand? While you were in A&E / the urgent care centre, how much information about your condition or treatment was given to you?

It is important that care is coordinated between staff, and that patients do not receive conflicting information. [NICE Quality Statement 3](#) states that patients should experience coordinated care, with a clear and accurate information exchange between relevant health and social care professionals.

Respondents were asked if sometimes a member of staff said one thing to them and then another said something quite different. Most respondents who attended a Type 1 department said that this did **not** happen to them (81% in 2016 and 80% in 2018) leaving 12% who said this happened ‘to some extent’ (11% in 2016) and 8% who said that this ‘definitely’ happened. For respondents who attended a Type 3 department, again most said that this did **not** happen (88%) leaving 7% who said it did ‘to some extent’ and 5% for whom this ‘definitely’ happened.

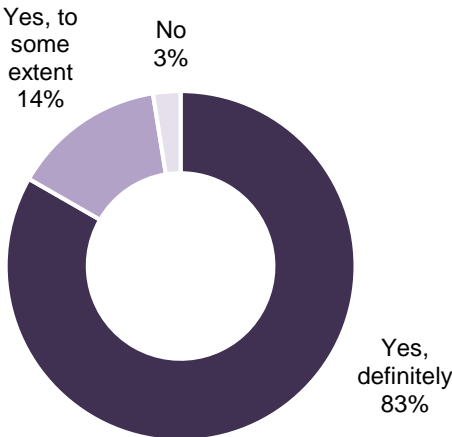
**Privacy**

The [NHS Constitution](#) states that all patients have the right to privacy and confidentiality. Having the necessary privacy will affect patients’ perceptions of being treated with dignity and respect (see [NICE Quality Statement 1](#)). In its [best practice guidelines for Emergency Department Care](#), the Royal College of Emergency Medicine state that clinical areas must enable patients to retain dignity and privacy (standard 4).

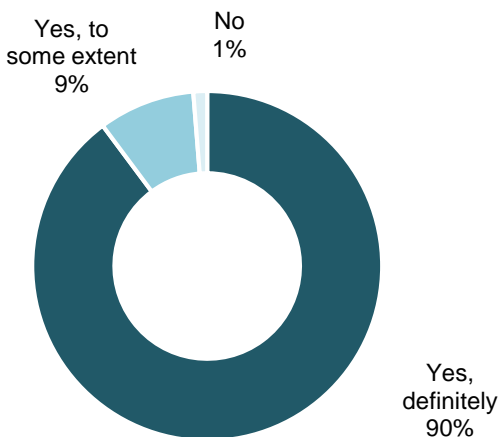
Most respondents said they were ‘definitely’ given enough privacy when being examined or treated: 83% of respondents who attended a Type 1 department (82% in 2016) and 90% of respondents who attended a Type 3 department (up from 88% in 2016) said that they were.

**Were you given enough privacy when being examined or treated?**

**Type 1 department (A&E)**



**Type 3 department (Urgent Care Centre)**



Number of respondents **Type 1** (2018: 41,907) | **Type 3** (2018: 7,255)  
 Answered by all.

We also analysed the results to check for variation in experience between different groups of patients. The analysis of a subset of questions relating to privacy for Type 1 respondents showed that younger respondents aged 16 to 35 and 36 to 50 and patients whose visit to A&E / the urgent care centre lasted for more than four hours reported poorer than average experiences.<sup>o</sup> Patients who preferred not to state their religion also reported poorer than average experiences within both the Type 1 and Type 3 data.

Above average experiences were reported within the Type 1 data for patients aged 66 to 80 and patients whose visit to A&E or the urgent care centre lasted for four hours or less. Patients aged 81+ also reported better than average experiences within both the Type 1 and Type 3 data.

## Responsiveness

It is important that patients can attract the attention of staff if they need it. In its [best practice guidelines for Emergency Department Care](#), the Royal College of Emergency Medicine state that patients should be clearly told how to access staff when they have needs or concerns (standard 27).

However, the ability of staff to be responsive to patients is dependent on having the right amount of staff with the right qualifications. Staffing was highlighted as a concern by CQC in its report into the impact of winter pressures on emergency departments. Inspections showed insufficient consultant cover, high level of use of bank and agency staff, and not enough suitably qualified, skilled and experienced nursing staff.

Respondents who attended a Type 1 department were asked whether, if they needed attention, they were they able to get a member of medical or nursing staff to help them.<sup>p</sup> Of those respondents who needed attention, 57% said that they were 'always' able to get a member of medical or nursing staff to help them, and 2% said that a member of staff was with them all of the time. This leaves just over two fifths who could not get help when they needed it, responding either that help was available 'sometimes' (33%) or that they could not find a member of staff to help them (9%).

We also analysed the results for this question to check for variation in experience between different groups of patients.<sup>q</sup> Within the Type 1 data, the analysis showed that poorer than average experiences were reported for younger patients (aged 16 to 35 and 36 to 50) and patients whose visit to A&E lasted for more than four hours.

Above average experiences were reported within the Type 1 data for older patients aged 66 to 80 and 81+, respondents who identified as Christian, people

<sup>o</sup> This was a composite theme and included the following questions: Were you given enough privacy when discussing your condition with the receptionist? Were you given enough privacy when being examined or treated?

<sup>p</sup> This question was not asked in the Type 3 questionnaire

<sup>q</sup> Please note that there were no questions within the Type 3 data for the 'receiving attention' theme

who do not have dementia and patients whose visit to A&E lasted for four hours or less.

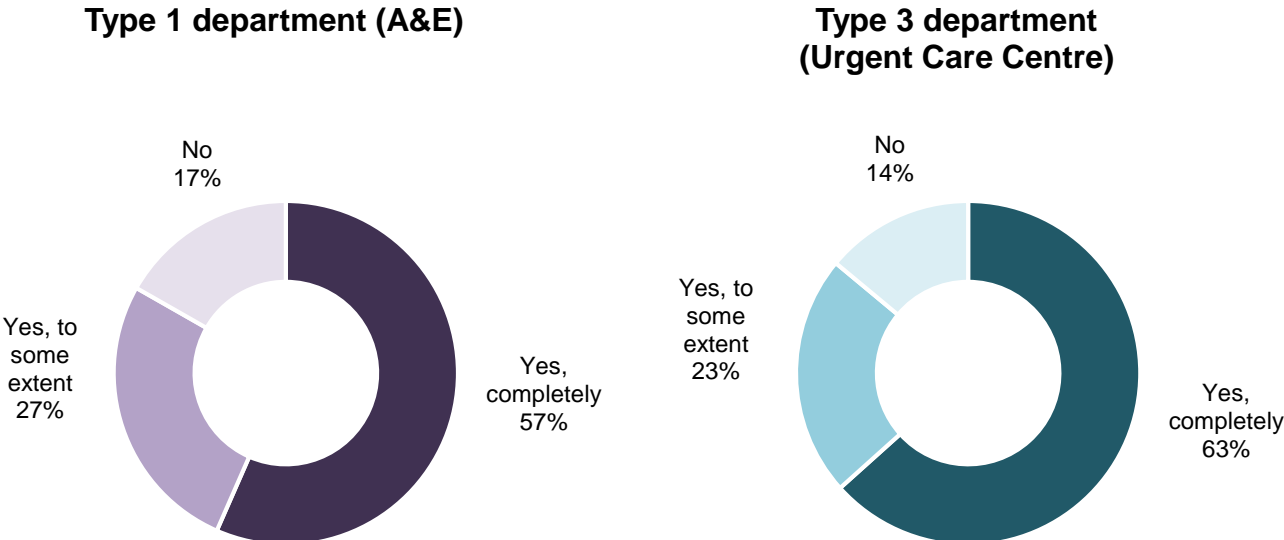
### Emotional support

Most recent national policy recognises that as part of providing patient-centred care, healthcare needs to meet both physical and emotional needs to improve patient experience.

The British Medical Association’s report *The psychological and social needs of patients* lists emotional support and relieving fear and anxiety as one of the six dimensions to patient-centred care, stating that “*the psychological and social needs of patients also need to be considered and addressed as a part of holistic healthcare delivery*”.<sup>42</sup> NICE Quality Statement 4 recognises that this is an important component of providing individualised care and recommends that patients are regularly checked if they need extra support with issues including anxiety. The associated NICE guidance states that staff should “...listen to and discuss any fears or concerns the patient has in a non-judgemental and sensitive manner”.

Of those respondents who had any anxieties or fears, 57% of respondents who attended a Type 1 department and 63% of respondents who attended a Type 3 department said that a member of staff ‘completely’ discussed this with them. This leaves just over two-fifths of people who attended a Type 1 department and just over a third of respondents who attended a Type 3 department who did not have this discussed completely.

### If you had any anxieties or fears about your condition or treatment, did a doctor or nurse / a health professional discuss them with you?



Number of respondents Type 1 (2018: 28,261) | Type 3 (2018: 4,414)  
Answered by all.  
Respondents who stated that they did not have any anxieties or fears have been excluded.



There was variation in experiences reported between different groups of patients for this question. For Type 1 respondents, the analysis showed that younger patients (aged 16 to 35) and patients whose visit to A&E lasted for more than four hours reported poorer than average experiences. Above average experiences were reported within the Type 1 data for patients whose visit to A&E lasted for four hours or less.<sup>f</sup>

## 5: Tests

Providing people with information about any tests they may need will help them to be fully involved in decisions about their care and treatment. The [NHS Constitution](#) says that people have the right to be given information about the test and treatment options available to them, what they involve and their risks and benefits. NICE [Quality Statement 6](#) says that patients should be supported by healthcare professionals to make informed choices about investigations, treatment and care that reflect what is important to them.

Seventy-four per cent of respondents (71% in 2016) who visited a Type 1 department, and 46% of respondents who visited a Type 3 department, said that they had any tests (such as x-rays, scans or blood tests). These people were asked about their experiences.

Most respondents who visited a Type 1 department said that a member of staff 'completely' explained why they needed the tests in a way they could understand (76%) leaving around a quarter who did not fully understand the explanation. For respondents who visited a Type 3 department, most said that a member of staff 'completely' explained why they needed the tests in a way they could understand (85%).<sup>g</sup>

<sup>f</sup> There were no noteworthy findings with the Type 3 data for the 'emotional support' theme.

<sup>g</sup> The number of respondents to the following questions about tests were quite low for the Type 3 survey in 2016. Whilst not discussed here as there were no statistically significant changes, we cannot know if the results would have been different had more people responded.

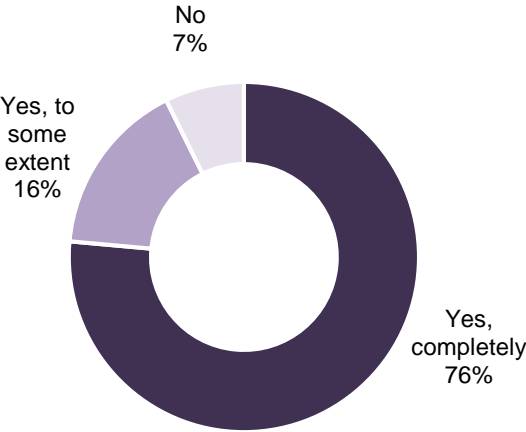
Q25: Did a member of staff explain why you needed these test(s) in a way you could understand?

Q26: Before you left the urgent care centre, did you get the results of your tests?

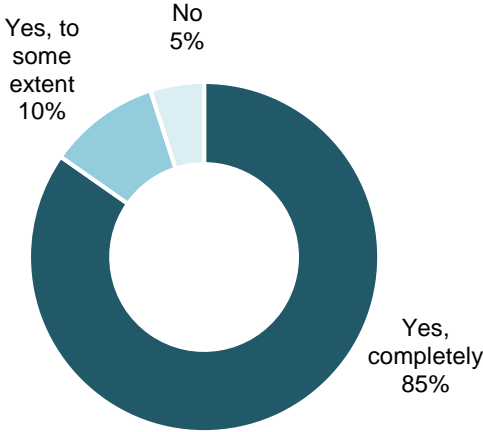
Q27: Did a member of staff explain the results of the tests in a way you could understand?

**Did a member of staff explain why you needed these test(s) in a way you could understand?**

**Type 1 department (A&E)**



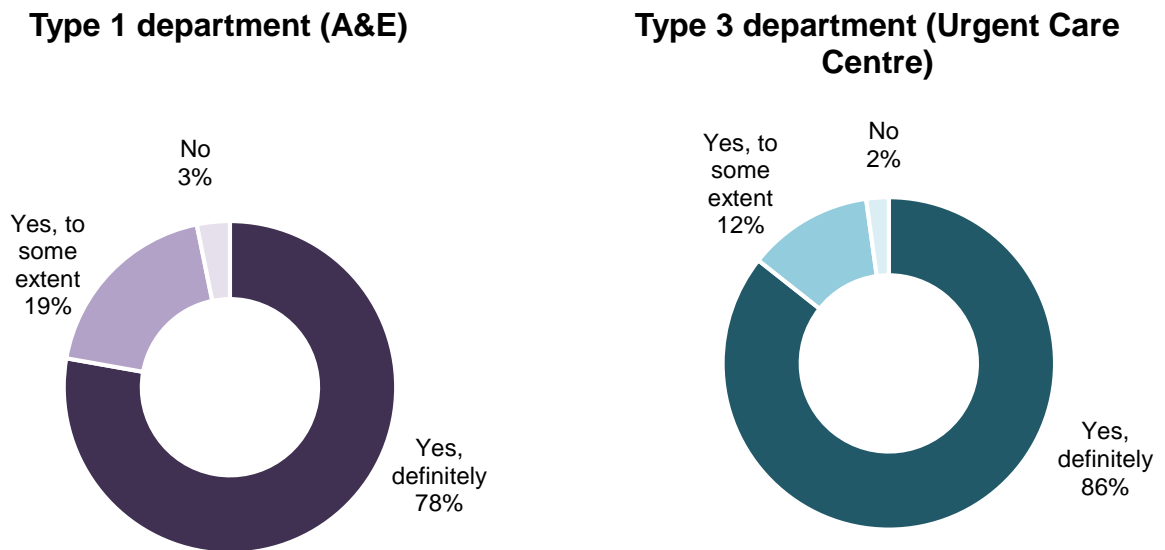
**Type 3 department (Urgent Care Centre)**



Number of respondents Type 1 (2018: 30,612) | Type 3 (2018: 3,213)  
 Answered by all who had tests.

Eighty-one per cent of respondents who visited a Type 1 department and 85% of respondents who visited a Type 3 department said that they received the results of the tests before they left. Of these people, most respondents who visited a Type 1 department said that a member of staff ‘definitely’ explained the results of the tests in a way they could understand (78%), leaving around a fifth who did not fully understand the explanation. For respondents who attended a Type 3 department, 86% said that a member of staff ‘definitely’ explained the results of the tests in a way they could understand, leaving 12% who said this happened ‘to some extent’ and 2% who said it did not.

## Did a member of staff explain the results of the tests in a way you could understand?



Number of respondents Type 1 (2018: 22,431) | Type 3 (2018: 2,128)

Answered by all who had tests and received the results before leaving A&E or the Urgent Care Centre

Respondents who stated that they were not sure / couldn't remember have been excluded.

People who attended a Type 1 department and who did **not** receive the results of their tests before they left were asked if a member of staff explained how they would receive them.<sup>†</sup> Just under half of these respondents (46%) said they were **not** told this.

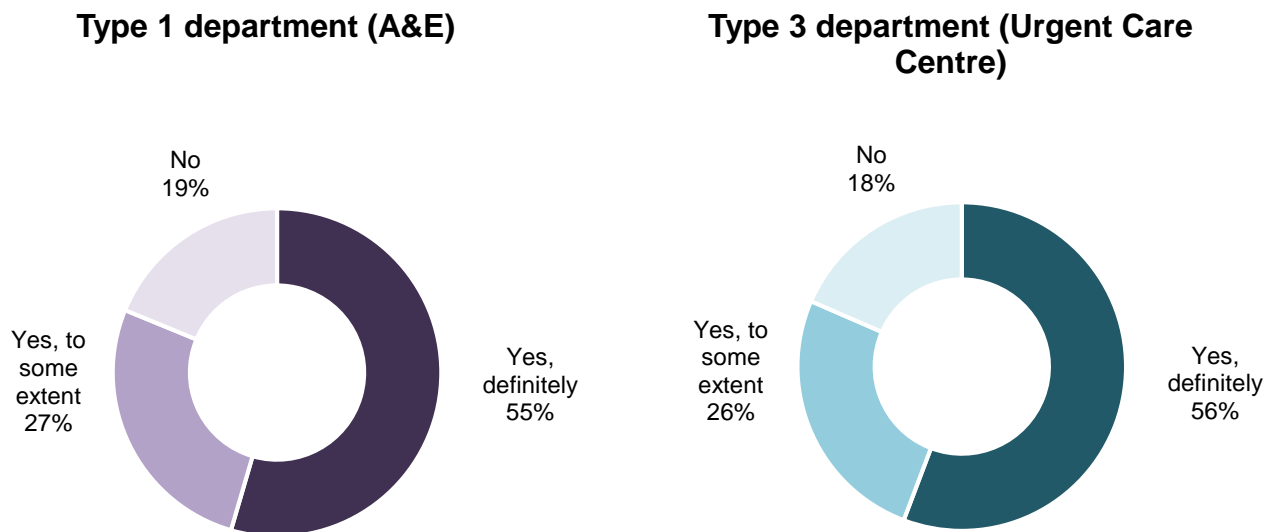
## 6: Pain management

The Royal College of Emergency Medicine has set out best practice guidelines for the management of pain in adults. It states that pain management is a core component of care and that '*recognition and alleviation of pain should be a priority when treating the ill and injured*'.<sup>43</sup> This process should be started at triage or the initial assessment, be monitored throughout the patients' time in the department and appropriate pain relief provided for discharge if needed. NICE [Quality Statement 4](#) also says that staff should regularly check if patients need any extra support with issues including pain relief.

Sixty-seven per cent of respondents who attended a Type 1 department (65% in 2016) and 64% of respondents who attended a Type 3 department said that they were in pain when they visited the A&E or urgent care centre. Results suggest that pain could be more effectively managed for these people as just over half (55% for Type 1 and 56% for Type 3) felt that staff 'definitely' did everything they could to help control their pain.

<sup>†</sup> This question was not asked within the Type 3 questionnaire

## Do you think the staff did everything they could to help control your pain?



Number of respondents Type 1 (2018: 26,605) | Type 3 (2018: 4,257)

Answered by all who were in pain.

Respondents who stated that they couldn't say / didn't know have been excluded.

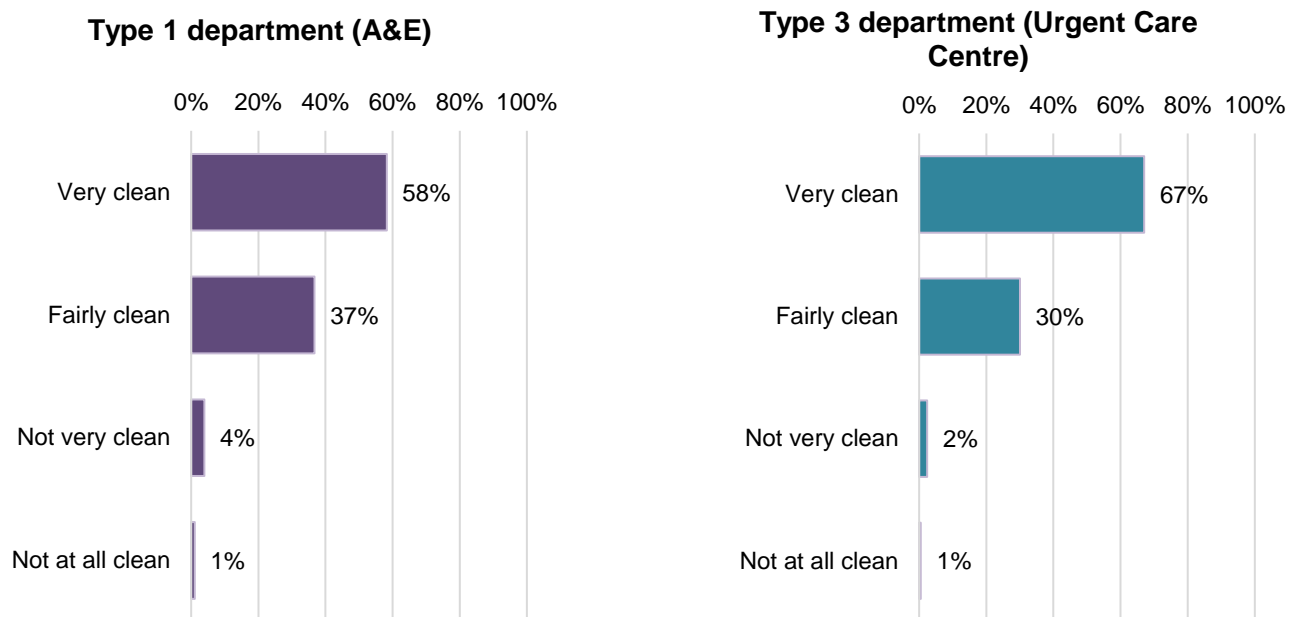
## 7: Environment and facilities

### Cleanliness

Cleanliness is essential to providing safe high-quality care and good infection control. [The Code of Practice on the prevention and control of infections](#), under the Health and Social Care Act 2008 states that good infection prevention (including cleanliness) is essential to ensure that people who use health and social care services receive safe and effective care.<sup>44</sup> This is also reflected in the [NHS Constitution](#), which states that people have the right to be cared for in an environment that is clean and safe.

As can be seen in the following graph, the majority of survey respondents described the A&E department or urgent care centre they visited as being either 'very clean' or 'fairly clean'.

## In your opinion, how clean was the A&E department / Urgent Care Centre?



Number of respondents Type 1 (2018: 40,685) | Type 3 (2018: 7,173)

Answered by all.

Respondents who stated that they couldn't say have been excluded.

## Safety

Receiving care in a safe environment is an important part of a positive patient experience.

The majority of respondents said that they did **not** feel threatened by other patients or visitors when they visited either A&E (92%) or the urgent care centre (95%).

## Access to food and drink

NICE guidance on patient experience in adult NHS services describes nutrition as an essential requirement of good care.<sup>45</sup> While the guidance notes that attention to such fundamental needs applies particularly to inpatient settings, they should also be addressed in other settings where healthcare is provided.

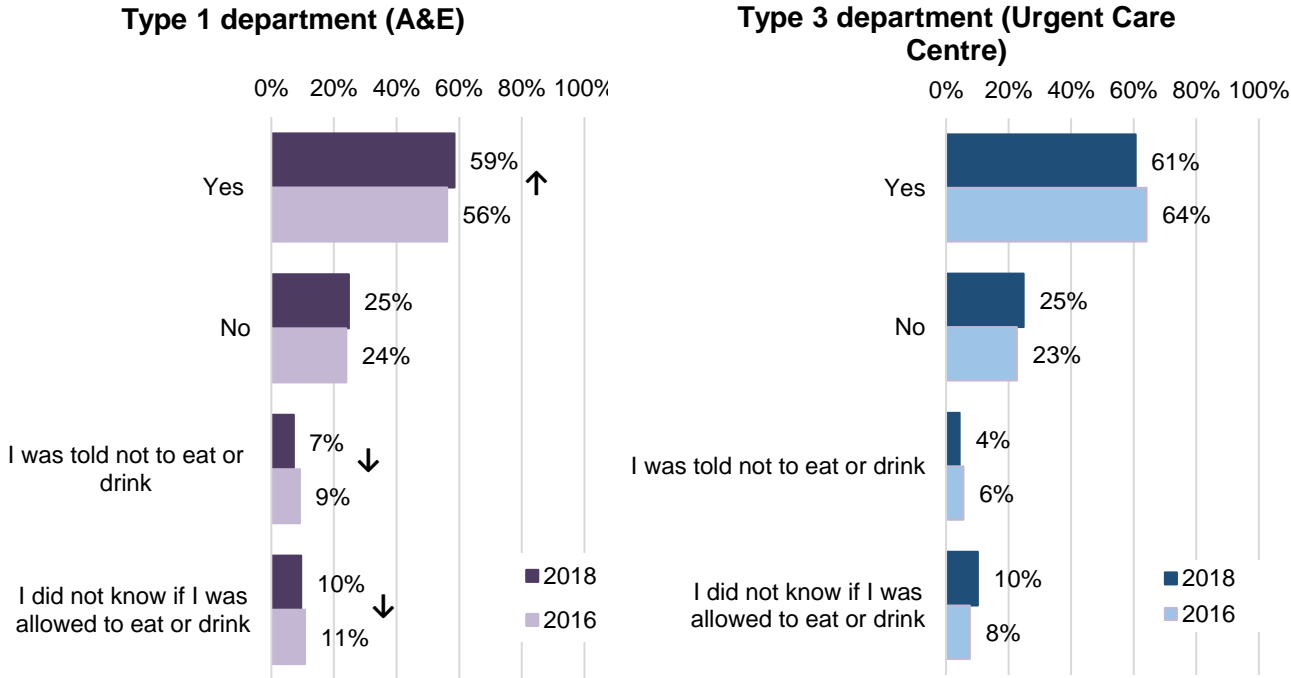
In 2014, The Hospital Food Standards Panel recommended that NHS hospitals adopt a set of standards as routine practice.<sup>46</sup> The focus was on food on wards, and although it recognised that hospitals may have less control over vending machines and onsite shops, the report encouraged hospitals to do all they can to work with contractors and providers to make it easier to choose a healthier option. In response, NHS England implemented 10 characteristics of good hydration and nutrition, one of which is that *“facilities and services providing nutrition and hydration are designed to be flexible and centred on the needs of the people using them, 24 hours a day, every day”*.<sup>47</sup>

CQC’s inspection framework for urgent and emergency care services includes guidance that arrangements should be in place in terms of food and drink for

patients (and accompanying friends and family) who are in the urgent and emergency care department for any length of time, and that healthy food and drink options should be available.<sup>48</sup>

It is important that patients have access to suitable food and drink, particularly if there is a long wait. Of those people who wanted something to eat or drink, 59% of respondents who attended at Type 1 department said that they were able to get suitable food or drink, which is up from 56% in 2016. A quarter (25%) said they could not. For respondents who visited a Type 3 service, 61% said that they were able to get suitable food or drink, and 25% were not. However, in both settings, a tenth of respondents did not know if they were allowed to eat or drink meaning information provision around this could be improved.

**Were you able to get suitable food or drinks?**



Number of respondents Type 1 (2016: 23,990 2018: 25,513) | Type 3 (2016: 630<sup>u</sup> 2018: 3,040) Answered by all. Respondents who stated that they did not want anything to eat or drink have been excluded. Arrows indicate statistically significant increase ↑ or decrease ↓ between 2016 and 2018. **Note that changes for Type 3 were not significant.**

<sup>u</sup> The 2016 Type 3 number of respondents is low for this question due to a lower sample size in 2016 and many trusts having their data suppressed for this question due to having less than 30 respondents. This means that comparisons between 2016 and 2018 should be treated with caution.

## 8: Leaving A&E or the urgent care centre

Research suggests that patients' experiences of leaving hospital can be poor. For example, results from the [2018 adult inpatients survey](#) showed that involvement in decisions around discharge from hospital remained an area for improvement. It also found that people's experience of integrated care have got worse, with fewer people reporting discussions with staff about the need for further health and social care services took place.<sup>49</sup>

A report from the British Red Cross suggests there is widespread variation in hospital discharge practices. Their research suggests that though patients may be clinically fit for discharge, their wider social and individual needs are not always considered. This can be detrimental to people's health and lead to readmissions.<sup>50</sup>

Questions in this section of the questionnaire asked people what happened at the end of their visit to A&E or the urgent care centre: respondents who visited a Type 1 department and were not admitted at the end of their visit (71%) and respondents who visited a Type 3 department and went home / somewhere else at the end of their visit (90%) were asked about their experiences.

### Medication

Medicines are commonly prescribed to relieve symptoms of illness or injury, or to cure or prevent illness. To help ensure that people take their medication correctly, [NICE guidance on medicines adherence](#) emphasises the importance of including people in the decision-making processes by effective communication and providing information.<sup>51</sup> It also states that people should be given information about taking medication and side effects.

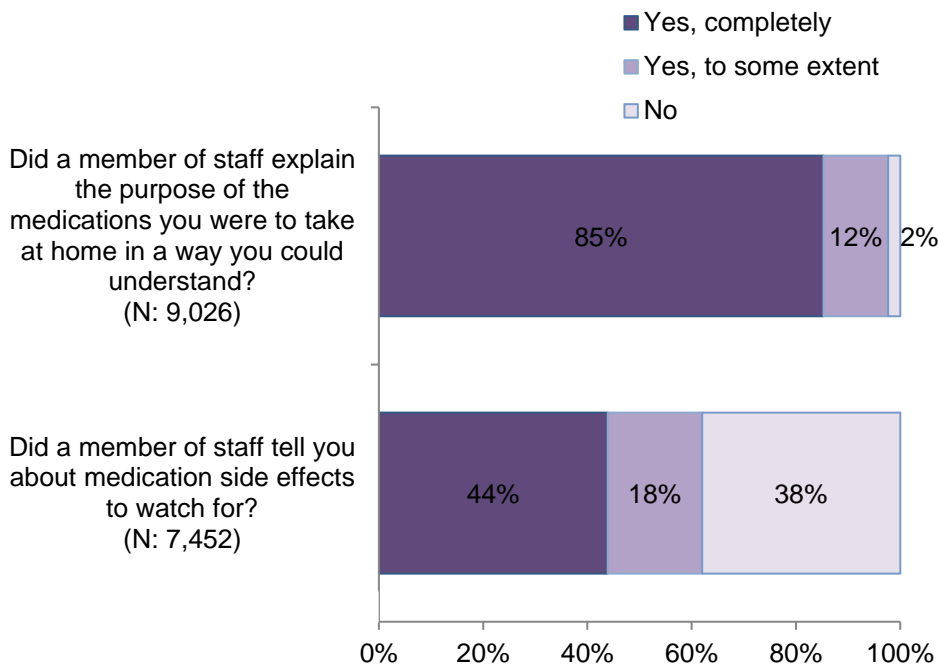
Around a third (31%) of respondents who attended a Type 1 department said that they were prescribed new medicines.<sup>v</sup> These people were asked about their experiences.

Most respondents (85%) said that they received a 'complete' explanation about the purpose of the medicines they were to take home in a way they could understand. However, less than half (44%) said that they were 'completely' told about the side effects of the medicines to watch out for.

<sup>v</sup> Whilst 33% of people who attended a Type 3 department said that they were prescribed new medication, the results for the two following questions asking about their experiences are not able to be reported due to many trusts having less than 30 respondents.

## Information provision for new medication

### Type 1 Department (A&E)



Answered by all who were not transferred to a hospital ward and were prescribed new medication(s).

Respondents who stated that they did not need an explanation or information have been excluded.

N is the number of respondents for each question

## Transition home and continuity of care

There is a strong focus on integrated healthcare systems providing better support outside of hospitals in recent policy. Providing people with information can empower them to look after themselves at home, which can improve patient experience and reduce repeat attendances.

All patients should be involved, as much as they would like to be, in decisions around leaving the urgent or emergency care service they visited. [NICE Quality Statement 6](#) describes how providing accurate information will help people to manage their own health.

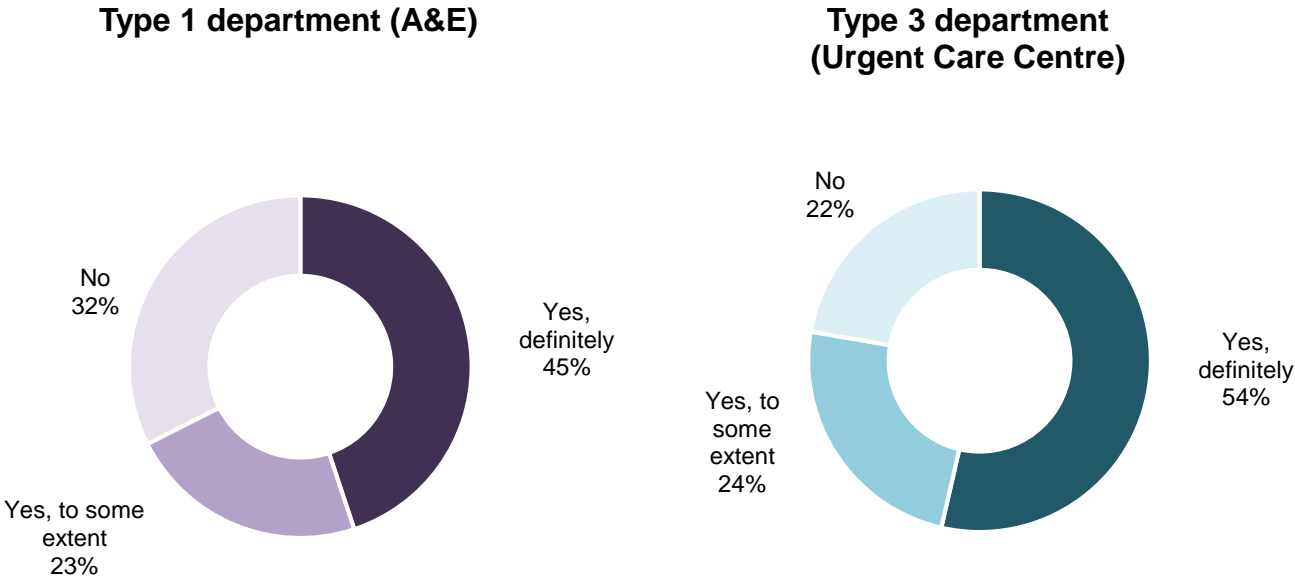
Guidance from the Royal College of Emergency Medicine on [giving information to patients](#) says that when patients are discharged they should be given a range of information, including advice about fitness to work and fitness to drive, about their illness or injury, advice about symptoms or signs to watch out for and relevant contact information. The guidance also notes the importance of providing written, as well as verbal information, as patient recall can be affected by any anxiety they may have around their condition.

Survey results suggest that people's experiences of receiving information when leaving A&E or the urgent care centre were not as positive as other aspects of their care.



Less than half (45%) of respondents who visited a Type 1 service and needed this information said that a member of staff 'definitely' told them when they could resume their usual activities, such as when to go back to work or drive a car. For respondents who visited a Type 3 service this proportion was 54%.<sup>w</sup>

**Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?**

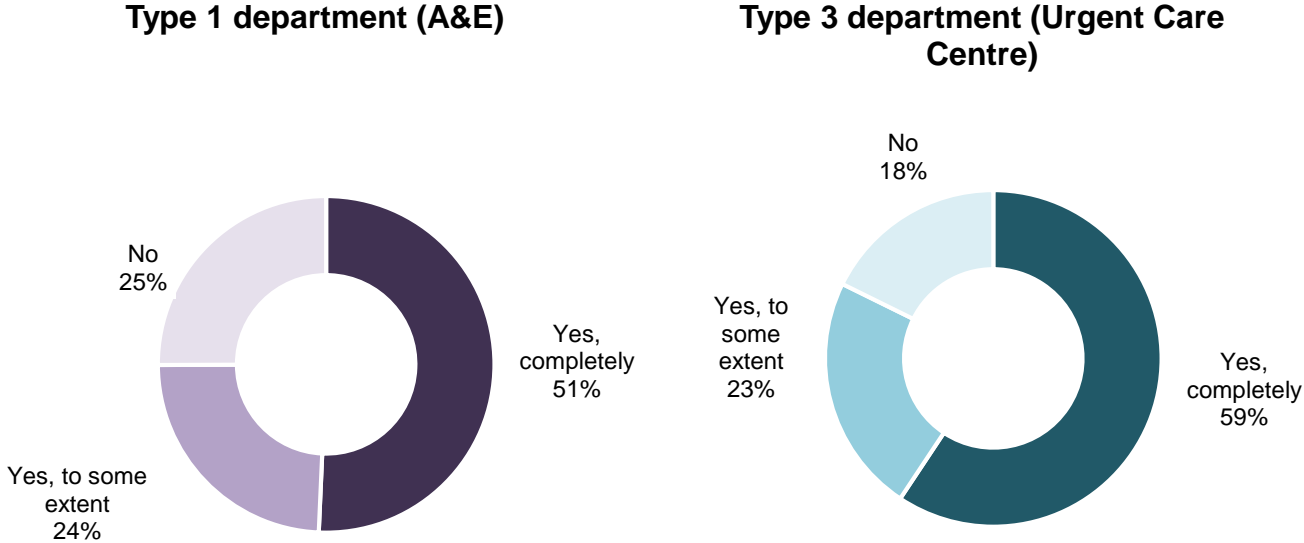


Number of respondents Type 1 (2018: 18,309) | Type 3 (2018: 3,969)  
 Answered by all who were not admitted at the end of their visit to A&E or went home / somewhere else from the urgency care centre  
 Respondents who stated that they did not need this type of information have been excluded.

Similarly, around half (51%) of respondents who visited a Type 1 service and needed this information said that a member of staff 'completely' told them what symptoms to watch for regarding their illness or treatment after they went home. For respondents who visited a Type 3 service this proportion was 59%.

<sup>w</sup> The number of respondents to this question quite low for the Type 3 survey in 2016. Whilst not discussed here as there were no statistically significant changes, we cannot know if the results would have been different had more people responded

**Did a member of staff tell you about what symptoms to watch for regarding your illness or treatment after you went home?**



Number of respondents Type 1 (2018: 21,811) | Type 3 (2018: 4,613)  
 Answered by all who were not admitted at the end of their visit to A&E or went home / somewhere else from the urgency care centre  
 Respondents who stated that they did not need this type of information have been excluded.

NICE quality statement 4 describes how patient care should be tailored to their personal needs and preferences, considering their circumstances, ability to access services and coexisting conditions. In its best practice guidelines for Emergency Department Care, the Royal College of Emergency Medicine state that discharge planning should include a check of social and welfare concerns (standard 30).

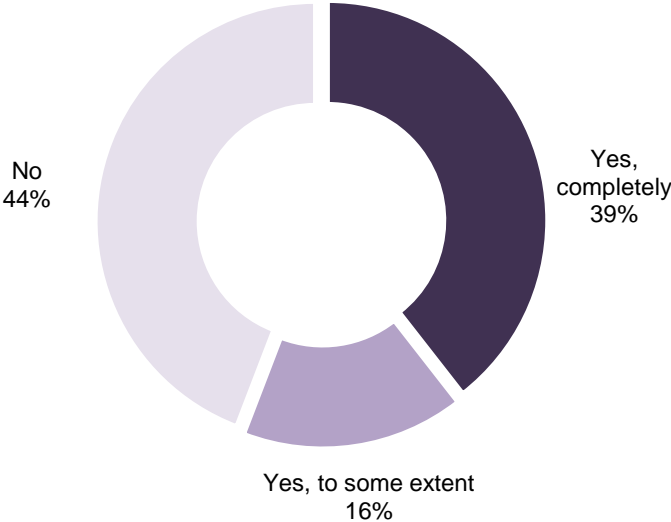
However, a report from the Queen’s Nursing Institute noted that leaving hospital is a complex and challenging process.<sup>52</sup> Constant pressures to discharge patients quickly mean that there is little time to holistically assess people’s needs.

Less four in ten respondents who visited a Type 1 service, said that a member of staff ‘completely’ took their family or home situation into account when they left A&E, if this was necessary (39%).<sup>x</sup>

<sup>x</sup> Type 3 results for this question are not able to be reported due to many trusts having less than 30 respondents

**Did hospital staff take your family or home situation into account when you were leaving A&E?**

**Type 1 department (A&E)**



Number of respondents Type 1 (**2018**: 12,308)  
Answered by all who were not admitted at the end of their visit  
Respondents who stated that this was not necessary, or that they didn't know / couldn't remember, have been excluded.

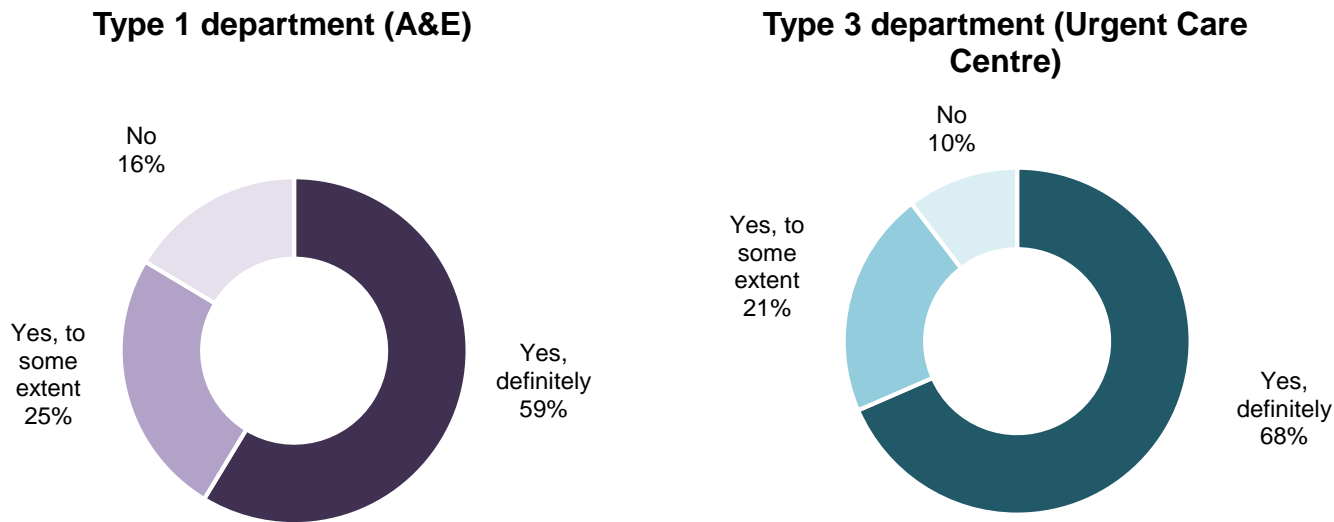
[NICE Quality Statement 2](#) states that patients must be given information about contacting healthcare professionals, which should include telling them who to contact, how to contact them and when to make contact about their ongoing healthcare needs.

Almost three quarters of respondents who visited a Type 1 service (73% in 2016 and 74% in 2018) said that hospital staff told them who to contact if they were worried about their condition or treatment after they left A&E, meaning more than a quarter (27% in 2016 and 26% in 2018) were not told this. For respondents who visited a Type 3 service, 79% were told this, leaving just over a fifth (21%) who were not.

[Urgent Treatment Centres Principles and Standards](#) says that urgent treatment centres should support patients to self-care. They should provide people with health and wellbeing advice and where needed signpost them to other services such as social services or pharmacies. They should also record the numbers of patients offered self-care management and patient education.

Almost three fifths of respondents who visited a Type 1 service (59%) said that staff 'definitely' gave them enough information to help them care for their condition at home. For respondents who visited a Type 3 service, this proportion was 68%.

## Did staff give you enough information to help you care for your condition at home?



Number of respondents Type 1 (**2018**: 23,899) | Type 3 (**2018**: 5,467)

Answered by all who were not admitted at the end of their visit to A&E or went home / somewhere else from the urgency care centre

Respondents who stated that they did not need this type of information have been excluded.

We also analysed the results to check for variation in experience between different groups of patients. The analysis of a subset of questions relating to transition and continuity for Type 1 respondents showed that people who would prefer not to state their religion, patients whose visit to A&E lasted for more than four hours and people who had visited the same A&E about the same condition or something related to it between one week and one month previously reported poorer than average experiences.<sup>y</sup> Patients whose visit to A&E lasted for four hours or less reported better than average experiences within the Type 1 data.<sup>z</sup>

## 9: Overall

Respondents were asked to reflect on their overall experiences of the care and treatment they received.

The [NHS Constitution](#) states that patients have the right to be treated with respect and dignity. This is also reflected in [NICE Quality Statement 1](#), which says that patients should be treated with empathy, dignity and respect, which are

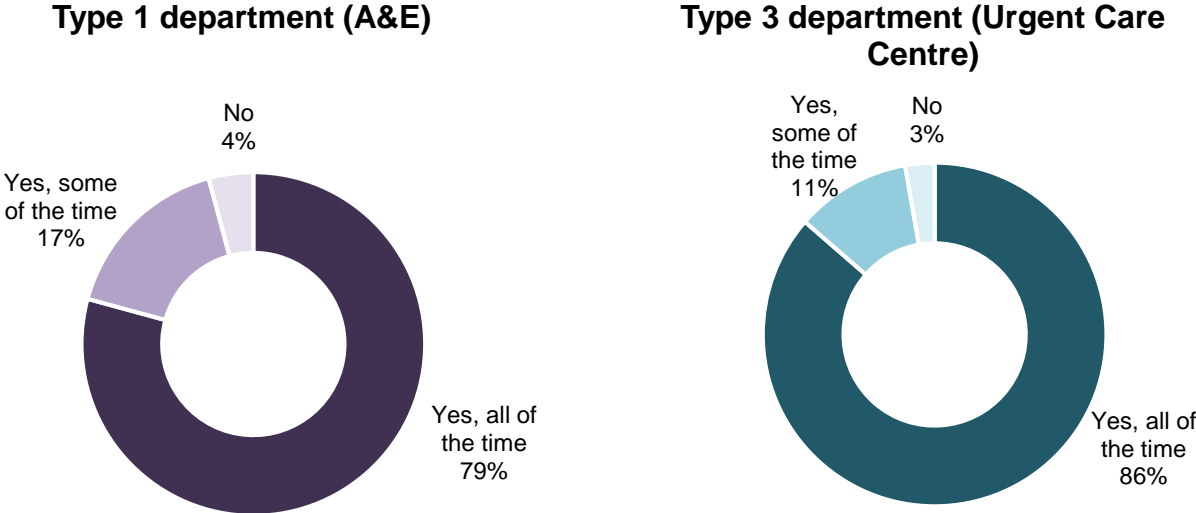
<sup>y</sup> This was a composite theme and included the following questions: Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car? Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left A&E? Did staff give you enough information to help you care for your condition at home?

<sup>z</sup> There were no noteworthy findings with the Type 3 data for the 'transition and continuity' theme.

fundamental to developing good relationships between them and the staff treating them.

The majority of respondents said that they were treated with respect and dignity 'all of the time'. For Type 1 services, 79% of respondents said this (78% in 2016) and for Type 3 services 86%.

**Overall, did you feel you were treated with respect and dignity?**



Number of respondents Type 1 (2018: 41,563) | Type 3 (2018: 7,209)  
 Answered by all.

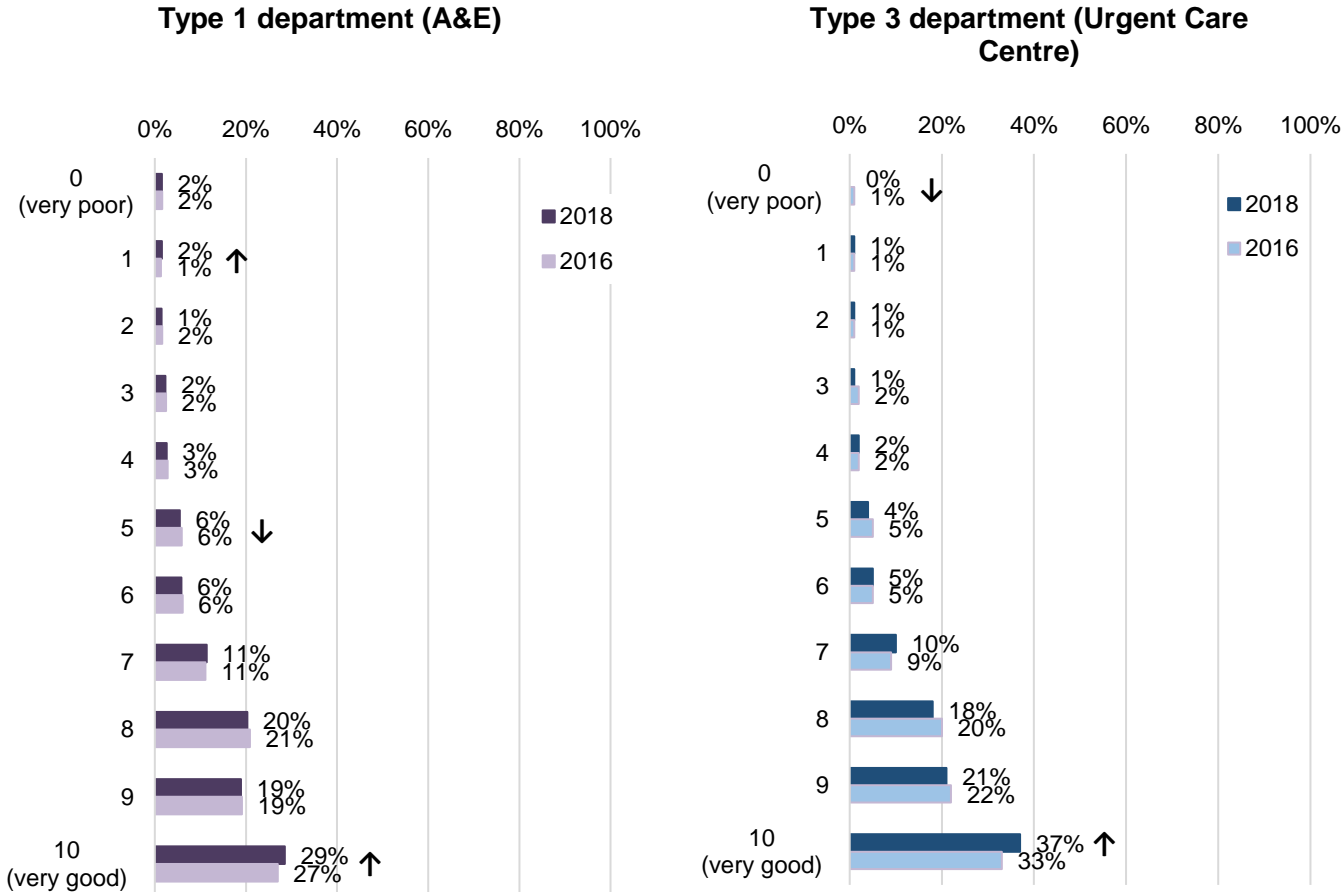
We also analysed the results for this question to check for variation in experience between different groups of patients. Within the Type 1 data, the analysis showed that poorer than average experiences were reported for younger patients (aged 16 to 35, and 36 to 50), people who would prefer not to report their religion, people who had a mental health condition and people who had visited the same A&E about the same condition or something related to it within the previous week. Patients whose visit to A&E or the urgent care centre lasted for more than four hours also reported poorer than average experiences within both the Type 1 and Type 3 data.

Above average experiences were reported within the Type 1 data for older patients aged 66 to 80 and 81+, people who do not have a mental health condition and people who had not previously visited the same A&E department about the same condition. Patients whose visit to A&E or the urgent care centre lasted for four hours or less also reported better than average experiences within both the Type 1 and Type 3 data.

When asked to rate their overall experience of the care they received on a scale of zero (very poor) to 10 (very good), 68% of respondents who visited a Type 1 service and 76% of respondents who visited a Type 3 service rated this as an 'eight' or above.

There were also statistically significant increases in the proportion of respondents who gave their experience a top score of '10' across both service types. Twenty-seven per cent of Type 1 respondents awarded the top score in 2016, which increased to 29% in 2018. A third (33%) of Type 3 respondents rated their experience as 10 in 2016, increasing to 37% in 2018.

**Overall.....**



Number of respondents Type 1 (2016: 39,645 2018: 39,870) | Type 3 (2016: 3,445 2018: 6,783)  
 Answered by all.  
 Arrows indicate statistically significant increase ↑ or decrease ↓ between 2016 and 2018.

Variations in experience between different groups of patients for overall experience broadly followed similar patterns as to other questions. Within the Type 1 data, poorer than average experiences were reported for younger patients (aged 16 to 35), people who would prefer not to report their religion, people who would prefer not to report their sexuality and people who had visited the same A&E about the same condition or something related to it within the previous week. Patients whose visit to A&E or the urgent care centre lasted for more than four hours also reported poorer than average experiences within both the Type 1 and Type 3 data.

Above average experiences were reported within the Type 1 data for older patients aged 66 to 80 and 81+, people who identified as Christian, people whose visit was between the hours of 5am to 8.59am and people who had not

previously visited the same A&E department about the same condition. Patients whose visit to A&E or the urgent care centre lasted for four hours or less also reported better than average experiences within both the Type 1 and Type 3 data.

## 10: How experience varies: summary of results for different subgroups of patients

### Background

This additional analysis compares how different groups of patients rated their experiences by using a 'multi-level model analysis'. This analysis compares the mean scores for a subset of questions by different groups of patients and allows us to explore potential relationships between patients' characteristics and their experiences.

The analysis modelled the mean scores of different subgroups (age, gender, religion, sexual orientation, ethnicity, long-term conditions, attendance time, attendance day, total length of visit and whether they have attended the same urgent and emergency care before).<sup>aa</sup>

Differences that are equivalent to at least 0.1 standard deviations from the overall mean of the target variable are treated as being noteworthy, provided that the confidence interval does not overlap the mean line.

Nine themes were selected for analysis based on key national policy and good practice for patient experience as set out in the [NHS Patient Experience Framework](#). These include receiving attention, respect and dignity, involvement and decision making, confidence and trust, emotional support, transition and continuity, privacy, information and overall experiences. For Type 3 services there were eight themes as 'receiving attention' was not included.

Three of these themes are composites using similar questions, and six are individual questions. The questions included in these themes and further information about the methodology are detailed in [Appendix A](#). The charts used for the analysis may be found in Appendix H, published as an [external appendix](#).

### Summary

For people who use Type 1 services, the analysis showed that, generally, older people (aged 66+) they report experiences that are more positive. Conversely, younger respondents (aged 16 to 35) report more negative experiences.

Where people spent longer than four hours in A&E or urgent care departments, they reported universally poorer experience. Within the Type 1 results, respondents who said that their visit to A&E lasted for more than four hours had a worse than average experience for all themes. Within the Type 3 data,

<sup>aa</sup> Within the Type 3 analysis, two subgroups were suppressed due to having less than 30 respondents (Jewish and Buddhist), and there were no questions in the 'receiving attention' theme.

respondents who said that their visit to the urgent care centre lasted for more than four hours had a worse than average experience for four out of eight themes.

The analysis also shows that Type 1 respondents who said that they had been to the same A&E about the same condition or something related to it within the past week have a poorer than average experience for four of the nine themes. Conversely, people who had not previously visited the same A&E had an above average experience for five of the nine themes.

Type 1 respondents who have a mental health condition had a worse than average experience for three out of nine themes. Conversely, respondents who did not have a mental health condition had an above average experience for the same three themes. Poorer experiences for people who self-report as having a mental health condition is consistent with the findings in other NHS patient surveys, including the findings from the 2018 adult inpatient survey.

Within the Type 3 analysis far fewer statistically significant differences were found which may be due to the lower sample size and therefore lower number of respondents in each sub group, which created wider confidence intervals.

## Age

The analysis showed a general trend that, as patients become older, they report experiences that are more positive.

Within the Type 1 results, respondents aged 16 to 35 had a worse than average experience across eight out of the nine themes, with the exception of transition and continuity. Scores for the 36 to 50 subgroup were below average for three themes including receiving attention, respect and dignity, and privacy.

In contrast, respondents aged 66 to 80 had an above average experience across six of the nine themes; receiving attention, respect and dignity, involvement and decision-making, confidence and trust, privacy and overall experience. Scores for people aged 81+ subgroup were above average for five of the nine themes: receiving attention, respect and dignity, confidence and trust, privacy and overall experience.

Within the Type 3 analysis, the only noteworthy finding was that respondents aged 81+ had an above average experience for the privacy theme.

## Gender

There were no noteworthy differences by gender across either Type 1 or Type 3 results.

## Religion

Within the Type 1 results, respondents who said that they would prefer not to state their religion had a worse than average experience across six out of the nine themes; respect and dignity, involvement and decision making, confidence and trust, transition and continuity, privacy and overall experience.



It is difficult to know the characteristics of people who prefer not to state their religion. However, research into the rise of people with no religion suggests it may be reasonable to assume that those who prefer not to state their religion have 'no religion', with the exception of small numbers who do not wish to identify themselves for reasons such as historic persecution.<sup>53</sup>

The Office for National Statistics (ONS) looked into reasons why people 'prefer not to say' when responding to questions about their sexuality and it may be reasonable to assume some of the same reasons may apply here.<sup>54</sup> Reasons include concerns regarding privacy and confidentiality or risk of being identified, and a belief that the question should not be asked (people who preferred not to state their sexuality also preferred not to say for other questions such as ethnicity).

People who identified as Christian had an above average experience for receiving attention and overall experience.

Within the Type 3 analysis, the only noteworthy finding was that respondents who said that they would prefer not to state their religion had a worse than average experience for the privacy theme.

### **Sexual orientation**

Within Type 1 results, respondents who said that they would prefer not to state their sexuality had a worse than average experience for their overall experience.

Respondents who described themselves as heterosexual / straight had an above average experience for involvement and decision making.

There were no noteworthy findings within the Type 3 results.

### **Ethnicity**

There were no noteworthy differences by ethnic group across either the Type 1 or Type 3 results.

### **Long-term condition**

Within the Type 1 results, respondents who said that they had a mental health condition had a worse than average experience for three out of nine themes; respect and dignity, involvement and decision making and information. Respect and dignity and involvement and decision-making were also reported as poorer for this group of patients in the [2016 survey](#). Other surveys within the programme have also found this patient group to consistently report poorer experiences, for example the [2018 Adult Inpatient Survey](#) found that patients with a mental health condition consistently reported poorer experiences of their time in hospital.

Conversely, respondents who did not have a mental health condition had an above average experience for the same three themes: respect and dignity, involvement and decision making and information. Respondents who did not have dementia also had an above average experience for receiving attention.

There were no noteworthy findings within the Type 3 results.

### Seven-day services (day and time of attendance)

Some research evidence suggested that people can have poorer experiences and outcomes if admitted to hospital as an emergency on certain days (the weekend) or at certain times (overnight).<sup>55,56</sup>

NHE England have set out an **ambition** that patients receive consistently high-quality care every day of the week. This is supported by 10 evidence-based clinical standards to address variation in care, which includes a standard on patient experience focussed on involvement and engagement with patients.<sup>57</sup> *Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21* sets out how NHS England expect this to be delivered locally through better integrated care.<sup>58</sup>

Analysis found no notable differences by day of attendance, though there was some limited evidence that experiences differ by time of attendance within the Type 1 data. People who attended A&E between 5am and 8.59am had an above average experience for their overall experience.

There were no noteworthy findings within the Type 3 results.

### Total length of visit

The operational standard is that 95% of people should spend four hours or less in the A&E or urgent care department, which continues to be a commitment in the [NHS Mandate for 2018-19](#).

We looked at people's experiences by how long their total visit lasted based on their responses to the question asking, 'How long did your total visit to the A&E / urgent care centre last?'. The results suggest that people who spend more than four hours in A&E have an experience that is poorer than average.

Within the Type 1 results, respondents who said that their visit to A&E lasted for more than four hours had a worse than average experience for **all** themes. Within the Type 3 data, respondents who said that their visit to the urgent care centre lasted for more than four hours had a worse than average experience for four out of eight themes: respect and dignity, involvement and decision making, information and overall experience.

Conversely, within the Type 1 data, respondents who said that their visit to A&E lasted for no more than four hours had an above average experience for **all** themes. Within the Type 3 data, respondents who said that their visit to the urgent care centre lasted for no more than four hours had an above average experience for four out of eight themes: respect and dignity, involvement and decision making, information and overall experience.

### Frequency of visit (reattendance)

Reattendance at A&E can suggest that the reason for the original visit was not resolved. [Guidance](#) from the Royal College of Emergency Medicine states that people who reattend should be treated with the same care and respect as other patients. However, the results suggest that people who said that they had been to the same A&E about the same condition or something related to it have a poorer than average experience.

Within the Type 1 results, respondents who said that they had been to the same A&E about the same condition or something related to it within the past week had a worse than average experience for four of the nine themes; respect and dignity, involvement and decision making, confidence and trust, and their overall experience. Respondents who said that that they had been to the same A&E about the same condition or something related to it between one week and one months earlier had a worse than average experience for one theme: transition and continuity.

Conversely, people who had not previously visited the same A&E had an above average experience for five of the nine themes: respect and dignity, involvement and decision making, confidence and trust, information and overall experience.

There were no noteworthy findings within the Type 3 results.

# Appendix A: Survey methodology

This appendix summarises the survey methodology covering questionnaire design, sampling, fieldwork and analysis. For more detailed information, and for information on data limitations, please see the [Quality and Methodology Report](#).

## 1. Survey design and development

To ensure that the [questionnaire](#) is up-to-date and in line with current policy and practice, questions are reviewed before each survey to determine whether any new questions are needed. An external advisory group ensured that a range of stakeholders had the opportunity to provide input during development of the survey. Membership included representatives from CQC, the Department of Health and Social Care, NHS England and NHS Improvement, acute trusts, third sector organisations and people who have used services.

Questionnaire development work has shown that questions are important to people who use services and to other stakeholders who use the survey data in their work. More information on how survey stakeholders use the data is provided in [Appendix E](#).

Wherever possible, questions remain the same over time to measure change. However, when necessary, we make changes to reflect changes in policy and methodological best practice, and to reflect feedback from stakeholders to make sure that questions stay relevant. Full details of changes can be found in the [survey development report](#), though in summary the following changes were made to the questionnaire for the 2018 survey:

- two questionnaires were used tailored to Type 1 and Type 3 services
- five new questions were added to the Type 1 questionnaire. Eleven questions had amends to the question wording, wording of response options or removal of response options. Two questions had their position moved. Three questions that had been included in 2016 were removed
- five new questions were added to the Type 3 questionnaire. Eleven questions had amends to the question wording, wording of response options or removal of response options. Two questions had their position moved. Six questions that had been included in 2016 were removed
- the covering letters were reworked following a successful pilot of similarly updated designs alongside the [2017 Community Mental Health Survey](#).

And the following changes were made to the survey methodology for the 2018 survey:

- the sample size for Type 3 departments increased from 300 in 2016 to 420 in 2018
- trusts with eligible Type 3 services unable to draw their full required sample from September were able to include August

- as has been done with other surveys in the NHS Patient Survey Programme, the covering letters were reviewed to make them more concise and engaging. Different versions were used for Type 1 and Type 3 services.
- following a successful pilot conducted alongside the 2017 Inpatient Survey<sup>bb</sup> a faster reminder has been introduced across the survey programme where the second mailings are sent five working days after the initial mailing.

## 2. Response rates

The 2018 survey saw an increase in response rates compared with the 2016 survey:

For Type 1 services, we received responses from more than 42,700 people, a response rate of 30%, which is up from 28% in 2016. For Type 3 services, we received responses from more than 7,400 people, a response rate of 29%, which is up from 25% in 2016.<sup>cc</sup>

We expect the increase in response rate to be due to methodological changes and questionnaire improvements as summarised in the section above and detailed in full in the [survey development report](#).

## 3. Survey method

As with most surveys in the NHS Patient Survey Programme, the urgent and emergency survey used a postal methodology. However, to make the questionnaire as accessible as possible, people were able to complete it over the phone in a language other than English.

People who did not respond received up to two postal reminders.

## 4. Sampling and fieldwork

People aged 16 and over were eligible for the survey if they attended a Type 1 or Type 3 urgent and emergency care department in an NHS trust between 1 and 30 September 2018. Trusts with eligible Type 3 services unable to draw their full required sample from September were able to include August. Trusts responsible for only Type 1 departments drew a stratified sample of 1,250 patients. Trusts that also directly ran Type 3 departments sampled 950 patients from Type 1 departments and 420 patients from Type 3 departments totalling 1,370 patients. The sample size, and the achieved response rate, is sufficient to allow analysis of results at individual trust level.

The 2018 survey included 63 trusts that had both a Type 1 and Type 3 service, with 69 having Type 1 only. Type 3 departments were only eligible for inclusion if they were run directly by the acute trust. Services run by another provider, or in collaboration with another provider were excluded.

<sup>bb</sup> Report unpublished at time of writing

<sup>cc</sup> The 'adjusted' response rate is reported. The adjusted base is calculated by subtracting the number of questionnaires returned as undeliverable, or if someone had died, from the total number of questionnaires sent out. The adjusted response rate is then calculated by dividing the number of returned useable questionnaires by the adjusted base.

Certain groups of people were excluded from the survey before providers drew their samples, including:

- anyone who was a current inpatient
- anyone who attended a walk-in centre
- any patients who were admitted to hospital through medical or surgical admissions units and therefore did not visit the UEC department
- anyone who had a planned attendance at an outpatient clinic run within the department (such as a fracture clinic)
- patients attending primarily to obtain contraception (for example, the morning after pill), patients who suffered a miscarriage or another form of abortive pregnancy outcome while at the hospital, and patients with a concealed pregnancy.

Fieldwork for the survey (the time during which questionnaires were sent out and returned) took place between October 2018 and March 2019.

For more detailed information on the sampling instructions, and inclusion and exclusion criteria, please see the [instruction manual](#) for the survey.

### 5. Comparability with previous years

The 2018 survey is only comparable with 2016. Major redevelopment work carried out ahead of the 2016 survey means that results are not comparable with other surveys (carried out in 2003, 2004/5, 2008, 2012 and 2014).<sup>dd</sup>

The results for most questions from the 2018 survey are comparable with 2016. The following questions are not comparable for the reasons outlined below:

**Table A1: Questions not comparable between 2018 and 2016**

Type 1 Question Wording	Type 3 Question Wording	Reasons for non-comparability
2. Before going to this A&E department, where did you go to, or contact, for help with your condition?	2. Before going to this urgent care centre, where did you go to, or contact, for help with your condition?	Changes to response options.
3. What was the MAIN reason for going to A&E following your contact with the service above?	3. What was the MAIN reason for going to the urgent care centre following your contact with the service above?	Changes to question wording and response options. Now single response (not multiple response).
N/A	6. Did you have an appointment on your most recent visit to the urgent care centre?	New question (Type 3 questionnaire only).

<sup>dd</sup> For more information please see the [survey development report for 2016](#)

<b>Type 1 Question Wording</b>	<b>Type 3 Question Wording</b>	<b>Reasons for non-comparability</b>
8. How long did you wait before you first spoke to a nurse or doctor?	7. How long did you wait before you first spoke to a health professional?	Not comparable for Type 3 due to changes to response options. Comparable for Type 1.
9. Sometimes, people will first talk to a doctor or nurse and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?	8. Sometimes, people will first talk to a health professional first and be examined later. From the time you arrived, how long did you wait before being examined?	Not comparable for Type 3 due to changes to response options. Comparable for Type 1.
10. Were you informed how long you would have to wait to be examined?	9. Were you informed how long you would have to wait to be examined?	Changes to question wording.
11. While you were waiting, were you able to get help from a member of staff to ask a question?	10. While you were waiting, were you able to get help from a member of staff to ask a question?	New question.
19. When you were at A&E, did you have a family member, friend or carer with you?	18. When you were at the urgent care centre, did you have a family member, friend or carer with you?	New question.
20. If a family member, friend or carer wanted to talk to a doctor, did they have enough opportunity to do so?	19. If a family member, friend or carer wanted to talk to a health professional, did they have enough opportunity to do so?	Changes to question wording and response options.
30. If you did not get the results of the tests when you were in A&E, did a member of staff explain how you would receive them?	N/A	New Question (Type 1 questionnaire only).
32. Do you think the hospital staff did everything they could to help control your pain?	29. Do you think the staff did everything they could to help control your pain?	Analysis suggested that the removal of two preceding questions impacted on how some people answer this question.
36. At the end of your visit to A&E, were you transferred to a hospital ward?	33. What happened at the end of your visit to the urgent care centre?	Changes to question wording and response options.

Type 1 Question Wording	Type 3 Question Wording	Reasons for non-comparability
42. Did a member of staff tell you about what symptoms to watch for regarding your illness or treatment after you went home?	39. Did a member of staff tell you about what symptoms to watch for regarding your illness or treatment after you went home?	Changes to question wording.
44. Did staff give you enough information to help you care for your condition at home?	41. Did staff give you enough information to help you care for your condition at home?	New question
52. Do you have any physical or mental health conditions, disabilities or illnesses that have lasted or are expected to last for 12 months or more?	49. Do you have any physical or mental health conditions, disabilities or illnesses that have lasted or are expected to last for 12 months or more?	New question
53. Do you have any of the following? Select ALL conditions you have that have lasted or are expected to last for 12 months or more.	50. Do you have any of the following? Select ALL conditions you have that have lasted or are expected to last for 12 months or more.	New question
54. Do any of these reduce your ability to carry out day-to-day activities?	51. Do any of these reduce your ability to carry out day-to-day activities?	New question

For more information on why question changes were made please see the [survey development report](#).

## 6. Comparability between service types

Results for Type 1 departments and Type 3 departments are detailed separately in this report. This is because it is not appropriate to compare the detailed question level results. Type 1 and Type 3 departments may be operationally very different, for example, Type 3 departments tend to have a different staff mix (they can be nurse or doctor/GP led) and are not usually open 24 hours. They will also have a different case mix as people attending a Type 3 department usually are less seriously unwell or injured.

## 7. Data analysis methodology

### Data cleaning

‘Data cleaning’ refers to all editing processes carried out on survey data once the survey has been completed and the data have been entered and collated. This is



done by the Survey Coordination Centre to ensure that this is comparable across trusts. For further information please see the [data cleaning document](#).

## Weighting

Two weights were calculated for the England level data for the 2018 urgent and emergency care survey:

1. A 'trust weight', which aims to weight responses from each trust to ensure they have an equal influence over the England average, regardless of differences in response rates between trusts.
2. A 'population weight', which aims to weight the results for each individual trust to that trust's eligible sample profile, with the intention of making each trust's results representative of their own population.

The demographic questions in the 'About You' section are not weighted, as it is more appropriate to present the real percentages of respondents to describe the profile of respondents, rather than adjust figures.

For more detailed information on the weighting strategy, please see the [Quality and Methodology report](#).

## Rounding

The results present percentage figures rounded to the nearest whole number, so the values given for any question will not always add up to 100%.

## Statistical significance

Statistical tests were carried out on the data to determine whether there had been any statistically significant changes in the results for 2018 compared with the last time the survey took place in 2016.

A 'z-test' set to 95% significance was used to compare data between the two years. A statistically significant difference means it is very unlikely we would have obtained this result by chance alone if there was no real difference.

The charts in this report display 'up' and 'down' arrows to indicate whether there has been a 'statistically significant' change between 2018 and 2016.

Please note that as there are currently only two data points (2016 and 2018) it is not possible to determine if any changes are the start of a trend or natural fluctuation within the data. Please also note that due to the smaller sample size for the Type 3 services, larger differences between years are required for changes to be significant.

## 8. Subgroup analysis methodology

The multi-level analysis of subgroups highlights the experiences of different demographic sub-populations. Results for each demographic subgroup were generated as adjusted means (also known as estimated marginal means or population marginal means) using a linear mixed effects model. These means

were compared within themes, derived from composites of questions, illustrated in the charts.

This model takes into account trust clustering, as trusts are likely to have a big effect on reported patient experience at a national level. To assess whether experience differs by demographic factors, statistical significance tests were carried out; F tests were performed on each factor (fixed effect) as a predictor of the target variable. P-values were also generated which showed how likely it is that the differences between groups observed in the results could have arisen from a population where there were no actual differences. They relate to the demographic factor as a whole rather than to compare between specific categories in the factor. Variables were also checked for multicollinearity to ensure co-efficient estimates were not being influenced by additional factors.

In this report, differences that are equivalent to at least 0.1 standard deviations from the overall mean of the target variable are treated as being noteworthy, provided that the confidence interval does not overlap the mean line.

Nine themes were selected for analysis based on key national policy and good practice for patient experience as set out in the [NHS Patient Experience Framework](#). Three of these themes are composites using similar questions, and six are individual questions. For Type 3 services there were eight themes as 'receiving attention' was not included. These are detailed in table A1 below.

The charts used for the analysis may be found in Appendix H, published as an [external appendix](#).

For more detailed information on the methodology, please see the [Quality and Methodology report](#).

**Table A2 Themes used in subgroup analysis**

<b>Overall</b>	<p><u>Type 1</u> Q46: Overall... (Please circle a number)</p> <p><u>Type 3</u> Q43: Overall... (Please circle a number)</p>
<b>Information, communication and education</b>	<p><u>Type 1:</u> Q13: Did you have enough time to discuss your condition with the doctor or nurse? Q14: While you were in A&amp;E, did a doctor or nurse explain your condition and treatment in a way you could understand? Q21: While you were in A&amp;E, how much information about your condition or treatment was given to you?</p> <p><u>Type 3</u> Q12: Did you have enough time to discuss your condition with the doctor or nurse?</p>

	<p>Q13: While you were in the urgent care centre, did a health professional explain your condition and treatment in a way you could understand?</p> <p>Q20: While you were at the urgent care centre, how much information about your condition or treatment was given you to you?</p>
<b>Privacy</b>	<p><u>Type 1</u>  Q6: Were you given enough privacy when discussing your condition with the receptionist?  Q22: Were you given enough privacy when being examined or treated?</p> <p><u>Type 3</u>  Q4: Were you given enough privacy when discussing your condition with the receptionist?  Q21: Were you given enough privacy when being examined or treated?</p>
<b>Transition and continuity</b>	<p><u>Type 1</u>  Q40: Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?  Q43: Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left A&amp;E?  Q44: Did staff give you enough information to help you care for your condition at home?</p> <p><u>Type 3</u>  Q37: Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?  Q40: Did a member of staff tell you who to contact if you were worried about your condition or treatment after you left the urgent care centre?  Q41: Did staff give you enough information to help you care for your condition at home?</p>
<b>Emotional Support</b>	<p><u>Type 1</u>  Q16: If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</p> <p><u>Type 3</u>  Q15: If you had any anxieties or fears about your condition or treatment, did a health professional discuss them with you?</p>

<b>Confidence and trust</b>	<p><u>Type 1</u> Q17: Did you have confidence and trust in the doctors and nurses examining and treating you?</p> <p><u>Type 3</u> Q16: Did you have confidence and trust in the health professional examining and treating you?</p>
<b>Involvement and decision making</b>	<p><u>Type 1</u> Q15: Did the doctors and nurses listen to what you had to say? Q25: Were you involved as much as you wanted to be in decisions about your care and treatment?</p> <p><u>Type 3</u> Q14: Did the health professional listen to what you had to say? Q23: Were you involved as much as you wanted to be in decisions about your care and treatment?</p>
<b>Respect and dignity</b>	<p><u>Type 1</u> Q45: Overall, did you feel you were treated with respect and dignity while you were in A&amp;E?</p> <p><u>Type 3</u> Q42: Overall, did you feel you were treated with respect and dignity while you were in the urgent care centre?</p>
<b>Receiving attention</b>	<p><u>Type 1:</u> Q23: If you needed attention, were you able to get a member of medical or nursing staff to help you?</p> <p><u>Type 3:</u> No questions</p>

## Appendix B: Who took part in the 2018 survey?

The survey collected basic demographic information from all people who took part. The demographics of respondents remains broadly unchanged in 2018 compared with 2016 and are summarised in this appendix. For full details please see the 'About the respondents' section within the open data [published on CQC's website](#).

Looking at the demographic characteristics for people who participated in the Type 1 survey, 55% were female and 45% male. Looking at age group, 12% were 16 to 35, 13% were 36 to 50, 25% were 51 to 65, 32% were 66 to 80 and 18% were 81+. Most respondents were from the White ethnic group (92%). Most described themselves as heterosexual or straight (93%). Over half (60%) said that they had a physical or mental health condition, disability or illnesses that had lasted or was expected to last for 12 months or more.

Looking at the demographic characteristics of people who took part in the Type 3 survey, 58% were female and 42% were male. Looking at age group, 14% were 16 to 35, 16% were 36 to 50, 29% were 51 to 65, 30% were 66 to 80 and 11% were 81+. Most respondents were from the White ethnic group (93%). Most described themselves as heterosexual or straight (93%). Less than half (46%) said that they had a physical or mental health condition, disability or illnesses that had lasted or was expected to last for 12 months or more.

There were some differences in demographics for respondents across the Type 1 and Type 3 services. The Type 3 survey had more younger respondents taking part compared with the Type 1: 59% of people who took part in the Type 3 survey were aged 16 to 65 compared with 50% in the Type 1 survey. More people in the Type 1 survey said they had a physical or mental health condition, disability or illness that had lasted or was expected to last for 12 months or more (60%) compared with Type 3 (46%); and that this condition reduced their ability to carry out every day activities 'a lot' (37% for Type 1 respondents and 26% for Type 3).

# Appendix C: Other sources of data related to survey results

There are multiple sources of data on urgent and emergency care, providing information on specific aspects of care. The information below provides links to some of these. Please note that these data sources do not measure patient experience and are therefore not directly comparable with findings presented in this report.

## NHS Outcome Framework Indicators

The NHS Outcomes Framework provides national-level accountability for the outcomes that the NHS delivers and to drive transparency, quality improvement and outcome measurement throughout the NHS.

The framework sets out the national outcome goals that the Secretary of State uses to monitor the progress of NHS England. It does not set out how these outcomes should be delivered.

Data from the NHS Patient Survey Programme are used to monitor Domain 4 'Ensuring that people have a positive experience of care'. This looks at the importance of providing a positive experience of care for patients, people who use services and carers.

For more information please see:

<https://digital.nhs.uk/data-and-information/publications/clinical-indicators/nhs-outcomes-framework>

## Staffing

Statistics on staffing numbers are provided in NHS Digital's statistical release on NHS Workforce Statistics. Please note this data covers all trust types (not just acute trusts with urgent and emergency care departments).

For more information, please see: <http://digital.nhs.uk/workforce>

## Waiting times

Most data on waiting times are from statistical publications by NHS England and NHS Digital. Trusts should also publish this information on their website. There are three sets of statistics relating to waiting times which are based on two data sources and the associated statistics are published in slightly different ways by different organisations:

**NHS England** publishes weekly and monthly A&E attendances and emergency admissions, which includes minor injuries units and walk-in centres, and of these, the number discharged, admitted or transferred within four hours of arrival. Also included are the number of emergency admissions, and any waits of over four hours for admission following decision to admit. Data are shown at organisation level, for NHS trusts, NHS foundation trusts and independent sector

organisations. Providers submit this data to NHS England in aggregate form, rather than from patient level data.

[www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/](http://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/)

**NHS Digital** publishes monthly A&E Quality Indicators. This set of clinical quality indicators was introduced to measure the quality of care delivered in A&E departments in England. The data used in these indicators are sourced from provisional A&E HES data (Hospital Episode Statistics) and also include more detail about A&E activity such as demographic information:

<https://digital.nhs.uk/data-and-information/publications/statistical/accident-and-emergency-quality-indicators>

NHS Digital also publishes more detailed data on A&E attendances, which is broken down by age and diagnosis.

<https://digital.nhs.uk/data-and-information/publications/statistical/hospital-accident--emergency-activity>

**Hospital Accident and Emergency Activity** is a joint annual publication between NHS Digital and NHS England. It uses two data sources: [Hospital Episode Statistics \(HES\)](#) and A&E Attendances and Emergency Admissions Monthly Situation Reports.

Data for 2017/18 which includes the time period covered by the survey (September 2018) can be found here:

<https://digital.nhs.uk/data-and-information/publications/statistical/hospital-accident--emergency-activity/2017-18>

Data for 2018/19 can be found here:

<https://digital.nhs.uk/data-and-information/publications/statistical/hospital-accident--emergency-activity/2018-19>

## Patient experience

### Emergency Care Data Set (ECDS)

The ECDS was designed to provide greater information about the patient journey and trusts began using this in a phased implementation from 2018. It provides extra detail including patient demographics, how and why people are accessing services and information on what happens when they leave (onward care, referrals etc).

For more information please see:

[www.england.nhs.uk/ourwork/tsd/ec-data-set/](http://www.england.nhs.uk/ourwork/tsd/ec-data-set/)

<https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/emergency-care-data-set-ecds>

### Friends & Family Test (FFT)

NHS England publishes results from the Friends and Family Test. This is a single question survey, which asks patients whether they would recommend the service they have received to friends and family who need similar treatment or care.

[www.england.nhs.uk/ourwork/pe/fft/friends-and-family-test-data/](http://www.england.nhs.uk/ourwork/pe/fft/friends-and-family-test-data/)

## Appendix D: Comparisons with other surveys

While Scotland, Northern Ireland and the Republic of Ireland have programmes of patient surveys, they do not currently include surveys on urgent and emergency care services. However inpatient surveys include a limited number of questions on A&E.

There is currently no similar survey undertaken in Wales.

The surveys in Scotland, Northern Ireland and the Republic of Ireland reflect people's experiences of different healthcare systems. Therefore, direct comparisons to this survey are not recommended because of the differences in methodology, the questions, and the periods over which the surveys were administered. Also, the questions are phrased differently, use different scale lengths, and different report and rating type scales. Each of these factors is associated with differences in responses. Furthermore, as the questions are included in a questionnaire covering inpatient services, these surveys only include people who went on to be admitted from A&E (and are therefore more likely to be more seriously ill or injured).

### Scotland

The Scottish Care Experience Survey Programme currently consists of four surveys: The Health & Care Experience Survey (covers GP services, out-of-hours care, social care and caring responsibilities), and surveys of inpatient, maternity and cancer patient experiences. Though there is not one specifically on UEC services, their inpatient survey includes questions on time spent in A&E.

The most recently published results are from the 2018 inpatient survey which was sent to a random sample of people, aged 16 and over, who had had an overnight stay in hospital in Scotland between April and September 2017.

The 2018 survey included four questions asking about experiences in A&E:

Q4. In A&E, were you kept informed about how long you would have to wait to be seen by a nurse or doctor?

Yes completely	44%
Yes to some extent	31%
No	25%

Q5. Once seen by a nurse or doctor, were you kept informed about what was happening?

Yes completely	63%
Yes to some extent	31%
No	6%



Q6. Did you feel safe when you were in A&E?

Yes completely	85%
Yes to some extent	13%
No	2%

Q7. Did a nurse or doctor discuss your condition with you in a way you could understand?

Yes completely	71%
Yes to some extent	24%
No	5%

The results from the 2018 Inpatient Survey are available here:

[www.gov.scot/publications/inpatient-experience-survey-2018-national-results/](http://www.gov.scot/publications/inpatient-experience-survey-2018-national-results/)

## Northern Ireland

Though there is no survey specifically on urgent and emergency care services, though their inpatient survey includes questions on time spent in A&E.

The most recently published results are from the 2017 inpatient survey which was sent to all eligible inpatients (aged 16+) that had been discharged from a hospital in Northern Ireland during a six week period in September/October 2017.

The 2017 survey included four questions asking about experiences in A&E:

Q6 Did the A&E / Emergency Care staff who were providing your care introduce themselves to you?

Yes	95%
No	5%

Q7 During your time in A&E / Emergency Department would you say your care and treatment was...

Excellent	56%
Good	33%
Fair	8%
Poor	2%
Very poor	1%

More information on the inpatient survey undertaken in Northern Ireland is available here:

[www.health-ni.gov.uk/publications/inpatient-patient-experience-survey-2017](http://www.health-ni.gov.uk/publications/inpatient-patient-experience-survey-2017)

## Ireland

The patient experience programme in Ireland currently consists of two surveys: the national patient experience survey which covers acute hospitals and the national care experience survey which covers health and social care services.

Though there is no survey specifically on urgent and emergency care services, their inpatient survey includes questions on time spent in A&E.

The most recently published results are from the 2018 national patient experience survey which was sent to all patients aged 16 years or older, discharged from 1 to 31 May 2018, who spent 24 hours or more in a public acute hospital and who held an address in the Republic of Ireland.

Although the 2018 questionnaire included five questions asking about the emergency department, percentage results are not publicly available as results are published as scores out of 10 in the [report](#).

More information on patient surveys undertaken in Ireland is available here: [www.patientexperience.ie/](http://www.patientexperience.ie/)

# Appendix E: Main users of the survey data

This appendix lists known users of data from the UEC survey and how they use the data.

## Care Quality Commission (CQC)

The Care Quality Commission will use the results from this survey in the regulation, monitoring and inspection of NHS acute trusts in England. CQC will use data from the survey in CQC Insight, an intelligence tool which identifies potential changes in quality of care and supports them in deciding on the right regulatory response. Survey data will also be used to support CQC inspections.

## Department of Health and Social Care

The Government's strategy sets out a commitment to measure progress on improving people's experiences through Domain 4 of the NHS Outcomes Framework 'ensuring people have a positive experience of care'.

The Framework sets out the outcomes and corresponding indicators that the Department of Health and Social Care uses to hold NHS England to account for improvements in health outcomes, as part of the Government's [Mandate](#) to NHS England. The Outcomes Framework survey indicators are based on the standardised, scored trust level data from the survey (similar to that included in the CQC benchmark reports), rather than the England level percentage of respondent's data that is contained within this report.

For more information, see the following link:

<https://digital.nhs.uk/data-and-information/publications/clinical-indicators/nhs-outcomes-framework>

## NHS England and NHS Improvement

NHS England uses questions from the NHS Patient Survey Programme to produce a separate index measure called [the Overall Patient Experience Score](#). The score forms part of a regular statistical series that is updated alongside the publication of each respective survey.

The scores are calculated in the same way each year, so that the experience of NHS users can be compared over time. As part of the supporting documentation, NHS England also produces and publishes a [diagnostic tool](#) to help NHS managers and the public understand what feeds in to the overall scores and to see how scores vary across individual NHS provider organisations.

More information is available at:

[www.england.nhs.uk/statistics/statistical-work-areas/pat-exp/](http://www.england.nhs.uk/statistics/statistical-work-areas/pat-exp/).

## **NHS trusts and commissioners**

Trusts, and those who commission services, use the results to identify and make the improvements they need to improve the experience of people who use their services.

## **Patients, their supporters and representative groups**

The survey data is made available on CQC's website for each participating NHS trust, under the organisation search tool. The data is presented in an accessible format to enable the public to examine how services are performing, alongside their inspection results. The search tool is available from the home page:

[www.cqc.org.uk](http://www.cqc.org.uk)

# Appendix F: Quality and methodology

All detail on data limitations can be found in the Quality and Methodology document, available on [CQC's website](#).

## Revisions and corrections

CQC publishes a [Revisions and Corrections Policy](#) relating to these statistics. The NHS Patient Survey Programme data is not subject to any scheduled revision as they capture the views of patients about their experiences of care at a specific point in time. All new survey results are therefore published on CQC's website and NHS Surveys, as appropriate, and previously published results for the same survey are not revised.

This policy sets out how CQC will respond if an error is identified within this and it becomes necessary to correct published data or reports.

# Appendix G: Further information and feedback

## Further information

The results for the 2018 survey are available on the CQC website. Here you can find an A to Z list to view the results for each trust, the technical document, which outlines the methodology, and the scoring applied to each question and a quality and methodology document:

[www.cqc.org.uk/uecsurvey](http://www.cqc.org.uk/uecsurvey)

Benchmark reports for each trust are available on the NHS surveys website:

<https://nhssurveys.org/all-files/03-urgent-emergency-care/05-benchmarks-reports/2018/>

The results for the 2016 survey can be found below. From here you can also access results for surveys carried out in 2003, 2004, 2008, 2012, 2014. However, please note that due to redevelopment work carried out ahead of the 2016 survey, **results from 2018 are only comparable with 2016.**

<https://nhssurveys.org/surveys/survey/03-urgent-emergency-care/year/2016/>

Full details of the methodology for the survey, including questionnaires, letters sent to patients, instructions on how to carry out the survey and the survey development report, are available at:

<https://nhssurveys.org/surveys/survey/03-urgent-emergency-care/>

More information on the patient survey programme, including results from other surveys and a programme of current and forthcoming surveys is available at:

[www.cqc.org.uk/surveys](http://www.cqc.org.uk/surveys)

More information about how CQC monitors hospitals is available on the CQC website at:

[www.cqc.org.uk/content/monitoring-nhs-acute-hospitals](http://www.cqc.org.uk/content/monitoring-nhs-acute-hospitals)

## Further questions

This report has been produced by CQC's Survey Team and reflects the findings of the Urgent and Emergency Care Survey 2018. The guidance above should help answer any questions you have about the programme. However, if you wish to contact the Team directly please contact Tamatha Webster, Survey Manager, at [Patient.Survey@cqc.org.uk](mailto:Patient.Survey@cqc.org.uk).

## Feedback

We welcome all feedback on the survey findings and the approach we have used to reporting the results, particularly from people using services, their representatives, and those providing services. If you have any views, comments or suggestions on how this publication could be improved, please contact Tamatha Webster, Survey Manager, at [Patient.Survey@cqc.org.uk](mailto:Patient.Survey@cqc.org.uk).

CQC will review your feedback and use it, as appropriate, to improve the statistics that we publish across the NHS Patient Survey Programme.

## National Statistics status

National Statistics status means that official statistics meet the highest standards of trustworthiness, quality and public value.

All official statistics should comply with all aspects of the Code of Practice for Official Statistics. They are awarded National Statistics status following an assessment by the Authority's regulatory arm. The Authority considers whether the statistics meet the highest standards of Code compliance, including the value they add to public decisions and debate.



It is a producer's responsibility to maintain compliance with the standards expected of National Statistics, and to improve its statistics on a continuous basis. If a producer becomes concerned about whether its statistics are still meeting the appropriate standards, it should discuss its concerns with the Authority promptly. National Statistics status can be removed at any point when the highest standards are not maintained, and reinstated when standards are restored.

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