Eastern AHSN

# Urgent & Emergency Care: acting on patient and public perspectives

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Part of The AHSN Network

Office for Life Sciences

NHS

# About Eastern AHSN

Our purpose is to turn great ideas into positive health impact. We were established by the NHS to convene all partners in the health sector, to develop and deliver innovative solutions in health and care. Our focus is the East of England, but we are part of a national network which enables us to deliver at scale. We believe citizens, academia, health services and industry will achieve more working together than they will in isolation. Our job is to make this happen. We do this by helping innovators to navigate complex systems, generate value propositions and connect stakeholders to overcome challenges together.

# Our project partners

This project was funded by the Digital, Urgent and Emergency Care Team at NHS England and completed in collaboration with four partner organisations.

# Our Steering Group

The Steering Group for the project consisted of representatives from digital Urgent and Emergency Care (UEC), Elective and Emergency Care (EEC) and UEC policy teams, NHS England national digital products leads, heads of Patient Experience, Integrated Urgent Care (IUC) clinicians and Healthwatch England, as well as consortium project partners.

# Contents

# At a glance

This report details insights into people's day-to-day experience of UEC including barriers and enablers to accessing appropriate services at the right time. The thematic analysis of the findings from the rapid review and social listening exercise identified five themes to inform our research questions for the focus groups, telephone interviews and survey:

1. **Initial point of access**: Participants' awareness and understanding of the different access points into UEC (in addition to A&E) and their experience of them.

2. **Preference for face to face or virtual**: People's preference for accessing UEC in person or via a virtual route, whether that was NHS 111, telephone, video consultations or other remote access.

3. **Delayed or inappropriate referrals or advice:** What advice people are receiving about where to go for UEC, and the impact of incorrect or delayed information on their experience.

4. **Digital:** People's use of digital channels to access UEC, with particular attention paid to digital exclusion.

5. **Connections:** How well and how often information was shared between staff, particularly when patients accessed multiple UEC services as well as primary care.

Following discussion with the Steering Group and feedback from key stakeholders at NHS England, three additional themes were identified as 'stop and share':

- Access and experience
- COVID-19
- Variations across regions

This meant that either enough information was known about the theme (access and experience and variations across regions), or it would require much more detailed, separate research to fully understand (COVID-19).

The report concludes with four recommendations for action that could be taken in the short- and medium-term, to support patients to access the full range of UEC services.

# Summary of recommendations

1. Identify which patient cohorts would benefit from focused communications on the digital offer, and target communications campaigns to them. Of particular note was the benefit of illustrating the offer with stories of patients who have successfully accessed the help they needed to build confidence and trust in these provisions

2. Share more information with NHS and social care colleagues on what the digital offers are. Staff will be better able to signpost to alternative UEC services that are better placed to treat patients. Building this awareness of digital access routes may also encourage a better understanding for those patients who may have been sent to a service, A&E for example, when they may have been directed to do so by 111

3. Continue to share this gathered insight with teams through a communications campaign including podcasts. In addition, particular consideration should be given to ensure the findings are reflected in ongoing patient engagement and planning in the wider NHS including Integrated Care Boards (ICBs) and through patient advocacy groups

4. While the focus of this project was on UEC, the public do not recognise the NHS-driven boundaries of services that may be in or out of UEC. Sharing these insights widely may help teams to consider access in to and out of UEC from the patient's perspective. Recognising that patients are less concerned about adherence to targets and may not always clearly identify where their treatment starts or ends, which may impact their impression of ongoing care

# About this report

## Looking at Urgent and Emergency Care (UEC) from patient and public perspectives

Addressing increasing demand on an already pressured UEC system is a significant challenge, with research showing that advising people not to come to A&E does not appear to have reduced attendances[1]. It is therefore important to engage with the public in an honest and impactful way, with a view to understanding their awareness of UEC services, their key motivators during an emergency, and their appetite for digital alternatives.

We set out to understand the problem of UEC from the perspective of patients who had engaged with that care, including how they might be supported by digital solutions. Our intention was to gather and present their personal views, using people's own words to describe how UEC is used. The project built on previous research[2] [3] into the public's experience of UEC, and focused on where people go for urgent care, gathering positive and negative patient experiences, and using engaging methods to explore patients' knowledge of existing digital services.

## How we undertook the research

NHS England commissioned Eastern AHSN to lead a consortium (Appendix 1) to deliver this patient and public engagement project. The consortium was commissioned on the basis of its combined range of skills, its unique expertise and its understanding of the healthcare landscape. Eastern AHSN, Patient Experience Library, Traverse, PEP Health, and Ethnic Opinions each led different aspects of the research. The methodology included a rapid literature review, a social listening exercise, interviews, focus groups and a survey. Under-represented groups such as those with a learning or physical disability, ethnic minority groups, and those living in rural or coastal communities were specifically encouraged to participate in the focus groups and interviews.

### Methodology

The research process was iterative, with the aim of drawing a number of perspectives together to shape the narrative of patients' (positive and negative) experiences of UEC. This began with the co-design of research questions and hypotheses by the consortium and members of a Steering Group which informed the rapid literature review and social listening exercise. This in turn helped to inform the research questions for the focus groups, telephone interviews and survey which gave us a broader and deeper understanding of people's experiences.

[1] https://www.bmj.com/content/367/bmj.l6542
[2] https://www.sheffield.ac.uk/scharr/research/centres/cure/projects/public-and-healthcare-staff-perspectives
[3] https://www.healthwatch.co.uk/report/2022-09-25/what-are-peoples-experiences-urgent-and-emergency-care

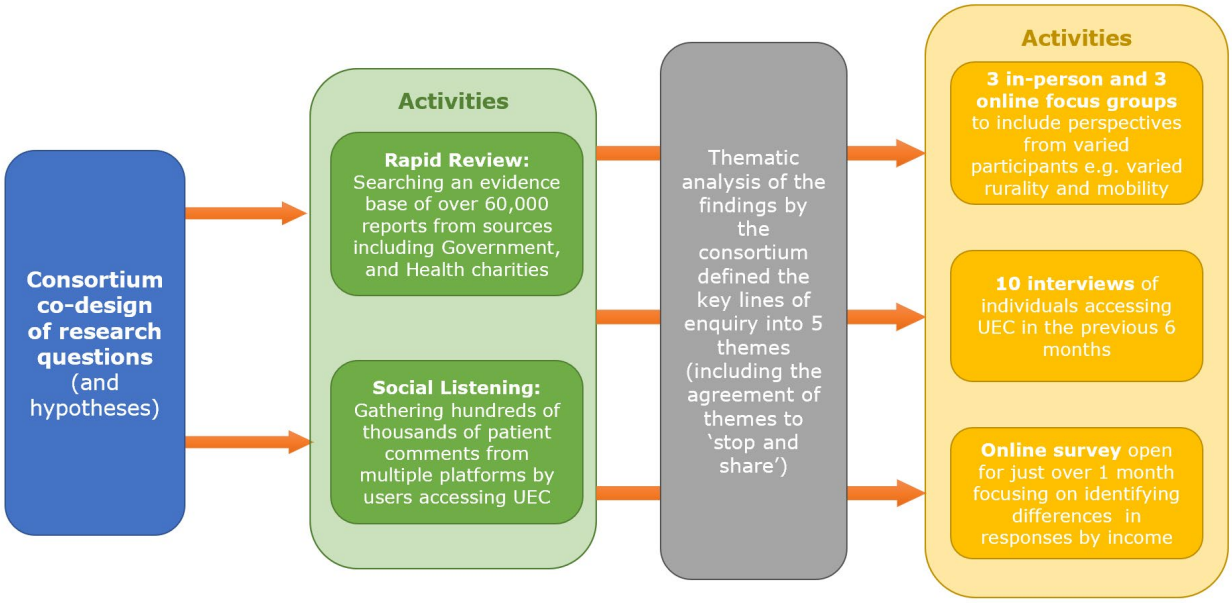



Figure 1: The research process

**Terminology**

We have used NHS England's definition of UEC[4], as follows:

Urgent: An illness or injury that requires urgent attention but is not a life-threatening situation. Urgent care services include a phone consultation through the NHS 111 Clinical Assessment Service, pharmacy advice, out-of-hours GP appointments, and/or referral to an urgent treatment centre (UTC). If unsure what service is needed, NHS 111 can help to assess and direct to the appropriate service/s.

Emergency: Life threatening illnesses or accidents which require immediate, intensive treatment. Services that should be accessed in an emergency include ambulance (via 999) and emergency departments.

## Rapid Literature Review

A rapid literature review (Appendix 2) was completed by Patient Experience Library (PEL)[5], to summarise people's experiences of UEC, including digital and remote access. The evidence was mostly qualitative and based on literature within the national PEL database, with over 60,000 studies and reports from sources including government, health charities and academic institutions. The search was conducted using search terms denoting 'emergency' and 'digital' and had some exceptions: the evidence was from the UK; up to 4 years old; drawn from open-access sources; and was filtered for relevance. After de-duplication and relevance filtering, analysis included 359 documents related to the search term 'emergency', and a further 150 documents related to 'digital'. 19 additional documents were shared by the project Steering Group and included in the review.

## Social Listening

PEP Health Patient Experience Platform led a social listening exercise to understand people's expectations and experience of UEC, to answer the question '*what are the*

[4] https://www.england.nhs.uk/urgent-emergency-care/about-uec/
[5] https://www.patientlibrary.net/cgi-bin/library.cgi

*positive and negative patient experiences of UEC in England, over the past 4 years?*'. This question was broken down into 14 sub-research hypothesis questions. Data collected covered the period January 2018 to June 2022. This involved gathering hundreds of thousands of patient comments across multiple platforms (review sites, social media, and other websites) where users publicly comment on the quality of care they have received for all hospitals and GP practices in England. Over 900,000 comments were analysed as potentially concerning primary and secondary care in England; of these 50,000 comments related to UEC, which were then analysed using natural language processing (NLP). The methodology is described in detail in the full report (Appendix 3).

**Focus Groups & Telephone Interviews**

Ethnic Opinions led the recruitment of participants to the focus groups and telephone interviews, using a screening survey to identify people who reported low confidence in using the internet, and who had used UEC in the previous six months. 10 people were identified from the screening survey (of 390 respondents) to complete a telephone interview. Traverse led the focus groups, which involved 32 participants across three in-person groups, and a further 35 participants across three online groups. There was a specific focus on a diverse range of perspectives, with participants prioritised if they had had recent interaction with UEC, were from remote coastal or rural communities, and if they were living with a learning disability or physical disability affecting mobility. Patient personas were developed (Appendix 4) to facilitate discussion at the focus groups. The interviews were recorded and transcribed, with the key themes and direct quotes drawn out across both the focus groups and interviews. Participants were offered £40 as a thank you for taking part.

**Survey**

An online survey was designed, distributed, and analysed by PEP Health, in consultation with the Steering Group. The survey was open from 26th August to 3rd October 2022 and was disseminated via the AHSN Network; PEP Health's network of hospitals and health services; a LinkedIn and Twitter campaign targeting national and regional health bodies; a nationwide press campaign, focusing on regional news outlets; and the Steering Group who shared the link with their NHS networks. An incentive to be entered into a prize draw for an Amazon voucher was offered to participants. 202 responses were received. The survey questions were informed by the rapid review, which had identified that variation in patient experience and expectation can be driven by income (as well as gender, age, and proximity to A&E). The survey therefore asked participants for their income band to identify differences in responses between income groups. £25,000 was identified as the median income of respondents, meaning that some of the data in this report shows responses from those earning over or under this threshold.

# Findings

This section summarises the findings from the rapid literature review, the social listening exercise, the focus groups and interviews and the survey, grouped by the following five thematic areas.


Figure 2: Five thematic areas identified through the research

# FINDINGS THEME 1: Initial point of access

We sought to understand participants' awareness and understanding of the different access points into UEC and their experience of them.

**NHS 111 as an initial access point to UEC**

NHS 111 was seen by patients as a first port of call with the **online and phone service easy to use, and helpful advice offered**. There was a common view that the service is for issues that are more urgent than needing a GP, but not as urgent as 999, which is in line with the communicated offer of NHS 111[6].

> *"If clearly not urgent you get good advice through 111 – they advise you that if the situation changes you should call 999. You have to wait and see if the situation escalates to emergency."*

Some patients reported that NHS 111 was a source of useful information, both in terms of seeking general advice, and to determine how severe a condition or injury is. People did state though that they had used **NHS 111 as an alternative to getting access to primary care** for example to schedule a GP appointment where this had proved too difficult. In some cases, NHS 111 was seen as a faster route to treatment and advice than 999 even for emergencies, due to A&E wait times and the fact it is available 24/7.

> *"It's difficult getting a GP appointment but I would rather talk to 111 over the phone as it's easier to explain my situation. It's triage without having to go into A&E."*
>
> *"111 is used when the GP closes for holidays and weekends and is not available…[it's] a kind of intermediate service between GP and hospital."*

Some patients showed a **lack of clarity about NHS 111 and what the service offers**. Patients voiced **concerns about the inability of NHS 111 staff to make a diagnosis** and therefore appropriate onward referral. Some patients identified that staff were reading from a script and felt they asked irrelevant or excessive questions, and therefore saw **NHS 111 as a time-consuming barrier to initial access to care**. This feeling of blockage was also expressed by those with previous negative experiences of calling 111 related to the perceived quality of advice given, and the lengthy process. However, most participants said they would use NHS 111 again, as it was better than nothing if sending an ambulance was not possible, and identified it could reduce pressures on A&E.

[6] https://www.nhs.uk/nhs-services/urgent-and-emergency-care-services/when-to-use-111/

*"I'm sure they are trained and its protocol but there's a lot of unnecessary questions…I think they need to get to the fundamentals quickly."*

*"Some of the questions seem a bit pointless. I know they follow a script but don't think their pathways are appropriate."*

*"Yes good service, made us feel safe. We did not feel alone or abandoned."*

*"A negative experience isn't going to necessarily be replicated every time."*

*"I was recently offered an ambulance really quickly and that surprised me, we should be saving resources. I would ring or go online to get advice or try to speak to a pharmacist."*

**Speed of initial access to UEC**

Patient satisfaction was dependent on fast access and how people were treated by staff; if they were dissatisfied with the advice given by NHS 111, they would still attend A&E or call the Ambulance Service, with a perception that A&E/999 is quicker and easier to access care than NHS 111.

*"I've used 111 a few times and since COVID. I recently needed to use 111 for my son who is 4 and I was on hold for 40 mins and I didn't know I was going to be on hold…I would have just rung an ambulance."*

*"There is a lot of misunderstanding of what an Urgent Care Centre (UCC) is, how it operates and when it is open."*

**A&E as an initial access point to UEC**

Proximity to A&E (rather than lack of knowledge of 111) had an impact on first point of access, with those living closest to an A&E department more likely to attend, and those furthest away preferring to access UEC via a GP practice or NHS 111.

For those experiencing delays due to 999 call wait times and A&E wait times (even in an emergency), patients were more inclined to call NHS 111 as it was seen as a faster route to treatment and advice. Conversely, those who did not get what they felt to be satisfactory advice from NHS 111 would turn to A&E for access.

**Communication during initial access to UEC**

The **impact of having to wait for UEC was mitigated if there was good communication** about wait times and next steps, and reassurance to patients while they waited. The social listening exercise also found that many patients were understanding of timeliness challenges arising from the COVID-19 pandemic. Comments included:

*"Accident and emergency services - very efficient and caring. In [this] COVID-19 environment, I was very impressed with the way I was dealt with and treated. I did not have to wait long, staff and doctors were caring and efficient - not easy with wiping equipment every time, etc. Social distancing was very well managed and I felt safe. Thank you 👍"*

*"Special thanks to @Moorfields Eye Hospital A&E for the excellent service I received on Saturday. They were so busy but still managed to inform patients of the waiting times etc. 👍😀"*

*"Had to take my mum to a&e@SONHStrust yesterday. Not the quickest service but have to say very thorough great communication from nursing staff to explain what results etc they were waiting for and how long they expected them to be great ward staff on 10 #ourNHS 👍"*

**Income group and initial access to UEC**

The survey provided insight into respondents' preference for different UEC services, differentiated by income group, as shown below:

***When you last accessed Urgent and Emergency Care for yourself or someone else, which of the following services did you use?***

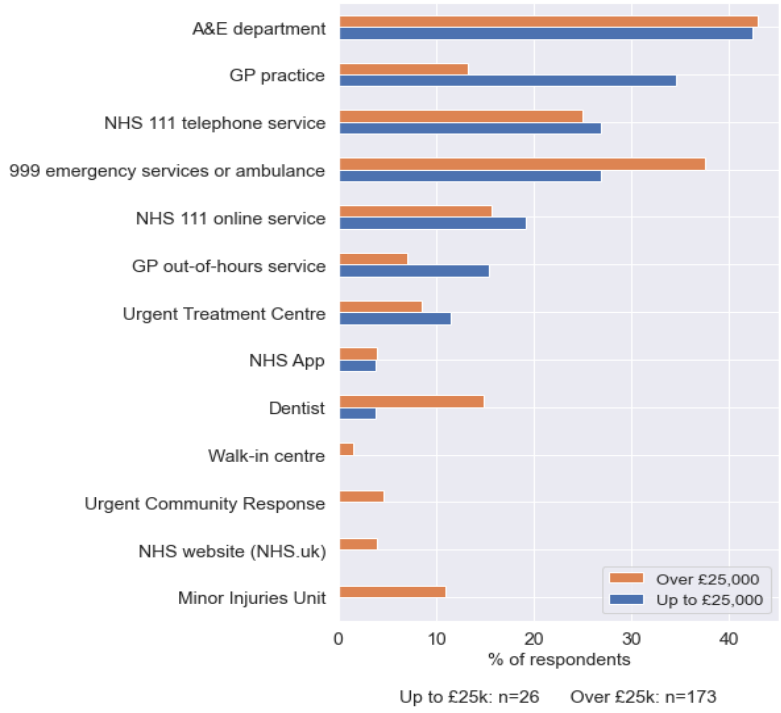



Figure 3: Response to survey question

When asked which UEC service respondents had most recently used, the majority said A&E or 999. Those on incomes lower than £25,000 were more likely to say GP practice, NHS 111 or Urgent Treatment Centre than those on incomes above £25,000.

**Other comments on initial access to UEC:**

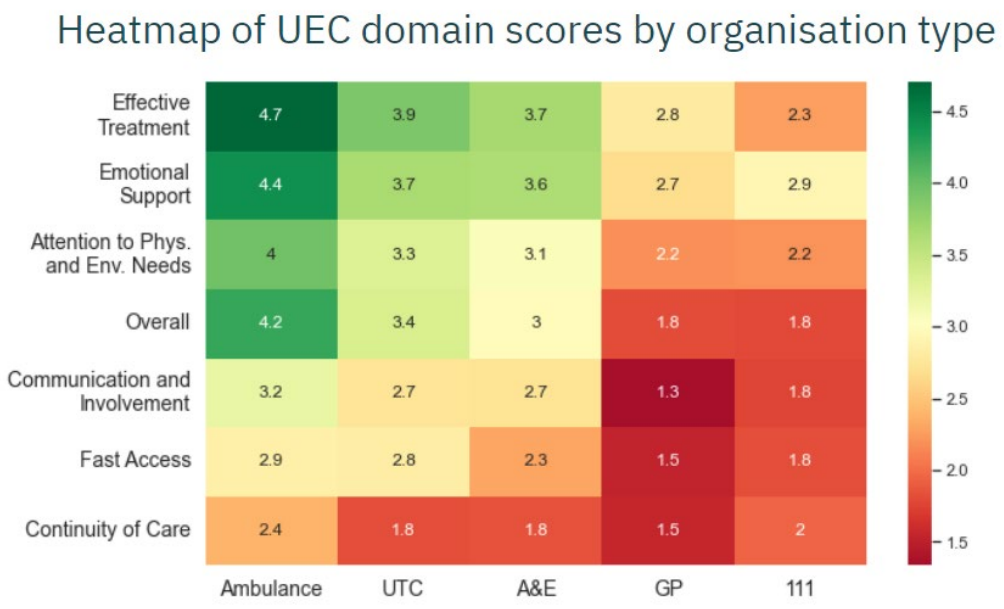



Figure 4: Heatmap from social listening report of UEC patient scores

**How to interpret the heatmap**
The heatmap is taken from the social listening report (Appendix 3). PEP Health's proprietary models classify and score comments against six quality domains. More detail can be found from slide 13 of the report.
These domains are all listed on the left of the heatmap and UEC services are along the bottom of the graph. The heatmap shows the patient experience responses from the social listening for each domain, against each UEC service. Scores range from 1 a strongly negative response, 3 a neutral response through to 5 a strongly positive response. As an example, continuity of care scores 2.4 for ambulance. 2.4 is a mid-range negative response.

In general, people seemed frustrated by a lack of care from the GP and wider health system and the requirement to 'resort' to accessing UEC for routine care. The rapid review identified a survey that showed more than one in three people (35.3%) are not getting the support they need to manage a long-term health condition in the community (Appendix 2).

Age, gender, income and geographical proximity influenced decisions to attend A&E, as did parental anxiety about an unwell child. The rapid review evidenced that parental anxiety was potentially driving inappropriate attendance to paediatric A&E and waiting times, with the potential to be turned away not acting as a deterrent.

The social listening exercise was inconclusive around what patients experience at their initial point of access. However, it showed that overall patient experience scores of UEC (UTC, A&E, GP, Ambulance, NHS 111) have been decreasing, with NHS 111 and GPs consistently scoring much lower than in previous years. The social listening report (Appendix 3) showed that the proportion of patient comments concerning UEC had quadrupled from 2018 from 2021 to more than 10% with the proportion of negative UEC-related experiences involving NHS 111 increased dramatically from 2.4% in 2018 to 10.4% in 2021.

# FINDINGS THEME 2: Preference for face to face or virtual

This theme explored people's preference for accessing UEC in person or via a virtual route, whether that was NHS 111, telephone, video consultations or other remote access.

**Reasons for not using digital services before**

The survey explored why people had not previously used a remote option for accessing UEC, as shown below:

***Why have you not previously used a telephone or internet-enabled device to access Urgent and Emergency Care services? Please select all that apply.***

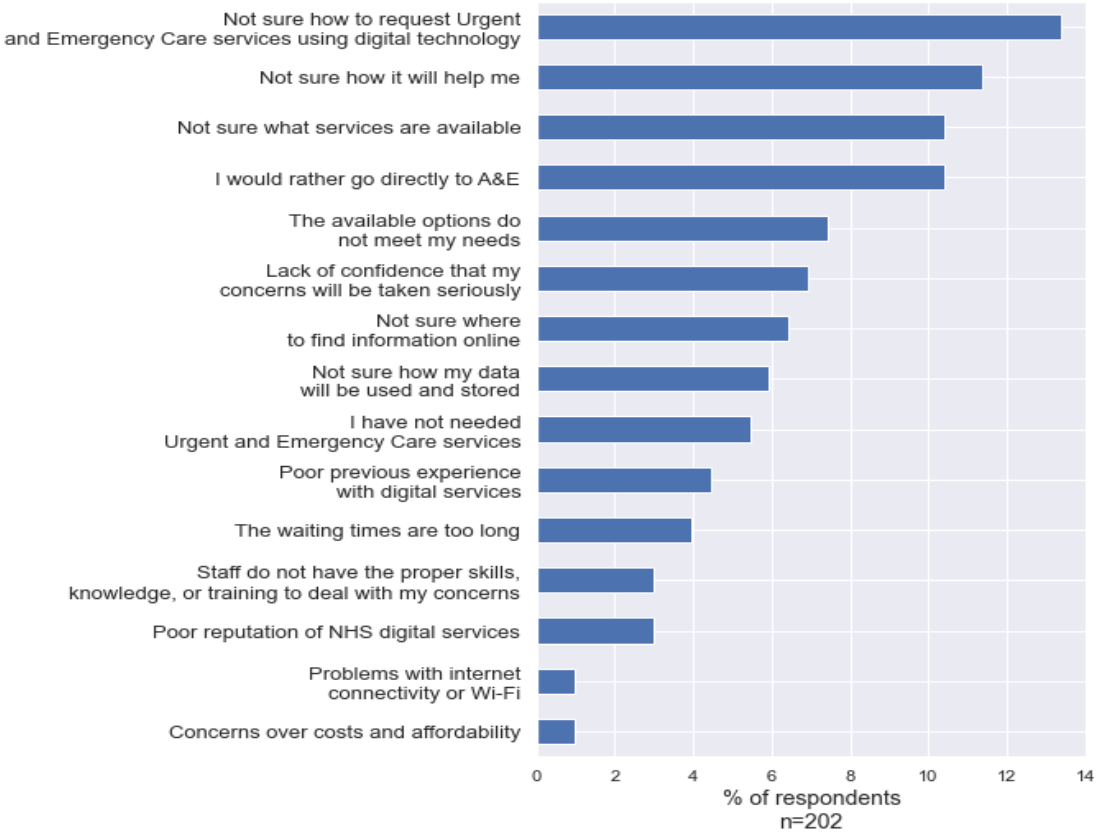



Figure 5: Responses to survey question

Respondents indicated that they **didn't feel they knew how to use the digital system** to ask for care and/or didn't understand the capabilities of a digital system to correctly acknowledge their request for care. Patients who reported a negative experience of UEC overall, were also less satisfied with digital access to UEC, and found digital channels more difficult to use.

There was also a high reporting of lack of understanding of the information governance and safety of the systems indicating a **lack of trust in virtual/digital services.** This feeling of 'distrust' was also demonstrated by the responses of some who felt reassured by face-to-face appointments over virtual appointments due to

concerns that parts of their care could be missed online, or incorrect advice or medication given.

> *"For urgent care, it doesn't work so well if you need reassurance which you get from face to face, not a chatbot."*
>
> *"I wouldn't feel safe taking medication that was prescribed without seeing a professional in person because it could make the situation worse – not necessarily the safest option."*
>
> *"I don't understand like it's the same sort of patients from before lockdown, same amount of people and how come after a long time all of a sudden our GPs are very busy and can't give you an appointment. It just doesn't make sense to me."*

There was feedback that there was **no communication of the reasoning behind virtual / digital services being offered** and why this was being offered instead of a face-to-face appointment. There was a difficulty for some to access the digital services identifying that they didn't have the skills or knowledge to access this.

**For less urgent and more routine appointments, people were far happier seeking information or advice virtually** as they were, in general, seen as the more convenient way access to treatment with shorter waiting times. For some types of treatment, participants identified that virtual appointments would be preferrable as they offered privacy over attending A&E / a UTC. However, the survey shows that for UEC, there was still a preference to attend A&E over a digital service.

> *"Certain things would be ok, like ordering a prescription would work lovely."*
>
> *"I have taken pictures for a mole and spoke to a doctor over the phone."*

**Lower and higher income groups (survey findings)**

For non-life threatening medical concerns, lower income respondents were far more likely to use their GP practice, NHS 111 telephone and walk-in centres than people with incomes above £25,000 (Figures 6 and 7).

People with a lower income preferred face to face medical care (being far more likely to use their GP practice or walk-in centre to get treatment), whereas higher income patients were happier with online services.

For life threatening medical conditions, responses from the two income groups were more similar (see Figure 8).

***Out of the following services, where are you most likely to seek help for a non-life threatening medical concern?***

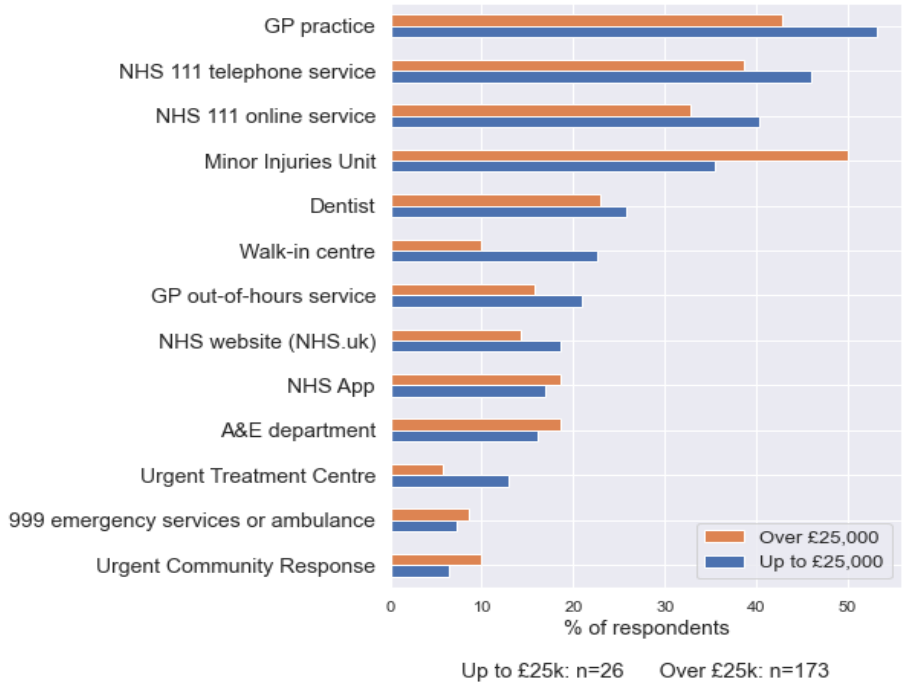



Figure 6: Responses to survey question

***For help with a non-life threatening medical concern, which of the following would you prefer?***

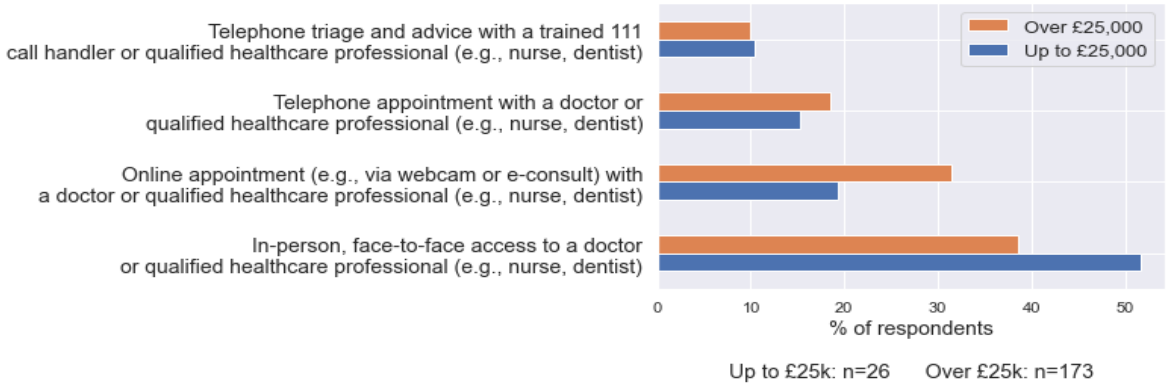



Figure 7: Responses to survey question

***Out of the following services, where are you most likely to seek help for a life threatening medical concern?***

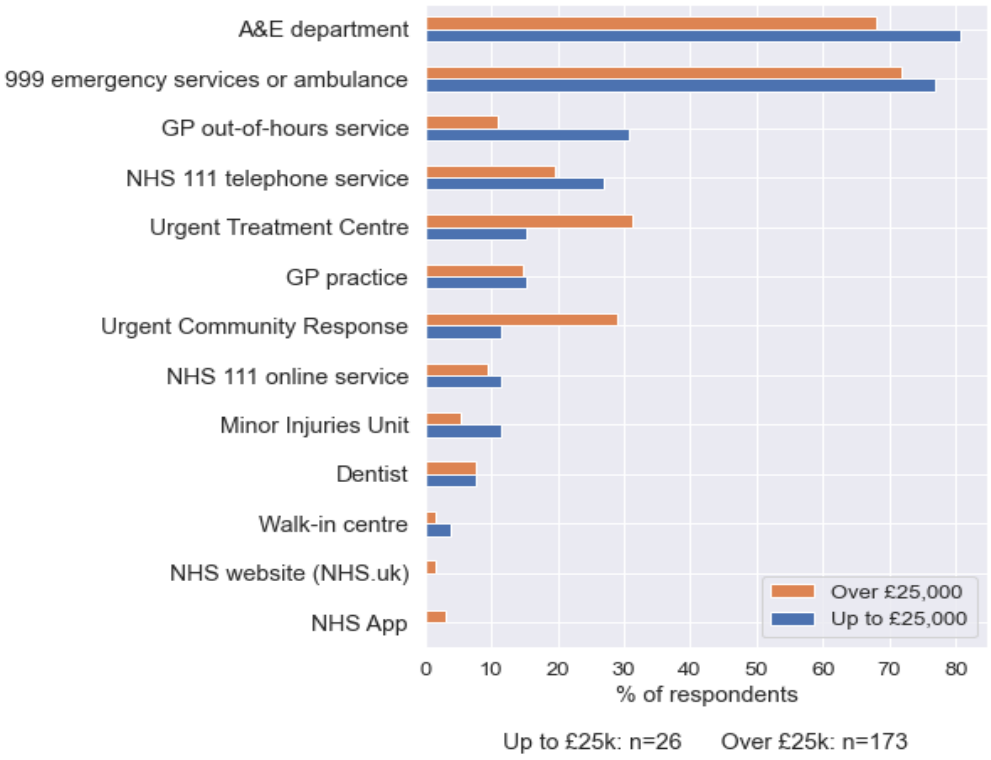



Figure 8: Responses to survey question

# FINDINGS THEME 3: Delayed or inappropriate referrals or advice

This theme sought to understand what advice people are receiving about where to go for UEC, and the impact of incorrect or delayed information on their experience.

It was reported that some people are being given inappropriate advice to attend A&E, by other health and social care services such as GPs, NHS 111 and care homes. In some cases NHS 111 advised patients to go to A&E, but on arrival they were deemed inappropriate and asked to contact their GP instead.

*"My friend went yesterday, she had a headache. I dropped her at A&E and they said she needs to go to urgent care, she had meningitis a couple of years ago so was worried. When she got to urgent care bit they said she needs to go back to A&E as they think it is meningitis."*

*"[I] felt I wasn't taken seriously, no referral and just discharged."*

**Communication**

As was found in theme 1 (initial point of access), patients felt that communication while waiting was important and that this provided reassurance. Patients wanted the correct information delivered in a timely fashion. If there had been **no communication or miscommunication, this negatively impacted** their experience:

*"I appreciate that there was a lack of staff available and the department were doing their best to cope but it has left me very nervous about my whole experience and my faith within the hospital. I also have no idea where to go today to get my eye checked it's appalling, the poor staff are tired, overworked and underpaid. While I appreciate it was busy it would have been courteous to be kept updated of waiting times."*

*"Attended A&E Sunday morning on advice from NHS 111. Made to queue outside in the cold before being sent to different entrance. Basic triage and initial tests reasonably quick, but with the usual need to explain the same info to every member of staff. What do all the uniforms mean? Who (if anyone) is coordinating my care? Then welcome to plastic chair hell. Hung on 7 hours waiting to be seen by a medic Why? Is it serious? Am I being admitted? How long is the wait? Nobody volunteered this information and when I asked I was fobbed off."*

Equally frustrating for patients were situations where they had to navigate different advice from NHS 111, A&E and Urgent Care Centres. The examples given below describe two patients' recent experiences of moving between services and receiving inconsistent advice.

**Patient 1:**

NHS 111 had advised a patient with excessive vomiting and stomach pain to attend the out of hours service at the local hospital. The patient was then advised by a GP to go home, however symptoms worsened so the patient attended A&E. A&E sent the patient back to the out of hours GP, who advised a return to A&E. The patient waited for nine hours to be seen before being treated with medication and sent home. The patient still returned to the GP after this point due to remaining unwell.

**Patient 2:**

A patient with a previous diagnosis of heart failure attended A&E with heart palpitations. They were triaged and an ECG were completed before being sent to the Urgent Care department. The patient was told the ECG was abnormal and that they should book a GP appointment.

# FINDINGS THEME 4: Digital

This theme further explored people's use of digital channels to access UEC, with particular attention paid to digital exclusion.

**Acceptability**

The research found that speed and convenience were shown to be the main reasons why some people preferred a digital route to care. For example, some found telephone and website contact to be easy, convenient and efficient. However, there were still some basic concerns over digital systems in the patient treatment journey and how it can sometimes add a barrier to care (such as slow, confusing GP booking systems). Some agreed that their needs might actually be better suited to a digital offer, for example in a non-emergency situation, seeing your GP, or for booking an appointment online. This indicated that digital systems were acceptable in some circumstances, but not in emergencies. There were mixed responses as to whether people trusted digital services, and there was a **general impression that a physical examination was needed to confirm a diagnosis**.

Most patients who used NHS 111 online used the symptom checker for an illness related issue and reported they found it very easy or easy to use and found the time it took to use it was about right. The feedback was that this online option was quicker than going through the script at 111.

A **lack of trust in and difficulty using digital services** were the two key barriers to engagement. Patients who reported a negative experience of UEC overall, also reported they were less satisfied with digital access to UEC, and found digital channels more difficult to use.

> *"If you are in an emergency, how do you get that across through a website."*
>
> *"Yes, I've done a lot of telephone consultations with the GP, we'll even still do them now, even though it's not COVID."*

While the focus of this research was UEC, survey respondents did not necessarily differentiate between a digital UEC service such as NHS 111, or a GP video consultation service. Rather they referred broadly to the digital health and care services that they were aware of. On this basis, of the digital services they would use again, survey respondents were most likely to use the NHS 111 telephone service, followed by the NHS 111 online service. They were least likely to use a GP video consultation service again.

***Which digital service(s) would you use again? Please select all that apply.***

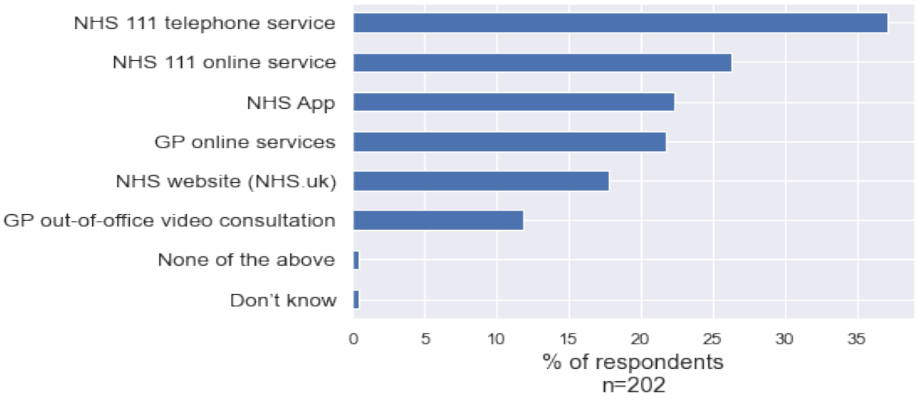



Figure 9: Responses to survey question

## Digital exclusion

There was **some acceptance that a digital offer is part of the future of health and care services, but concerns remained about using digital routes during an emergency**.

Barriers identified as being faced by specific groups included age, language, ethnicity and culture, lack of experience using computers, having a complicated medical history, and overall knowledge of how the NHS works. There was also a fundamental issue with access to the internet for some. It was noted that there is a lack of consistency in terms of which digital services are offered in which localities.

*"Mum, aunties and uncles wouldn't use a telephone or the computer as they don't speak much English."*

*"I've only been using a screen for the last two months, so I'll give it a go but when something goes bonkers, you feel totally inadequate."*

*"I've tried a smartphone but couldn't use it as my fingers won't register – because of Parkinson's."*

*"When it's not urgent I find that e-consult works well – especially since COVID it's clear that seeing someone in person means waiting."*

*"That online health service is great when you are ill, when you are in bed. And you get text reminders for appointments. Now I have moved and it has gone backwards, and you have to ring, and there's no text reminders."*

## Age

The survey showed that respondents over 55 are more likely to have found digital services easy to use than patients aged under 55. Patients over 55 were also shown to be more likely to have had a good experience of digital UEC services with very few showing any issues with connectivity, affordability, or technical skill.

## Lower and higher income groups

Both income groups reported having used telephone or internet-enabled devices to access UEC, and had access to similar technology, but higher income groups unsurprisingly had greater access to iPads and smart devices.

Lower income patients preferred to go straight to A&E than use digital UEC and more frequently selected reasons for not using digital services as a lack of trust or low confidence. Higher income patients were more likely to use digital services than attend A&E, this may be due to the higher level of accessibility using smart devices.

## Utilising digital apps in other ways

While the focus of this project was on UEC, there were a number of findings about non-UEC which have been included in the report for completeness. The rapid review (Appendix 2) showed that large numbers of people would like digital systems to be a route to treatment in general. 49% of people believed that doctors should be able to prescribe digital health apps (which usually charge the customer on purchase) in the same way they prescribe medicines as this would enable the patient and ultimately save the NHS money.

# FINDINGS THEME 5: Connections

This theme explored how well and how often information was shared between staff, particularly when patients accessed multiple UEC services as well as primary care.

**Information sharing**

In general, people want to be kept informed of their treatment plan, and to be assured that there would be a follow up after the UEC incident. Patients expected clinicians to share information about their needs for this to work well but it was identified that **information sharing between clinicians was felt to be lacking**.

Similarly, it was felt there should be effective communication between services, associating this with improved treatment and overall experience; a poor connection between services can and has led to negative experiences for patients. The social listening exercise showed that poor continuity of care is a significant irritation for patients. It showed that there was a feeling that there could be improvement specifically in the sharing of information between NHS 111 and the next stage of a patient's treatment.

*"Have been on the NHS111 today with my symptoms, not only did they diagnose and reassure me, they even phoned my local chemist to sort out a complicated prescription after our local Boots had cancelled it! (She told them off!) Pamela from NHS111 is my hero!!! #forevergrateful."*

*"Worse than a waste of time, with a broken wrist and ribs, I was told an appointment with A&E had been made for me in 4 hours time. A&E had no record of this at the hospital concerned and I was too ill by then to stay to be seen...in pain and in shock. Went back the next day to be told management of my wrist would be much more difficult now. Thanks 111, you are there to block, not advise."*

Conversely, some participants felt that **repeating their story to clinicians and other services is a necessary part of ensuring effective and accurate treatment** is given.

As has been identified in the other theme findings, good communication that keeps patients informed can help mitigate the negative effects of a long wait. However, it was understood that capacity constraints of services were a key reason why communication might not be prioritised.

*"In an ideal world yes the message would have gone through, but I wouldn't have expected anything because it's unrealistic. So much changeover with nurses and doctors running a million miles an hour."*

*"When I went to the A&E with my son, they were supposed to send us to the children's centre, but they took the name down wrong, and then left us in adult care. but that's what happens when things get hectic and busy."*

# Conclusion and recommendations

This research focused entirely on patient and public perspectives, using a range of novel methods to engage with less heard groups, and elicit their views. Through focus groups, interviews, a survey, a rapid review of the literature and social media analysis, it has provided rich insights into people's day-to-day experience of UEC.

The first step in writing the recommendations was to present the key findings to a workshop attended by the Digital UEC, UEC Strategy and Policy teams. The presentation was structured as:

- What we confirmed
    - Overall, effect of COVID and regional variations
    - Quality, what makes people happy and unhappy
    - Awareness of services

- What we explored
    - Experiences
    - Digital acceptability

The findings can be summarised into a striking summary, which was shared at the workshop:

**To make people unhappy give slow access.**
**To make people happy give effective treatment and emotional support.**
**Even better if you keep them informed.**

Our recommendations are based on the workshop discussions - building on the findings, particularly the difference in awareness and needs from various groups of the public and addressing the general confusion of what specific UEC services are for, beyond A&E and GP. All in an aim to support patients to access the services they require, in the most efficient way possible.

**Recommendations:**

1. Identify which patient cohorts would benefit from focused communications on the digital offer, and target communications campaigns to them. Of particular note was the benefit of illustrating the offer with stories of patients who have successfully accessed the help they needed to build confidence and trust in these provisions.

2. Share more information with NHS and social care colleagues on what the digital offers are. Staff will be better able to signpost to alternative UEC services that are better placed to treat patients. Building this awareness of digital access routes may also encourage a better understanding for those patients who may have been sent to a service, A&E for example, when they may have been directed to do so by 111.

3. Continue to share this gathered insight with teams through a communications campaign including podcasts. In addition, particular consideration should be given to ensure the findings are reflected in ongoing patient engagement and planning in the wider NHS including Integrated Care Boards (ICBs) and through patient advocacy groups.

4. While the focus of this project was on UEC, the public do not recognise the NHS-driven boundaries of services that may be in or out of UEC. Sharing these insights widely may help teams to consider access in to and out of UEC from the patient's perspective. Recognising that patients are less concerned about adherence to targets and may not always clearly identify where their treatment starts or ends, which may impact their impression of ongoing care.

# Appendices

**Appendix 1:** Consortium membership

**Appendix 2:** Rapid Review Report

**Appendix 3:** Social Listening Report

**Appendix 4:** Focus Group Personas

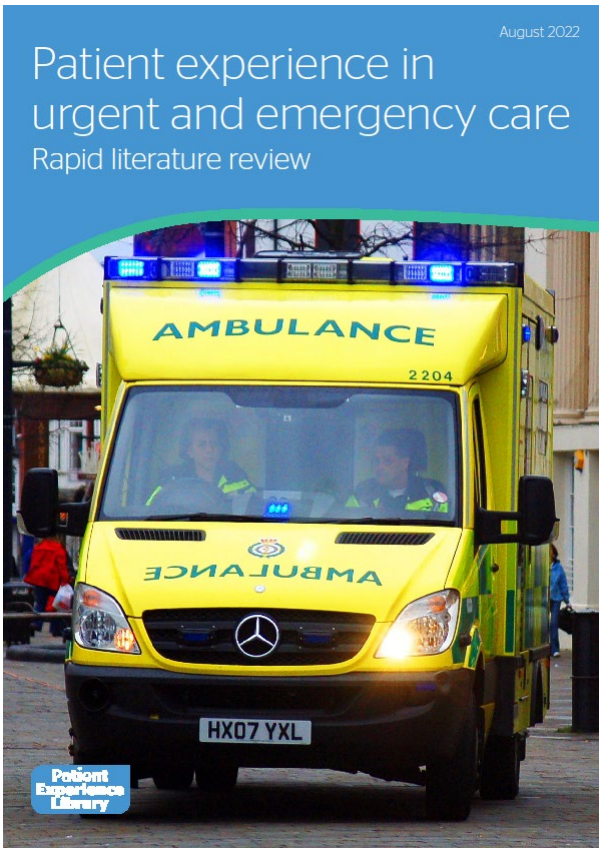
**Appendix 5:** Survey Analysis

# Appendix 1: Consortium membership

The partner organisations working alongside Eastern AHSN were:

- Patient Experience Library, a social enterprise which catalogues and reviews patient experience evidence
- Traverse, a social purpose consultancy offering expert research, evaluation, engagement, and advisory services
- PEP Health, a patient experience platform using machine learning to combine online feedback in real-time with data from other NHS sources; and
- Ethnic Opinions, a specialist in recruiting diverse individuals for fieldwork and research.

# Appendix 2: Rapid Review by Patient Experience Library



# Appendix 3: Social Listening Report by PEP Health

# Appendix 4: Focus Group Personas by Traverse

# Appendix 5: Survey Analysis by PEP Health