NHS Patient Survey Programme

# 2016 Emergency Department Survey

## Statistical release

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Independent data analysis

# Contents

# Summary of findings

For many people in an urgent health crisis, the first place they will go to seek help is their local emergency department or urgent care service. By understanding what this care is like from the point of view of the people who receive it, we can gain a picture of the quality of services across England.

Although surveys of emergency departments have been carried out previously, we cannot compare them with the results from the 2016 survey due to changes to the sampling and analysis strategies.

The focus of this report is mainly on the experiences of people who attended a Type 1 department (a major 24-hour department that is consultant-led). However, for the first time, in 2016 we also surveyed patients who had used a Type 3 department (typically a minor injuries unit or urgent care centre) run by an acute NHS trust.

The results for Type 1 and Type 3 services need to be considered separately. This is because of the different case-mix that these departments handle, as patients present with different severity of conditions: we would expect people attending a Type 3 department to be less seriously unwell. There are also different types of staffing and facilities involved. In addition, the survey only included Type 3 departments for which the acute trust had direct responsibility.

## Type 1 departments: summary of results

Emergency department services are working under increasing pressure, and facing increasing challenges, with the number of attendances rising every year. This is reflected in the Care Quality Commission report The state of care in NHS acute hospitals: 2014 to 2016, which highlights how hospitals are facing rising demand coupled with economic pressures.

In recent years, there have been a number of changes to the way urgent and emergency care is organised, aimed at reducing pressures and demand on major (Type 1) services. These changes are a commitment in NHS England's Five Year Forward View and are still ongoing. The main thrust of most recent policy is a desire to encourage non-urgent patients to seek alternative services where possible, for example, by providing advice services such as NHS 111 to sign post people to appropriate services. Over half (58%) of the respondents in this survey said that the emergency department was the first place they went to, or contacted, to get help for their condition. Of the respondents who had contacted another service before the emergency department, most had contacted their local GP (33%), called NHS 111 (23%) or called 999 (19%). Almost three quarters (76%) said that they then went on to attend the emergency department because they were either referred there, or taken there, by the first service they contacted.

## Positive results

Patients were generally positive when answering questions about their interactions with staff. For example, most people said that they: 'definitely' had enough time to discuss their health or medical problem with a doctor or nurse (73%), 'definitely' had confidence and trust in the doctors and nurses examining and treating them (75%) and that the doctors and nurses 'definitely' listened to what they had to say (78%). Most people also said that they felt they were treated with respect and dignity 'all of the time' (78%).

It is easier to involve people in their care when they have enough information and there is clear communication. Most people felt they received the 'right amount' of information about their condition or treatment (77%), and that if they had any tests, a member of staff 'completely' explained why they needed the tests in a way they could understand (76%). Eighty-one per cent said they did **not** receive contradictory information from different members of staff.

Over four-fifths of respondents (82%) said that they 'definitely' had enough privacy when being examined or treated.

## Areas for improvement

There were less positive results for questions asking about receiving timely pain relief, emotional support, and information provision when leaving the emergency department.

Of those respondents who were in pain and who requested pain relief, 29% waited over 15 minutes before they received this, and 7% said they did not receive pain relief at all.

Sixteen per cent of respondents who had anxieties or fears about their condition or treatment said that a doctor or nurse did **not** discuss these with them, while 27% felt staff had discussed this 'to some extent'. Of those who felt distressed while they were in the emergency department, less than half (48%) said that a member of staff 'definitely' helped to reassure them.

Respondents who were not transferred to another hospital or a nursing home were asked about the information they received to support self-care when they were discharged. Less than half said they were 'definitely' told when they could resume their usual activities, such as when to go back to work or drive a car (44%), and 47% said they were 'completely' told about any danger signals regarding their illness or treatment to look out for after leaving the emergency department. For those who were prescribed any new medication, less than half (45%) said a member of staff 'completely' told them about side effects to watch for.

For some people, staff need to take into account their family or home situation when they leave hospital. Of the respondents who felt this was necessary, over two-fifths (45%) said this did **not** happen.

Over a quarter of respondents (27%) said they were **not** told who to contact if they were worried about their condition or treatment after they left the emergency department.

### How experiences vary for different patient subgroups

Analysis of the experiences of different subgroups of patients showed that, generally, older respondents reported more positive experiences. However, people had poorer experiences if they had previously attended the same emergency department for the same condition within the last week, or if they self-reported a having a mental health condition.

Poorer experiences for people who self-report as having a mental health condition is consistent with the finding found in other NHS patient surveys, including the findings from the 2016 acute inpatient survey.

## Type 3 departments: summary of results

Almost two-thirds of respondents who had used a Type 3 department (65%) said this was the first place they contacted or visited for help with their condition.

Responses were generally positive across many of the questions, particularly those concerning interactions with staff. For example, a large proportion of respondents felt they were always treated with dignity and respect (86%), they 'definitely' had enough time to discuss their health problem with a doctor or nurse (81%) and 'definitely' had confidence and trust in those examining and treating them (80%).

Responses were also generally positive for questions that asked about providing information. For example, 78% of respondents said that while they were in the department, a doctor or nurse 'completely' explained their condition and treatment in a way they could understand, and 84% were given the 'right amount' of information about their condition or treatment.

Three-quarters (75%) rated their overall experience as '8' or above on a scale of 0-10 (where 0 is 'I had a very poor experience' and 10 is 'I had a very good experience').

# Introduction

## Urgent and emergency care services

For many people in an urgent health crisis, one of the first places they will go to seek help is their local emergency department or urgent care service.

Urgent and emergency care is a complex system with departments divided into four different types of services, which provide different levels of care:[1]

**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.**

Other sources of urgent care and advice include out-of-hours GP services, community pharmacies, mental health crisis care and NHS 111 services.

## Terminology used in this report

There are many different terms used to describe urgent and emergency care services and it is important to be clear which type of service is being referred to. In this report, we use the following terminology based on information from NHS Choices.[2]

**Emergency department -** may also be known as 'A&E' 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 walk-in 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 the Emergency Department Survey

This survey is part of a wider programme of NHS surveys, which covers a range of topics including adult inpatient services, children and young people's inpatient and day-case services, community mental health services and maternity services. To find out more about the survey programme and to see the results from previous surveys, please see website links in the further information section (Appendix F).

Although surveys of emergency departments have been carried out previously, results from the 2016 survey are **not comparable** with these because of changes to the sampling and analysis strategies. These changes include a change to the sample month, a change to the scope of the survey (to include Type 3 departments) and a change to the weighting methodology. For more detailed information please see Appendix A.

The 2016 survey of people who used emergency department services involved 137 NHS trusts. People aged 16 and over were eligible to participate if they attended a Type 1 or Type 3 service[a] provided by the trust between 1-30 September 2016. For Type 1 services, we received responses from more than 41,000 people, a response rate of 28%. For Type 3 services, we received responses from more than 3,500 people, a response rate of 25%.[b]

Previous surveys focused solely on **Type 1** departments. For 2016, to reflect recent changes in the provision of urgent and emergency care, the survey was expanded to also include people who attended **Type 3** departments that are provided directly by the acute trust.

The survey included 49 trusts with both a Type 1 and a Type 3 emergency department and 88 trusts with only a Type 1 emergency department.

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 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 180 Type 3 and 4 urgent care services, which means the survey has included around a quarter of these.

Local provision will affect the case-mix seen at a Type 1 department. While 88 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

[a] 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.

[b] 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.

services outside of the scope of the survey, such as walk-in centres (Type 4), a minor injuries unit or urgent care 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 more seriously ill or injured patients in its Type 1 department, and have far 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 when interpreting trust level results published on CQC's website.

Two weights were applied to the survey results data: a trust weight to ensure that each trust contributes equally to the England average, and a population weight, to make sure that each trust's results are representative of their own sample and do not over-represent groups such as older respondents. For more information please see appendix A and the Quality and Methodology report.

Appendix A provides more information on the survey methodology. This covers the development of the survey, the analysis of results, and comparability with previous surveys. Detailed information on the limitations of the data is provided in the Quality and Methodology Report.

The survey collected basic demographic information from all people who took part, available in the 'About the respondents' section within the open data published on CQC's website. Looking at the respondents who had visited a Type 1 department: more females (55%) responded to the survey than males (45%).There were more responses from older people aged 51-65 (25%), 66-80 (32%) and 80+ (17%) than from younger people aged 16-35 (12%) and 36-50 (14%). Most respondents were from the White ethnic group (94%) and described themselves as heterosexual or straight (93%). Over half (52%) had a long-term health condition.

# Background to the emergency department survey

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

## The importance of people's experiences

There is a wealth of research about what matters to patients, which has shaped recent policy. The importance of a positive patient experience is increasingly recognised both by the NHS and within government health policy.

Research, including that undertaken in the development work for the NHS Patient Survey Programme, has identified many aspects of care that are important to people who use services. These include being kept informed and offered options about care, being listened to and having enough time with staff, and being involved in their own care.[3]

The NHS Constitution (2012, updated in 2015) committed the NHS to encouraging feedback from patients to improve services.[4] The NHS Outcomes Framework (first published 2013/14) sets out high-level national outcomes that the NHS should be aiming to improve, and includes a focus on the need to ensure that people have a positive experience of care.[5] This emphasis on good quality patient experience continued in The Five Year Forward View (2014),[6] which made a commitment to enabling people to have greater control of their own care, and the NHS Mandate 2016 to 2017, where patient experience is cited as an integral part of service quality.[7]

People's experiences are shaped by the care they receive. The NHS National Quality Board published the NHS Patient Experience Framework (2012) to highlight important elements of patient experience.[8] 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. The Emergency Department Survey questionnaire covers all these areas.

The National Institute for Health and Care Excellence (NICE) has also issued important guidance, which states that all providers should take into account patients' needs and preferences, and enable people to make informed decisions about their care and treatment.[9] NICE also published Quality Standards for Patient Experience in Adult NHS Services (2012)[10], which provides trusts with evidence-based statements that will help them to meet this guidance and ensure a positive patient experience.

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.[11] A review of academic research has also confirmed the positive association between patient experience and clinical outcomes.[12]

Involvement in care is made easier by shared decision-making, which in turn is enabled by providing clear communication and information. Shared decision-making is seen as key to improving patient experience. The NHS Constitution pledges to ensure that patients are offered information that is easily accessible, reliable, relevant and in a form that can be understood. This principle has become embedded in recent healthcare policy and involving people in their care is now enshrined in law. The Health and Social Care Act 2012 states that those who commission services must promote and facilitate the involvement of patients and carers in decisions about their care and treatment.[13] To achieve this, NHS England called for transformational changes, to embed shared decision making at different levels, including relationships between patients and staff, and in the commissioning of services. The Department of Health's NHS Mandate for 2016/17 includes an objective that the NHS becomes better at involving patients and carers.

## Health inequalities

Collecting demographic data within the survey supports our ability to look at differences in experiences for different groups of patients. The Department of Health's NHS Mandate for 2016/17 includes a goal to reduce inequalities in people's experience of the health system.

Analysis by the Care Quality Commission has found that certain groups are less likely to feel involved in their care. These include people with long-term conditions, young people (18 to 24 years), the oldest age groups (over 75 years), and people using health and adult social care services in the community, including mental health care and their GP.[14]

The Five Year Forward View for Mental Health highlights the close link between mental and physical health conditions.[15] People with severe mental health conditions have a lower life expectancy, and people with long-term physical health problems who develop a mental health condition can suffer more complications. Objective 6 of the NHS Mandate for 2016/17 pledges that people with a mental health condition should receive better quality care at all times.

There is a greater focus in government policy on achieving 'parity of esteem' between mental and physical health, which is the ambition that mental health should have the same priority, and quality of services, as physical health. No Health Without Mental Health[16] made explicit the government's objective to give equal priority to mental and physical health, stating "….*we are clear that we expect parity of esteem between mental and physical health services*".

Despite this, there is some evidence that people with a mental health condition have poorer experiences of healthcare services. In 2015, the Care Quality Commission reported that "*….there is a distinct gap between people's [with a mental health condition] perceptions of how they are treated by staff working in accident and emergency (A&E) departments and specialist mental health services compared to other services*."[17]

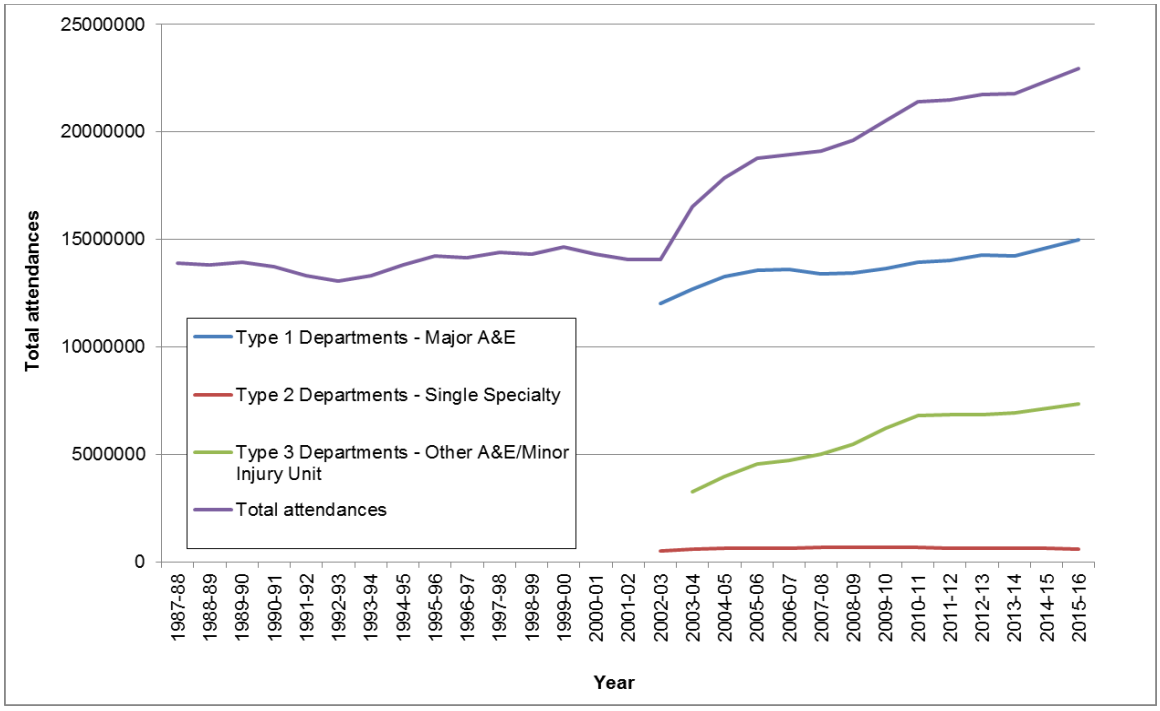
## Urgent and emergency care policy context

### Increased demand

Urgent and emergency care services are working under increasing pressure, with attendances rising every year.

Statistics published by NHS England show that annual attendances increased by around 5.1 million (28%) between 2004/05 and 2015/16 (figure 1). Type 1 attendances increased by around 1.7 million (13%) over the same period.[18]

**Figure 1: Emergency department attendance 1987/8-2015/16**




**Source:** NHS England
www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/statistical-work-areasae-waiting-times-and-activityae-attendances-and-emergency-admissions-2016-17/

In 2016, there were 23.57 million attendances at England's urgent and emergency care services, of which 65% were at a Type 1 department and the remainder were at minor injuries units, walk-in centres (Type 3 or Type 4) and single specialty facilities (Type 2).

The Care Quality Commission highlighted how hospitals are facing rising demand coupled with economic pressures.[19] In particular, hospitals are facing an unprecedented demand for emergency department services, with a third of trusts

issuing alerts in December 2016, warning that they needed urgent action to cope with the pressure of patient numbers. Despite such challenges, CQC found some organisations are able to deliver high-quality care.

## Use of urgent and emergency care

According to data published by NHS digital on hospital accident and emergency activity 2015-16, the demographic profile of people attending has remained relatively stable.[20] In 2015-16, 49% of attendances were for male patients and 50% were for female patients. Ten per cent of all attendances were for children under the age of five and over a quarter of all attendances were for patients aged between 20 and 39.

The report also notes that there has been little change in patterns of day and time of attendance. Monday is the busiest day, with more attendances than any other. In terms of time of day, there is a peak in activity between 9am and 12pm every day, (particularly pronounced on Mondays) and a smaller but distinct peak in activity between 4pm and 6pm on weekdays.

## Changes to the provision of urgent and emergency care services

Over the years there have been a number of reviews of urgent care and policy recommendations for service changes – all of which were aimed at improving access to, and delivery of, urgent care. The most recent drivers for change come from the review of the NHS urgent and emergency care system in England (2013)[21] and the Five Year Forward View, both of which aspire for a redesigned system that is easier to understand. The urgent and emergency care system is therefore still evolving.

In response to growing concerns about pressures facing Type 1 emergency departments, the NHS Medical Director, Professor Sir Bruce Keogh, undertook a review into how urgent and emergency care services in England are organised, which reported in November 2013. The report sets out a vision for a new system to help ensure that people can have quick access to high-quality, urgent care in an appropriate setting. It highlighted five key elements for change needed to achieve this:

1. To provide better support for self-care.
2. To help people with urgent care needs get the right advice in the right place, first time.
3. To provide highly responsive urgent care services outside of hospital, so people no longer choose to queue in A&E.
4. To ensure that those people with serious or life-threatening emergency care needs receive treatment in centres with the right facilities and expertise, to maximise chances of survival and a good recovery.
5. To connect all urgent and emergency care services together, so the overall system becomes more than just the sum of its parts.

The Five Year Forward View sets out NHS England's strategy for the NHS and outlines five new models of care.[c] For urgent and emergency care, the new model aims for better integration between urgent and emergency care services (such as A&E departments, GP out-of-hours services, urgent care centres/minor injuries units and, NHS 111) to help prevent unnecessary attendance at Type 1 departments. The improvement and reform of urgent and emergency care includes a series of initiatives, including vanguard sites, which are testing new models of care. At the time of writing, there are 50 vanguards in total, of which eight are urgent and emergency care.[d]

Next Steps on the NHS Five Year Forward View sets out how these goals will be implemented.[22] For example, by simplifying the range of services patients can attend with an urgent health issue and making urgent care an integral part of local services.

In response to these policy drivers, in recent years there have been a number of changes to the way urgent and emergency care is organised aiming to encourage non-urgent patients to seek alternative services to Type 1 departments. NHS 111 was established in 2013 to try to simplify the process by providing advice on the appropriate service to access. To help divert less urgent cases away from Type 1 departments, people are encouraged to seek help from alternative services including minor injuries units (MIU), urgent care centres (UCC), walk-in centres or out-of-hours GP services.

### Navigating the urgent and emergency care system

These changes mean that there is a great deal of variation in how urgent and emergency care services are organised and delivered in England (see for example the Primary Care Foundation, 2012).[23]

While some acute trusts provide only major (Type 1) emergency 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 the emergency department 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 the emergency department, or receiving advice, for example through NHS 111. There is also variation in who provides the services: urgent and emergency care can be provided by other types of trusts (such as a community trust) by clinical commissioning groups (CCGs)[e] or by independent companies.

As the number of additional urgent and emergency services has grown, research has shown that that this presents additional complexity to the decision-making process regarding the appropriate services to use. For example, in 2015, the GP Patient Survey reported that only just over half of respondents (56%) said they knew who to contact out of hours.[24] People may not be aware of these

c The other four cover: Integrated primary and acute care systems, multispecialty community providers, enhanced health in care homes and acute collaborations.

d Vanguard sites are listed on: www.england.nhs.uk/ourwork/new-care-models/vanguards/care-models/uec/.

e. For more information on CCGs see for example: www.nhscc.org/ccgs/.

alternatives, unable to determine the severity of their condition, or may be unable to decide which service to use. Faced with a number of different service options, people may default to a major A&E department; which the Urgent and Emergency Care Review phase one report suggests is a known and trusted 'brand' to the public. Some evidence suggests that urgent care centres are not effective in reducing attendances at Type 1 departments except when they are co-located and integrated with A&E departments.[25]

This confusion has prompted NHS England to commit to introducing a standardised new system of urgent care called urgent treatment centres. It proposes that they will be GP-led and open 12 hours a day, and that 150 of these will be rolled out by December 2019.

## Waiting times

For many years, access to, and performance of, NHS urgent and emergency care services has been measured by waiting time targets or standards. The various associated statistics are published in slightly different ways by different organisations: NHS England publishes monthly situation ('Sit Rep') reports for attendances and admissions based on aggregated data submitted by providers. NHS Digital publishes data from a different source, Hospital Episode Statistics (HES), based on patient level data and enabling more detailed analysis.[f] Statistics are also published by trusts themselves.

These targets or standards have always had a high profile, attracting both media attention, and being the subject of numerous research and policy papers, some of which we discuss in this section.

The use of targets or standards to monitor waiting times was set out in the NHS constitution (first published in 2009 and updated in 2013 and 2015), which included a commitment for "…..*a maximum four hour wait in A&E from arrival to admission, transfer or discharge*". Over time, there have been some changes in both definition and how this is measured.

Historically this commitment was measured by a four-hour waiting time standard. This was first committed to in the NHS Plan in 2000 and in 2004 the Department of Health introduced a new standard by stating that at least 98% of patients must been seen, treated, discharged or admitted within four hours of arrival. In May 2011, to enable a more comprehensive picture, the Department of Health announced that the four-hour standard would be replaced by a set of clinical quality indicators, and that the operational standard would be changed from 98% to 95%. These indicators were set out in the Operating Framework for the NHS in England 2011/12.[26] Data from these indicators is published by NHS Digital[27] and should also be published by trusts themselves, to help them monitor performance, improve the quality of care, and to provide information to commissioners and the public. Indicators covering waiting times are:

f. NHS Digital advise that Sit Rep data should be used in preference to HES for information that is held in both data sets, such as total attendances. There will be differences between the two collections due to Type 3 departments submitting to Sit Reps but not to HES.

- **Time to initial assessment:** this applies to patients arriving by ambulance only and is the time from arrival to assessment by medical staff. Good practice is for people to be seen within 15 minutes.
- **Time to treatment:** is the time from arrival to the time when a patient is seen by a clinical decision-maker who can diagnose the problem, decide the plan for the patient and start or arrange treatment if required. Good practice is for people to be seen within one hour.
- **Total time spent in the A&E department:** is the time from arrival to the time the patient leaves by admission to hospital, transfer or discharge. It is expected that 95% should be spend four hours or less in the A&E department.
- **Unplanned re-attendance rate:** people who return to A&E within seven days of the original attendance are classed as an unplanned attendance if they have not been specifically asked to re-attend. Good practice is for this to be less than 5%.[28]

The operational standard that 95% should spend four hours or less in the emergency department continues to be committed to in the NHS Mandate for 2017-18 and applies to all department types.

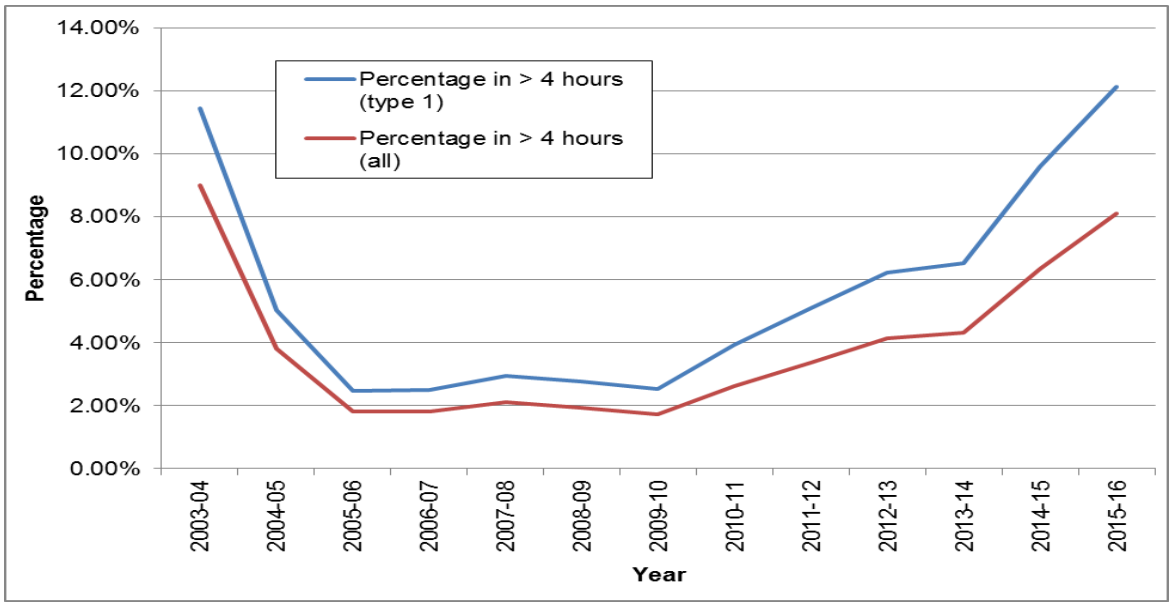
In December 2016, NHS Improvement announced another review of how performance will be measured and that a new 'scorecard' will capture a broader perspective including clinical and patient experience data. Despite some media speculation to the contrary[g], the four-hour standard is expected to remain.[29] At the time of writing, no further information regarding implementation was available.

With a continued rise in attendances, the NHS has struggled to meet this standard recently. The proportion of people waiting more than four hours dropped with the introduction of the waiting time standard in 2004. The relaxation of the threshold from 98% to 95% and the change to clinical indicators in 2011 saw a gradual increase in patients waiting more than four hours. The proportion of patients not admitted, discharged or transferred within four hours has increased substantially since 2014, and peaked in the winter of 2015/2016 (figure 2).

However, the length of time people spend in urgent and emergency care services depends on the type of service they visit. While Type 2 and Type 3 services usually treat people in less than four hours, major (Type 1) departments who deal with higher numbers of attendees and more serious cases, find it harder to achieve the four-hour target.[30]

[g] See for example: www.bbc.co.uk/news/health-38563742

**Figure 2: Percentage waiting more than four hours 2003/4-2015/16 (all department types)**




**Source:** NHS England
www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/statistical-work-areasae-waiting-times-and-activityae-attendances-and-emergency-admissions-2016-17/

In March 2017, NHS England and NHS Improvement wrote to the providers of emergency department services to describe the key actions that they need to take to get performance back on track. The letter identified three consistent themes: difficulties in discharging inpatients when they are ready to go home; rising demand coupled with the fragmented nature of out-of-hospital services unable to offer patients adequate alternatives; and complex oversight arrangements between trusts, CCGs and councils. The letter asks providers to take action to: free up hospital beds, manage demand at Type 1 departments by providing urgent care services, and to recover performance to achieve the 95% waiting time standard by March 2018.[31]

Research into the rise in waiting times suggests a number of reasons may interact. A report from Quality Watch identifies several reasons, including: the need to increase capacity and staffing, overcrowding at peak times, the need to improve efforts to divert less urgent cases from Type 1 departments, temperature extremes (in summer and winter) and an increasing and ageing population with related increase in long-term conditions.[32] A report from Monitor, which looked particularly at declines in performance against this standard in 2014/15, found that hospitals were struggling to cope with increased emergency admissions due to high bed occupancy rates, which reduced flow through the system.[33] This, in turn, means that patients in emergency departments are not able to progress through the system. Other explanations include increased pressure because people attend a Type 1 emergency department when they should go somewhere else, for reasons such as a lack of GP appointments or out-of-hours services.[34] NHS England estimate that up to three million people who go to a Type 1 department each year could have their needs addressed elsewhere in the urgent care system.

## Integrated care

The Royal College of Physicians and the Care Quality Commission have both recently called for recognition that the four-hour standard is also a measure of how well the system is working as a whole. In The State of Care In NHS Acute Hospitals, the Care Quality Commission found that "*……on some of our inspections, we have found a cultural barrier between the A&E and the rest of the hospital, with the 'door' into the main hospital acting as much a cultural as a physical barrier*." A challenge is to achieve more effective integrated care, both with other departments within the hospital and the wider health and social care system. The report also notes that the physical environment of many emergency departments is a concern, with many built at a time when demand was much lower, and are now unable to cope with increased numbers.[35]

## Staffing

Ensuring that NHS hospitals are staffed with the appropriate number and mix of clinical professionals is vital to deliver high-quality care and to keep patients safe from avoidable harm.[36]

The Care Quality Commission's report on acute hospitals also reported that some trusts are having difficulty recruiting the specialist staff they need for their urgent and emergency services.

# Results from the survey

This section presents the results from the 2016 Emergency Department Survey, and explains how to interpret them.

Although surveys of Emergency Departments have been carried out previously (in 2003, 2004/5, 2008, 2012 and 2014) results from the 2016 survey are **not comparable** with these because of changes made to the sampling and analysis strategy. For more detailed information please see Appendix A.

The results focus on the experiences of people who attended a Type 1 department. It is not appropriate to compare the results for Type 1 and Type 3 departments directly. This is because the two populations are very different in terms of the case-mix as patients present with different severity of conditions: we would expect people attending a Type 3 department to be less seriously unwell, therefore the services provided are different, as well as the types of staffing and facilities. The survey also does not have full coverage of all Type 3 departments as it only included departments run directly by the acute trust. The results for Type 3 departments included in the survey are therefore summarised separately in section 11 of this report.

The figures shown are the evaluative responses to a question. Responses such as 'don't know / can't remember' are not included in the percentages. We included these options in the set of responses to allow someone to respond to the question if they could not remember or did not have an opinion, to distinguish those reasons from all others and to avoid people making a 'best guess'.

We also excluded responses that indicated that a question is not relevant to a respondent. For example, Q7 asks: "Were you given enough privacy when discussing your condition with the receptionist?" Responses of "I did not discuss my condition with a receptionist" were not included in the results.

Results are presented in the order in which they appear in the questionnaire and follow the patient's journey through the emergency department from their decision to attend, what happened while they were there, and what happened when they were discharged.

Results for all questions in the 2016 survey are published in the open data section on the CQC website.

The Equality Act 2010 requires that public bodies have due regard to the need to eliminate discrimination and to advance equality of opportunity and foster good relations between people who share certain protected characteristics and those who do not. The protected characteristics are: age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation. The Act provides an important legal framework, which should improve the experience of all patients using NHS services. We therefore also include analysis looking at the experiences of different patient subgroups. We present these findings throughout the report, and provide a full summary of results in section 10.

The analysis modelled the mean scores of different subgroups (age, gender, religion, sexual orientation, ethnicity, long-term conditions, attendance time, attendance day and whether they have attended the emergency 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. For more details on the analysis method please see Appendix A).

# 1: Arrival at the emergency department

## Deciding to go to the emergency department

In recent years, there have been a number of changes to the way urgent and emergency care is organised, to try to reduce pressures and demand on major (Type 1) departments, and these changes are ongoing. The most recent policy changes aim to encourage non-urgent patients to seek alternative services, where possible. The Five Year Forward View has an emphasis on ensuring that patients access services that are appropriate for their needs, rather than only using traditional (Type 1) departments.

The questionnaire therefore included a number of questions to try to understand whether people sought help from other services before they arrived at the emergency department.

Over half (58%) of respondents said that the emergency department was the first place they went to, or contacted, for help with their condition. This means that less than half (42%) had contacted another service first.

Of those respondents who had contacted another service first, the most common responses were that they had contacted their local GP (33%), called NHS 111 (23%) or called 999 (19%). Most said that they then went on to attend the emergency department because the service they contacted either referred them or took them there (76%), or because their condition became worse (19%).

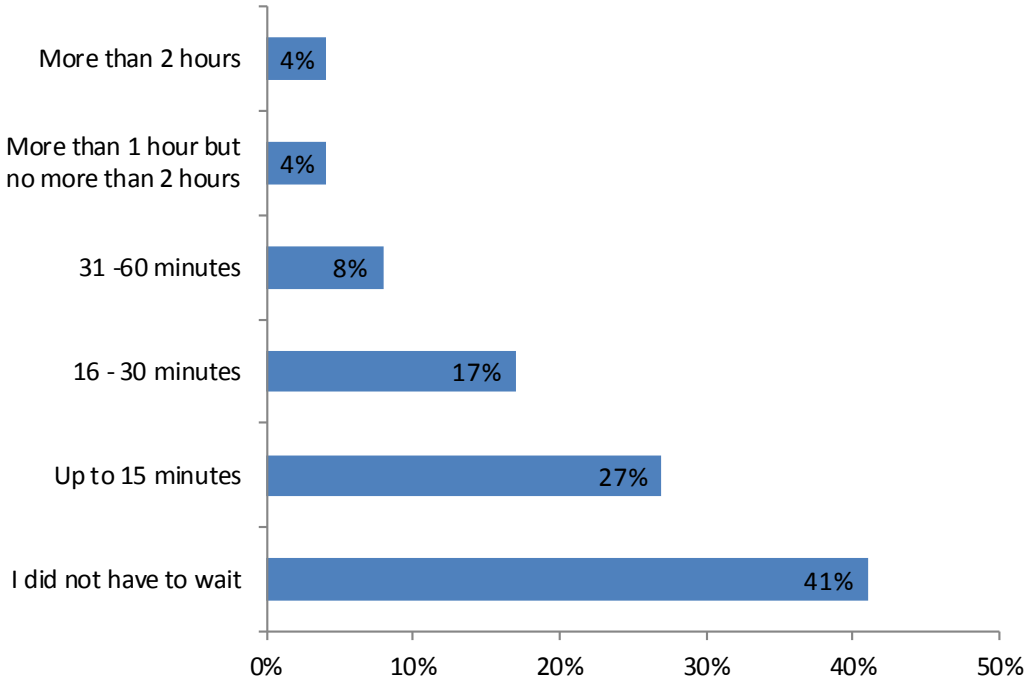
## Arriving by ambulance

Delays in the handover of care between ambulance and hospital staff may have an impact on care and cause poorer patient experiences. The Department of Health's clinical quality indicator states that good practice is for patients arriving by ambulance to be seen within 15 minutes. Some recent media coverage has suggested that some patients who arrive at the emergency department by ambulance experience lengthy delays before being handed over to emergency department staff.[h]

h. See for example: www.bbc.co.uk/news/health-37680171.

Almost a third (32%) said that they were taken to the emergency department in an ambulance. Of these people, 41% said they did not have to wait with the ambulance crew before their care was handed over to the emergency department staff and 27% waited up to 15 minutes. This means that a third (33%) were not handed over within 15 minutes.

**Q5 Once you arrived at the emergency department, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?**




Number of respondents: 12,588.

Answered by those who arrived by ambulance.

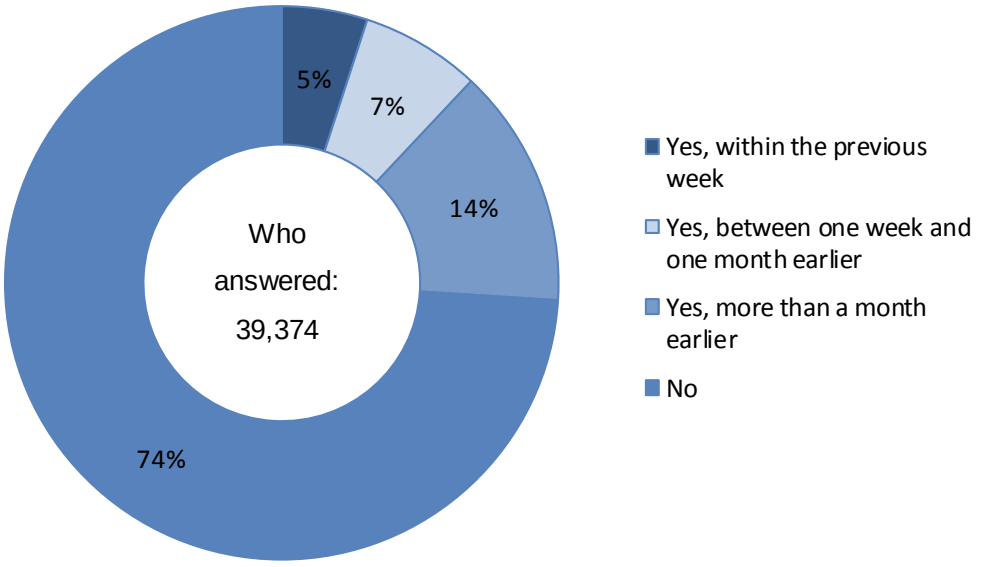
**Notes:** Figures exclude people who selected the response option 'don't know/can't remember'.

## Re-attendance

The Department of Health's clinical quality indicator on unplanned re-attendance states that no more than 5% of patients should re-attend the emergency department within seven days of their first attendance for the same condition.

Nearly three-quarters (74%) said that before their most recent visit to the emergency department, they had **not** previously been to the same emergency department about the same condition or something related to it. This leaves just over a quarter who said that they had, and of these people, 5% said that this was within the previous week.

**Q6 Before your most recent visit to the emergency department, had you previously been to the same emergency department about the same condition or something related to it?**




Answered by all.

**Notes:** Figures exclude people who selected the response option 'don't know/can't remember'.

## Privacy

The NHS Constitution states that patients have the right to privacy and confidentiality, and that they can expect the NHS to keep people's confidential information safe and secure.

Of those respondents who had discussed their condition with the receptionist, just over half (51%) said they were 'definitely' given enough privacy, while 37% were 'to some extent' and 11% said that they did not have enough privacy.

# 2: Waiting

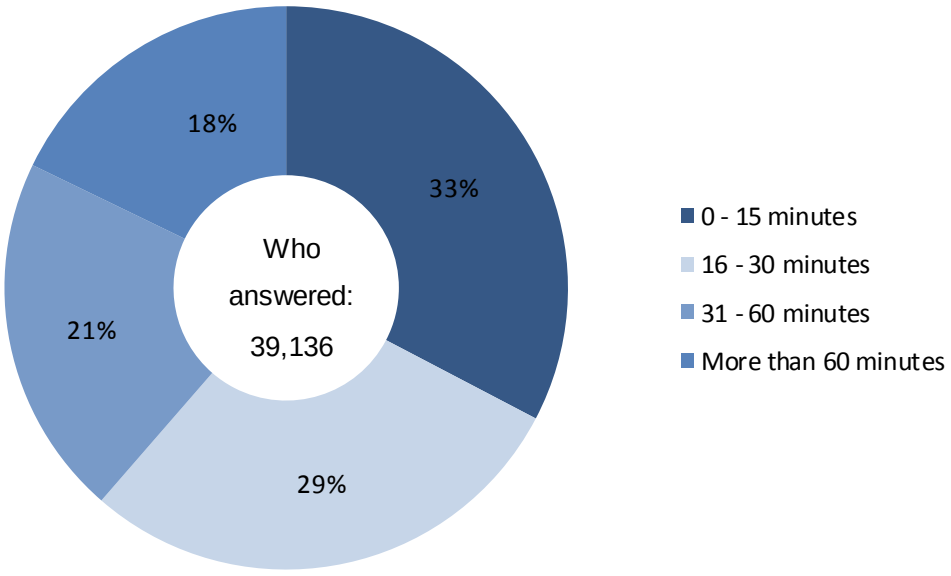
In 2011, to help present a more comprehensive picture of waiting times, the NHS Operating Framework replaced the four-hour waiting time standard with a series of clinical indicators. The operational standard is that 95% should spend four hours or less in the emergency department, which continues to be a commitment in the NHS Mandate for 2017-18.

Appendix B provides further information on published statistics on waiting times.

Although we provide the relevant policy on waiting times to give context, survey results are a different type of data about people's self-reported experience and are **not** directly comparable with published statistics on waiting times for several reasons. For example, patients may not have the same definitions as official data, for example, they may not have realised that they have been moved from the emergency department 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.

A third of respondents (33%) said they waited 15 minutes or less before first speaking to a nurse or doctor, with 18% stating that they waited for more than an hour.

**Q8 How long did you wait before you first spoke to a nurse or doctor?**



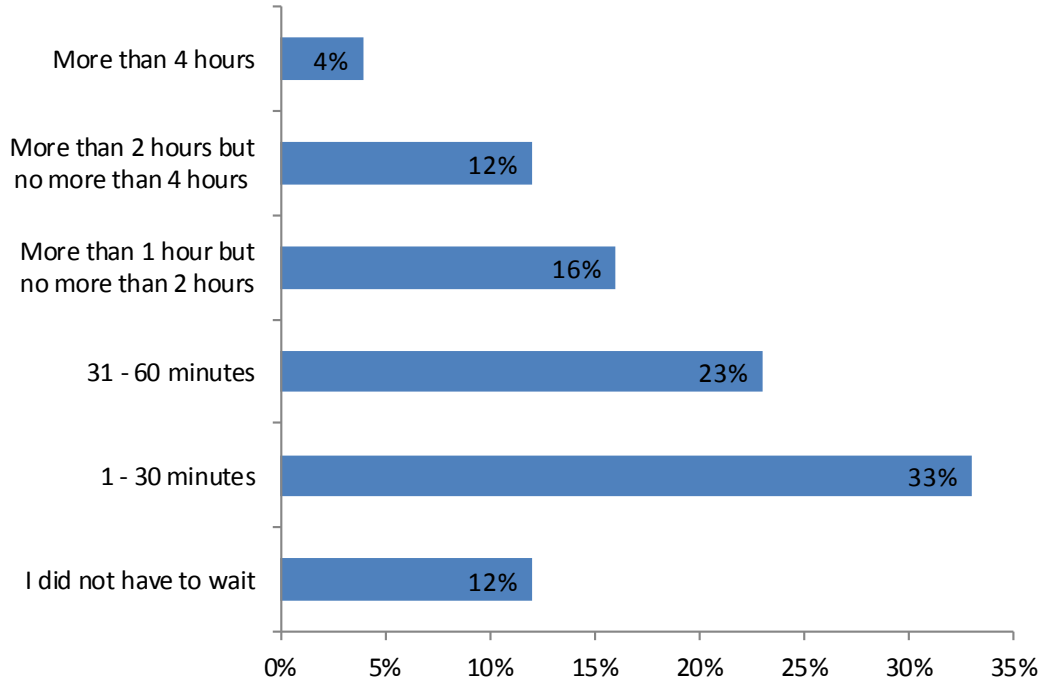

Answered by all.

**Notes:** Figures exclude people who selected the response option 'don't know/can't remember'.

The Department of Health's clinical quality indicator states that good practice is for all patients to be seen within one hour by a clinical decision-maker who can diagnose the problem, decide the plan for the patient and start or arrange treatment if required.

Around a tenth (12%) did not have to wait to be examined by a nurse or doctor. Almost a third (32%) waited more than 60 minutes.

**Q9 Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?**




Number of respondents: 38,927.

Answered by all.

**Notes:** Figures exclude people who selected the response options 'can't remember' or 'I did not see a doctor or nurse'.

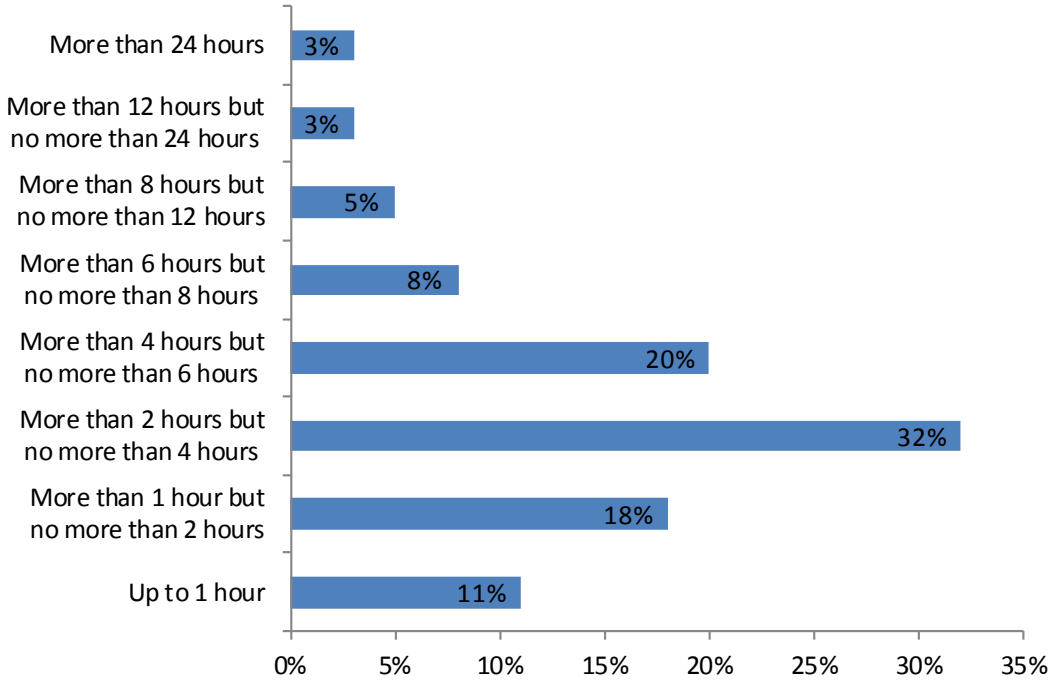
Over half of the people who had to wait to be examined by a doctor or nurse said they were not told how long they would have to wait (59%). Of those who were told, 14% said the wait was shorter, 11% that it was longer and 17% said that the wait was about the same length as they were told.

NHS England has an operational target that 95% of patients at emergency departments should be discharged, admitted or transferred within four hours of their arrival. Attendances are on the rise and figures suggest that people are presenting with more serious health issues than ever before, which require them to be admitted into hospital.[37] As acknowledged in research (see for example Focus on A&E Attendances by Quality Watch) and policy publications (see for example Next Steps on the Five Year Forward View), increased pressure means that the NHS has struggled to meet this standard in recent years.

Please note that, as explained at the start of this section, the survey results cannot be directly compared with other published data or used as an accurate assessment of policy targets.

Sixty per cent of respondents said that their visit to the emergency department lasted four hours or less.

**Overall, how long did your visit to the emergency department last?**




Number of respondents: 39,329.

Answered by all.

**Notes:** Figures exclude people who selected the response option 'can't remember'.

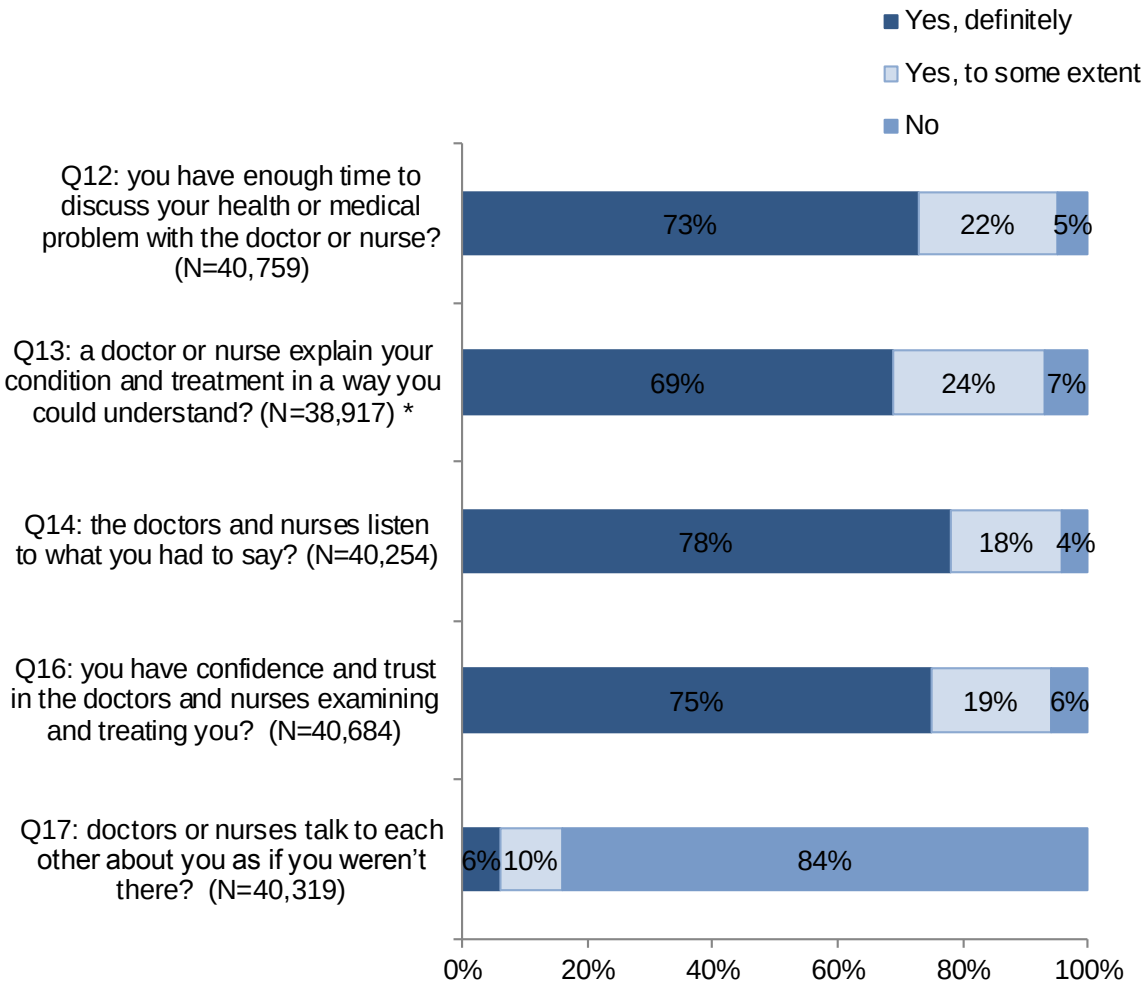
# 3: Doctors and nurses

## Communication and interactions

Having a good experience of care can depend on people's interactions with hospital staff. NICE Quality Statement 2 covers the importance of patients being cared for by staff who are able to communicate with them in a clear and understandable way. Quality Statement 4 says that patients should have the opportunity to discuss their health beliefs, concerns and preferences, and have these taken into account when decisions are made about their care. The survey included a number of questions about interactions and communication with staff.

Effective communication helps patients to be involved in their care, and most respondents who saw a doctor or nurse while in the emergency department reported experiences of good communication. For example, many people said that the doctors and nurses 'definitely' listened to what they had to say (78%) and that they 'definitely' had trust and confidence in the doctors and nurses examining or treating them (75%).

**Q12-Q17 In the emergency department, did…**




Answered by those who saw a doctor or nurse.

**Notes:** N= is the number of respondents for each question
*First response option for Q13 is 'Yes, completely'

The analysis compared the experiences of people in different subgroups for the question about having confidence and trust in the doctors and nurses examining and treating them.

The scores were above average for older respondents (aged 66-80 and 81+), those without a mental health condition, heterosexual or straight respondents and those who had not previously attended the same emergency department for the same condition or something related to it.

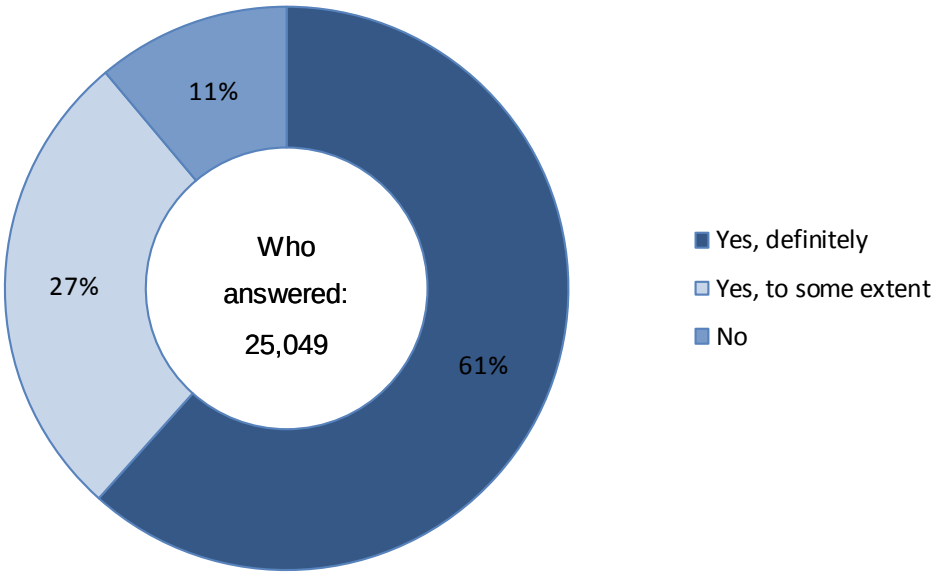
The scores were below average for younger respondents (aged 16-35, and 36-50), those with a self-reported mental health condition, respondents revisiting the same emergency department about the same condition within a week, and those who preferred not to report their religion.

## 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 13 says that a patient's preferences about the involvement of others must be respected. Research from the Kings Fund suggests such involvement can increase people's knowledge, confidence and understanding in dealing with health issues.

Of those respondents whose family, or someone else close to them, wanted to talk to a doctor, 61% said they 'definitely' had opportunity to do this.

**Q18 If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?**




Answered by those who saw a doctor or nurse.

**Notes:** Figures exclude people who selected the response options 'no family or friends were involved' or 'my family or friends did not want or need information' or 'I did not want my family or friends to talk to a doctor'.

# 4: Care and treatment

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

## Involvement in care

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.

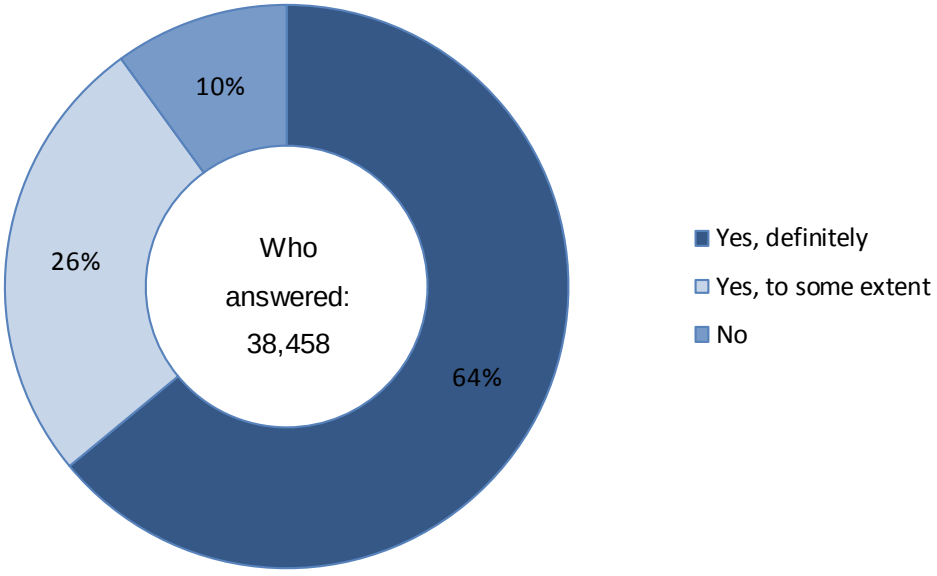
A review of academic research has confirmed the positive association between patient experience and clinical outcomes. Research from the Kings Fund further shows that involving people in their care has many benefits, including improved decision-making and increased knowledge.

The Five Year Forward View committed to giving patients far greater control of their own care by improving how information is provided, supporting people with long-term conditions to self-manage, and by improving choice.

However, a report by the Care Quality Commission about patients' involvement in their care found little change over the last 10 years in people's perceptions of how well they are involved in their health or social care, despite the national drive for person-centred care.

Just under two-thirds of survey respondents (64%) said that they were 'definitely' involved as much as they wanted to be in decisions about their care and treatment.

**Q23: Were you involved as much as you wanted to be in decisions about your care and treatment?**




Answered by all.

**Notes:** Figures exclude people who selected the response option 'I was not well enough to be involved in decisions about my care'.

Providing understandable information helps to enable involvement in care. Since August 2016, all NHS trusts are legally required to follow the Accessible Information Standard.[38] This requires that people who have a disability, impairment or sensory loss are provided with information that they can easily read and understand, or that they receive support to do so, supporting them to communicate effectively with health services.

Most respondents (77%) said that they were given 'the right amount' of information about their condition or treatment; leaving 15% who were not given enough, 7% who were not given any and 1% who were provided with 'too much'.

It is important that care is coordinated between staff, and that patients do not receive conflicting information. NICE Quality Statement 12 states that patients should experience coordinated care, with a clear and accurate information exchange between relevant health and social care professionals. Respondents were asked whether, while they were in the emergency department, one member of staff said one thing and another said something quite different. Most (81%) said that this did **not** happen, leaving 8% who said this 'definitely' happened and 11% who said this happened 'to some extent'.

## 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 respect, kindness, dignity, compassion, understanding, courtesy and honesty (see NICE Quality Statement 1).

Most people (82%) said that they were 'definitely' given enough privacy when being examined or treated, with 15% saying they were 'to some extent' and 3% that they were not.

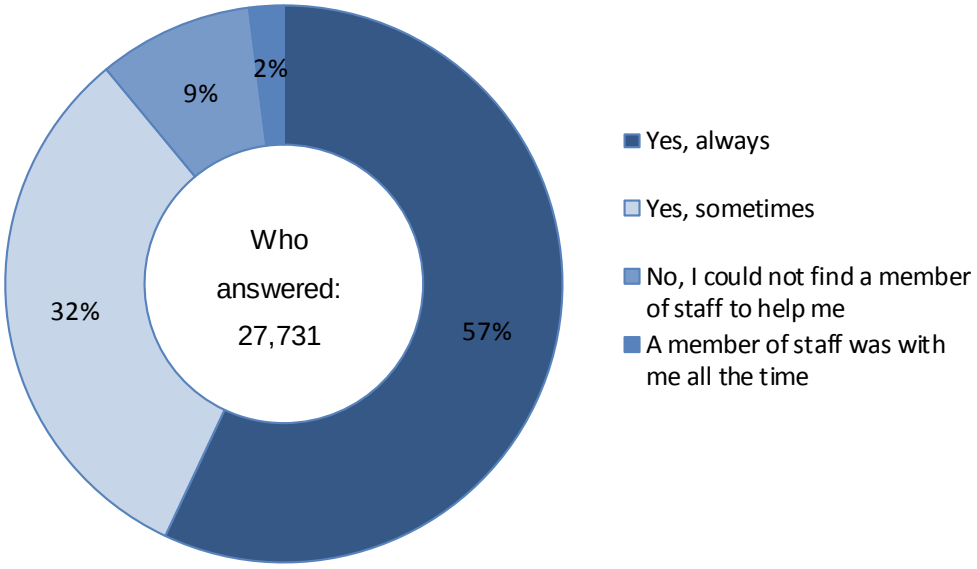
## Responsiveness

It is important that patients are able to attract the attention of staff if they need it. In 2012, the Care Quality Commission carried out a review of care for older people in care homes and NHS hospitals, which focused on whether they were treated with respect and dignity, and could access food and drink that met their needs.[39] The report found that, in some hospitals, staff were not responding to patients in a reasonable time.

The report Leading Change, Adding Value: A framework for nursing, midwifery and care staff[40] recognises that the biggest threat to delivering high-quality care is a shortage of resources. The framework has 10 'aspirational commitments', of which, commitment 9 is to "*have the right staff in the right places at the right time*".

Of those respondents who needed attention while in the emergency department, 57% said that they were 'always' able to get a member of medical or nursing staff to help them.

**Q21: If you needed attention, were you able to get a member of medical or nursing staff to help you?**




Answered by all.

**Notes:** Figures exclude people who selected the response option 'I did not need attention'.

We compared the experiences of different subgroups of patients for this question.

Scores were above average for older respondents (aged 66-80 and 81+), those without dementia, respondents visiting the emergency department in the morning between 5am and 9am, and those who have not previously attended the same emergency department for the same condition or something related to it.

Scores were below average for younger respondents (aged 16-35), those with dementia, and those who preferred not to state their religion.

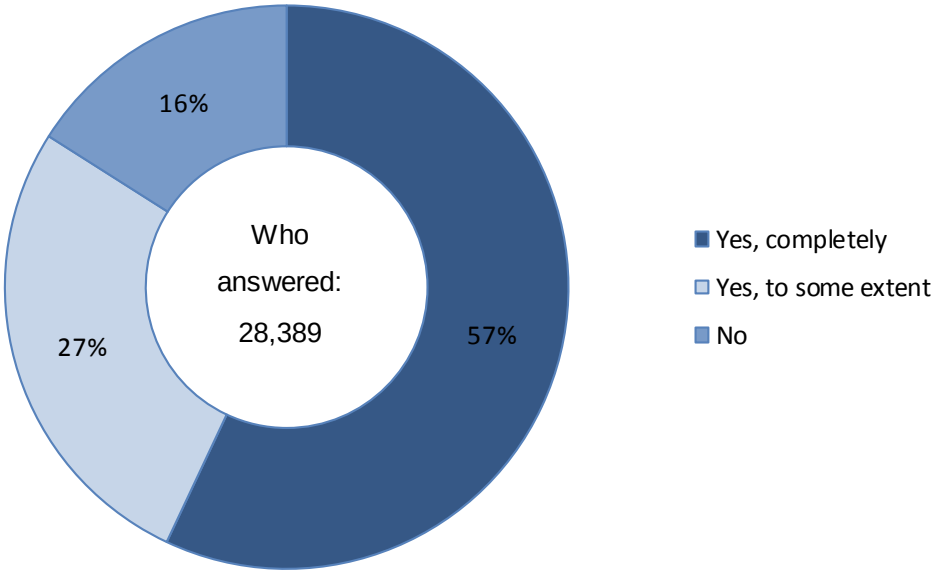
## Emotional support

The British Medical Association's report, The psychological and social needs of patients[41], 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*". The importance of assessing psychological needs of patients is also recognised in the NICE guidance on Patient experience in adult NHS services. This notes that patients can have needs other than a physical health condition, and recommends recognising the need for psychological and emotional support. It states that staff should "…..*listen to and discuss any fears or concerns the patient has in a non-judgemental and sensitive manner*".

For this reason, respondents were asked about support if they had anxieties or fears, and/or felt distressed.

Of those respondents who had anxieties or fears about their condition or treatment, over half (57%) said that a doctor or nurse 'completely' discussed these with them.

**Q15 If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?**

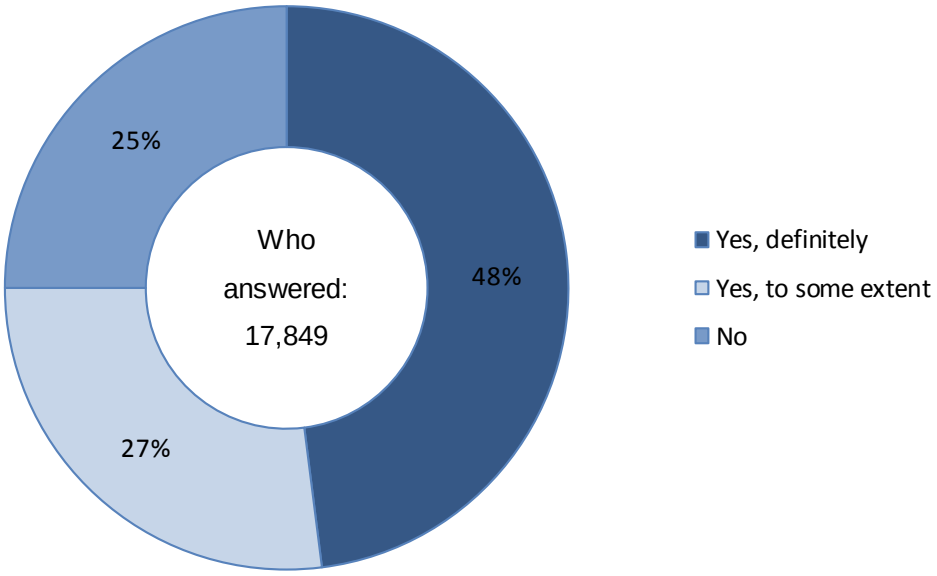



Answered by those who saw a doctor or nurse.

**Notes:** Figures exclude people who selected the response option 'I did not have any anxieties or fears'.

Of those who felt distressed while they were in the emergency department, less than half (48%) said that a member of staff 'definitely' helped to reassure them.

**Q24 If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?**




Answered by all.

**Notes:** Figures exclude people who selected the response option 'I was not distressed' or 'not sure / can't remember'.

We compared the experiences of subgroups of people for the questions on emotional support. Scores were above average for older people (aged 66-80) and respondents without a mental health condition.

Scores were below average for younger respondents (aged 16-35), those with a mental health condition and those who preferred not to state their religion.

## 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.

Just under three-quarters (71%) said that they had tests (such as X-rays, scans or blood tests) when they visited the emergency department. These people were asked about their experiences.

Most people (76%) said that a member of staff 'completely' explained why they needed any tests in a way they could understand; 16% said this was explained 'to some extent' and 8% said that it was not.

Most people who had tests received the results before they left the emergency department (81%). Of these people, 78% said that a member of staff 'definitely' explained the results of the tests in a way they could understand; 19% said this was explained 'to some extent' and 3% said that it was not.

## 6: Pain management

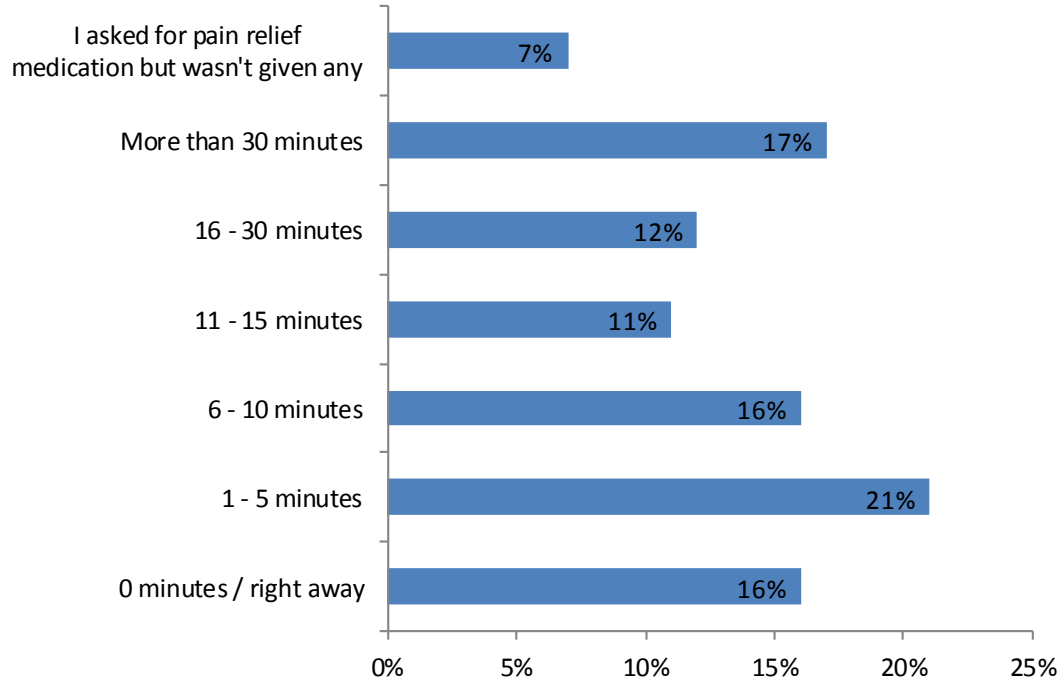
Managing pain is an important aspect of providing high-quality patient care, and can be a key component of recovery.[42] The College of Emergency Medicine has set out best practice guidelines for the management of pain in adults. It states that pain management is a core component of care and that "*recognition and alleviation of pain should be a priority when treating the ill and injured*".[43]

NICE Quality Statement 10 encourages hospital staff to assess and address patients' physical and psychological needs regularly. This includes checking if they need any pain relief.

Almost two-thirds (65%) of respondents said they were in pain while they were in the emergency department. Of these, 32% requested pain relief medication, 24% were offered or given this without asking and 44% did not ask for any.

Of those people who requested pain relief medication, 37% waited five minutes or less to receive this. Over a quarter (29%) waited over 15 minutes before they received pain relief medication, with 7% saying they did not receive any.

**Q31 How many minutes after your requested pain relief medication did it take before you got it?**




Number of respondents: 8,254.

Answered by those who requested pain relief.

Sixty one per cent of those who experienced pain said that hospital staff 'definitely' did everything they could to help control their pain; 24% said they did 'to some extent', but 15% did not feel that hospital staff did everything they could to help control their pain.

# 7: Environment and facilities

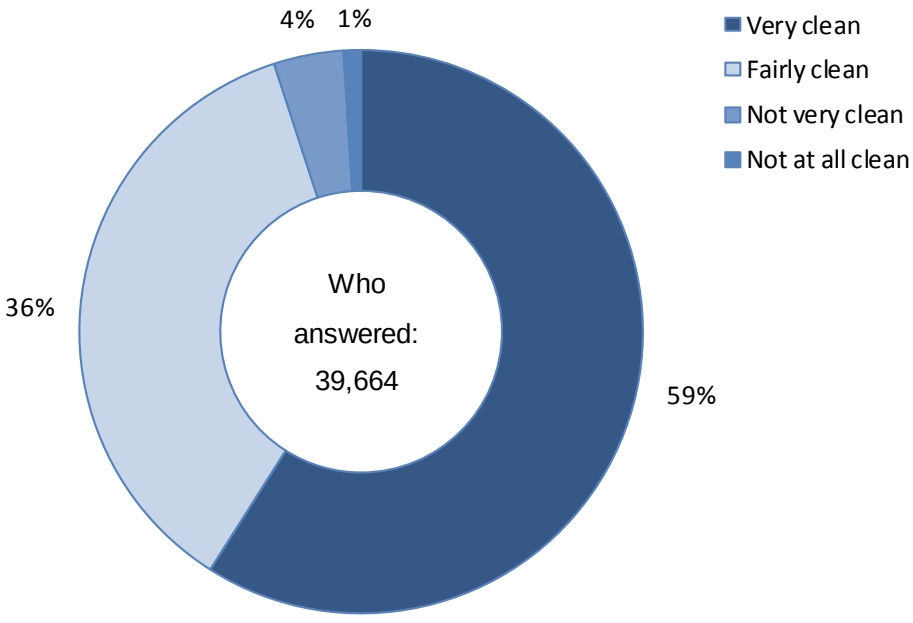
## Cleanliness

Cleanliness is essential to 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.[44] 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.

Since 2013, Patient Led Assessments of Care Environment (PLACE) have taken place in each hospital, and aim to promote principles from the NHS Constitution. The assessments focus on how the environment supports service provision and patient care, looking at non-clinical aspects such as cleanliness and food and hydration. The criteria included in PLACE are not standards, but are aspects of care that patients and the public have identified as important, as well as good practice. PLACE results for 2016 show that cleanliness achieved the best results and had improved from 2015. However, average scores for food and hydration saw a small decrease.[45]

Over half (59%) of survey respondents said that the emergency department was 'very clean'.

**Q33 In your opinion, how clean was the emergency department?**




Answered by all.

**Notes:** Figures exclude people who selected the response option 'can't say'.

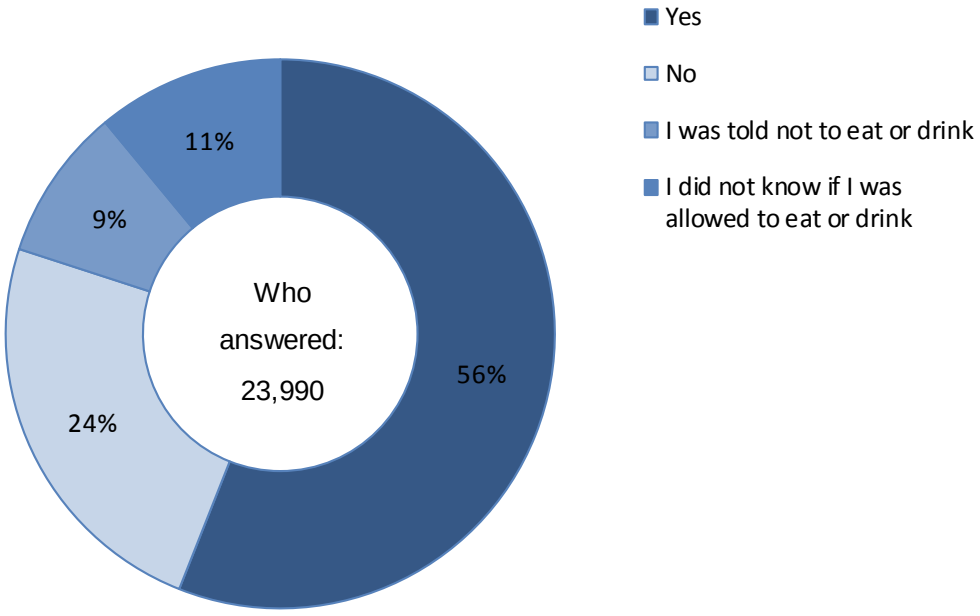
The majority of respondents (92%) said that while in the emergency department, they did not feel threatened by other patients or visitors. The remaining 8% felt threatened, either 'definitely' (2%) or 'to some extent' (6%).

## Access to food and drink

In 2014, The Hospital Food Standards Panel[46] recommended that NHS hospitals adopt a set of standards as routine practice. 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*".[47]

It is important that patients have access to suitable food and drink while they are waiting in the emergency department, particularly if there is a long wait. Of those people who wanted something to eat or drink, over half (56%) said they were able to get suitable food and drink when they were in the emergency department, though almost a quarter (24%) said they could not.

**Q35 Were you able to get suitable food or drinks when you were in the emergency department?**




Answered by all.

**Notes:** Figures exclude people who selected the response option 'I did not want anything to eat or drink'.

# 8: Leaving the emergency department

Research suggests that patients' experience of leaving hospital can be poor. There is evidence of this in the results of the Adult Inpatients Survey, which reports deterioration in results for questions about support at discharge.[48]

An inquiry by Healthwatch England[49] into discharge processes gathered evidence of the experiences of more than 3,000 vulnerable people (older people, homeless people and people with a mental health condition). It identified a number of reasons why things can go wrong for people when they are discharged from hospital, including: not being involved in decisions, not having support after leaving hospital and not having their full range of needs considered.

Questions in this section of the questionnaire asked people what happened at the end of their visit to the emergency department. Most respondents (70%) went home, with just over a quarter (26%) being admitted to hospital. A minority went to stay with a friend or relative (2%) or went to stay somewhere else (1%).

People who were not admitted to hospital were asked about their experiences of leaving hospital.

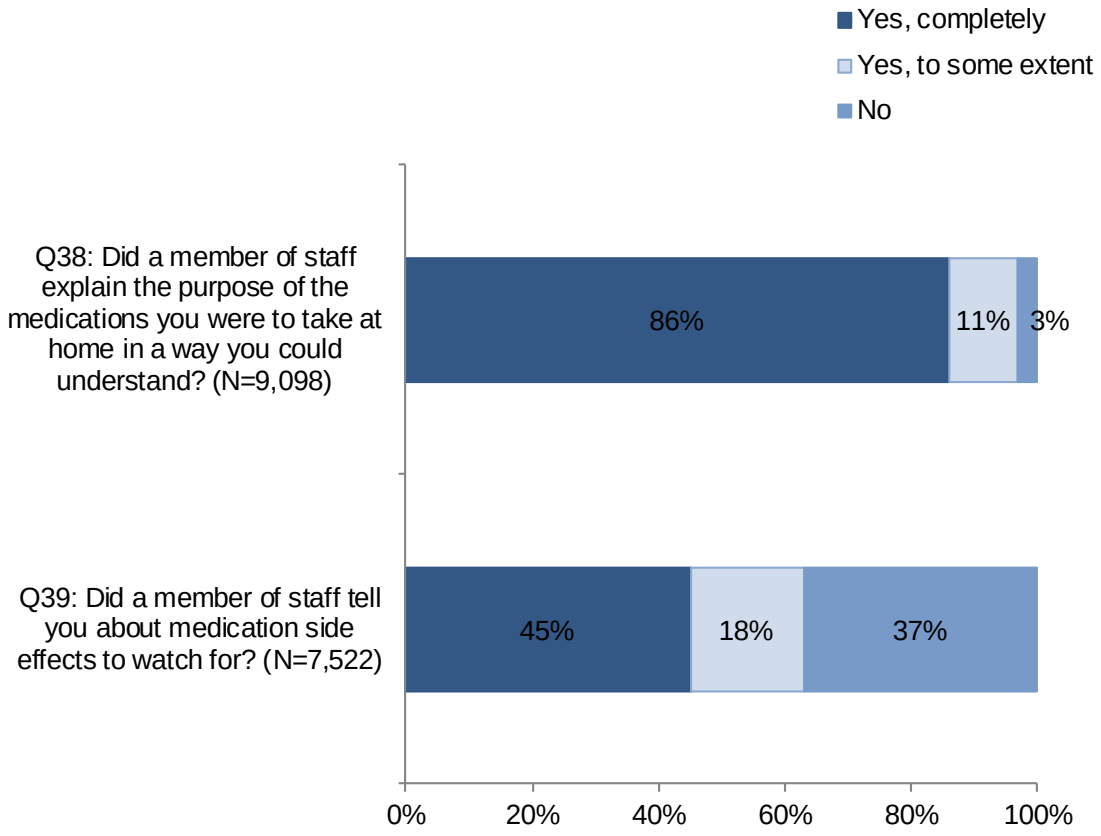
## Medication

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[50] emphasises the importance of including people in the decision-making processes by effective communication and providing information.

Almost a third (32%) of respondents said that before they left the emergency department they were prescribed new mediation(s). These people were asked questions about their experiences.

Most (86%) said that a member of staff 'completely' explained the purpose of the medications they needed to take home in a way they could understand. However, less than half (45%) said that a member of staff 'completely' told them about side effects to watch for.

**Q38-Q39 Information on medication**




Answered by those who went home, went to stay with a friend or relative, or who went to stay somewhere else and were prescribed new medication.

**Note**: N= is the number of respondents for each question.

## Information

All patients should be involved, as much as they would like to be, in decisions around leaving the emergency department. Guidance from NICE recommends that patients should be given the information and support they need to enable them to be actively involved in their own self-care and to self-manage their conditions.

Survey results suggest that people's experiences of receiving information when leaving the emergency department were not as positive as other areas of their care. Less than half (44%) said that they were 'definitely' told when they could resume their usual activities, such as when to go back to work or drive a car, while 34% were not told at all. The remainder (22%) were told this 'to some extent'.

Less than half (47%) said that they were 'completely' told about any 'danger signals' regarding their illness or treatment to watch for after they went home, and a little under a third (30%) were not given this type of information at all. The remaining (23%) were told this 'to some extent'.

A report from the Queen's Nursing Institute[51] noted that leaving hospital is a complex and challenging process. Constant pressures to discharge patients quickly mean that there is little time to holistically assess people's needs.

Around two-fifths of respondents (39%) said that hospital staff 'completely' took their family or home situation into account when they were leaving the emergency department, if this was necessary. A higher proportion (45%) said this was **not** taken into account. The remainder (17%) responded 'to some extent'.

NICE Quality Statement 14 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. Although most people (73%) said that hospital staff told them who to contact if they were worried about their condition or treatment after they left the emergency department, this leaves more than a quarter (27%) who were not told this.

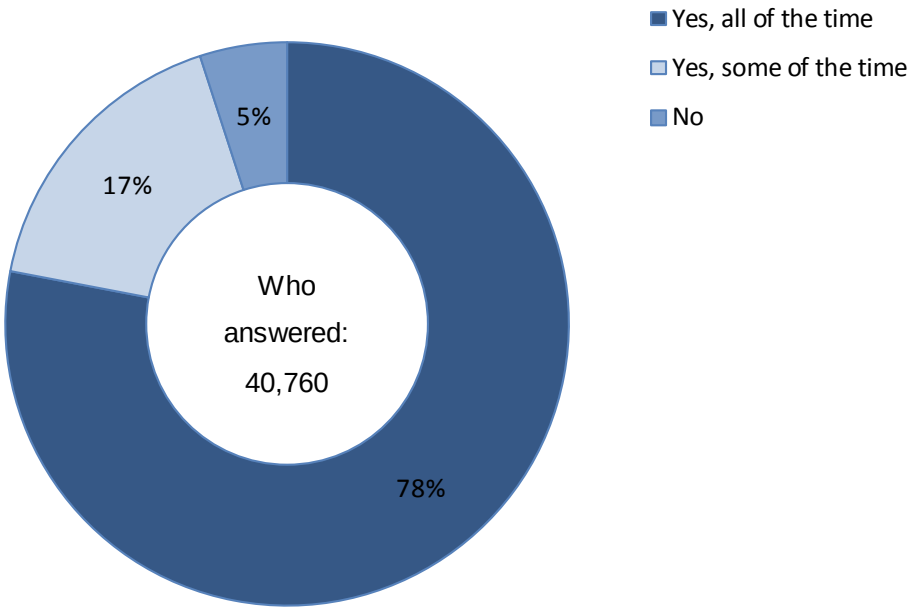
## 9: Overall

Respondents were asked to reflect on their overall experiences of care and treatment while in the emergency department.

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 states that patients should be treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty.

Most respondents (78%) said they felt they were treated with respect and dignity 'all of the time'.

**Q44 Overall, did you feel you were treated with respect and dignity while you were in the emergency department?**



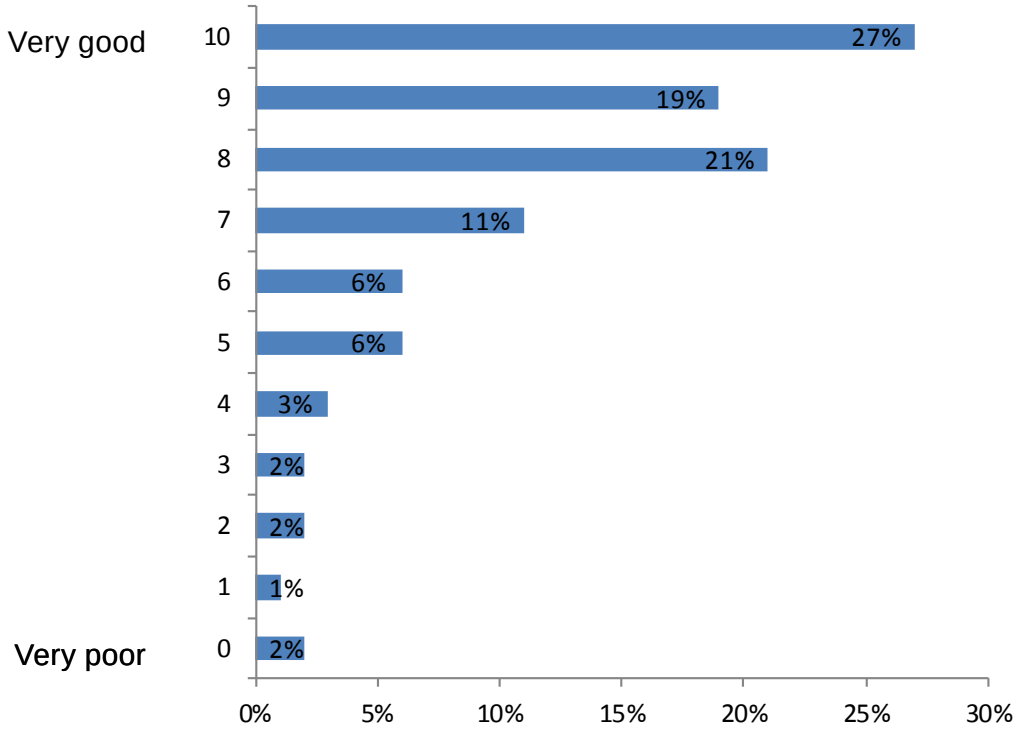

Answered by all.

We compared the experiences of subgroups of people for this question. Scores were above average for older people (aged 66-80 and 81+), those who described themselves as heterosexual or straight, those without a mental health condition, those attending in the morning between 5am and 9am and people who had not previously attended the same emergency department for the same condition or something related to it.

Scores were below average for similar groups, as shown elsewhere in this report, including younger respondents (aged 16-35 and 36-50), people who prefer not to state their religion, and people who self-reported as having a mental health condition.

When asked to evaluate their overall experience on a scale of 0 to 10 (where 0 is 'I had a very poor experience' and 10 is 'I had a very good experience'), just over two-thirds (67%) gave a score of 8 or above.

**Q45 Overall...**




Number of respondents: 39,645.

Answered by all.

Scores were above average for this question for older people (aged 66-80 and 81+), people who do not have dementia, respondents who attended in the morning between 5am and 9am, and those who had not previously attended the same emergency department for the same condition or something related to it.

Scores were below average for younger respondents (aged 16-35 and 36-50), people who preferred not to state their religion, people of Asian or Asian British background, people with dementia, or who had attended between 9pm and midnight, and respondents revisiting the same emergency department about the same condition within a week.

# 10: Summary of results for subgroups of patients

## Background

This additional analysis compares how different patient subgroups rated their experiences in **Type 1** emergency departments by using a multi-level model analysis. The subgroup analysis compares the mean scores for a subset of questions by different groups and allows us to explore the 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 and whether they have attended the emergency department previously) for a set of eight themes aligned with the NHS Patient Experience Framework. Four of these themes are composites using similar questions, and four are individual questions. The themes are:

**Information, communication, and education**

Q43: Did hospital staff tell you **who to contact** if you were worried about your condition or treatment after you left the emergency department?

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?

Q13: While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?

**Privacy**

Q7: Were you given enough privacy when discussing your condition with the **receptionist**?

Q20: Were you given enough privacy when **being examined or treated**?

**Emotional support**

Q15: If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?

Q24: If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?

**Involvement and decision-making**

Q14: Did the doctors and nurses 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?

**Confidence and trust**

Q16: Did you have confidence and trust in the doctors and nurses examining and treating you?

**Attention from staff**

Q21: If you needed attention, were you able to get a member of medical or nursing staff to help you?

**Respect and Dignity**

Q44: Overall, did you feel you were treated with respect and dignity while you were in the emergency department?

**Overall Experience**

Q45: Overall…

See Appendix G for detailed subgroup analysis charts and the Quality and Methodology report for detailed information about the methodology.

## Summary

The analysis showed that, generally, as patients become older, they report experiences that are more positive. However, people who have previously attended the same emergency department for the same condition within the last week had poorer experiences, as did people who self-report as having a mental health condition.

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 2016 Adult inpatient survey.

## Age

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

Scores were below average for respondents aged 16-35 for all themes. Scores for the 36-50 subgroup were below average for four of the eight themes: confidence and trust, overall experience, and dignity, respect and privacy.

In contrast, scores for respondents aged 66-80 were above average for seven out of eight of the themes, with the exception of 'information, communication, and education'. Scores for the subgroup aged 80+ were above average for five of these themes: attention from staff, confidence and trust, overall experience, dignity and respect and privacy.

## Gender

There were no noteworthy differences by gender.

## Religion

Scores were below average for respondents who 'prefer not to say' their religion, for seven out of the eight themes, with the exception of 'privacy'.

It is difficult to know the characteristics of people who prefer not to state their religion. However, some recent 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.[52]

The Office for National Statistics (ONS) looked into reasons why people 'prefer not to say' when responding to questions about their sexuality[53] and it may be reasonable to assume some of the same reasons may apply here. 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).

## Sexual orientation

Scores were above average for heterosexual/straight respondents for three out of the eight themes: involvement and decision-making, confidence and trust, and respect and dignity.

## Ethnicity

There were very few noteworthy differences by ethnicity. Respondents who described their ethnicity as Asian or Asian British had below average scores for overall experience.

## Long-term conditions

Scores were below average for patients who self-reported as having a mental health condition for four of the eight themes: involvement and decision-making, confidence and trust in staff, respect and dignity and emotional support. Conversely, respondents with no mental health condition had above average scores for these themes.

Scores were below average for respondents with dementia for two of the eight themes: overall experience and attention from staff. Conversely, respondents who did not have dementia had above average scores for these two themes.

## Previous attendance

Scores were above average for people who had **not** previously attended the same emergency department for the same condition, or something related to it, for five of the eight themes: involvement and decision-making, attention from staff, confidence and trust in staff, overall experience and dignity and respect.

Conversely, scores were below average for respondents revisiting the same emergency department about the same condition, or something related to it, within a week, for three of the eight themes: involvement and decision-making, confidence and trust in staff and overall experience.

## Seven-day services

Recently, some evidence[54, 55] has suggested that people have poorer experiences and outcomes if admitted to hospital at the weekend. The NHS committed to a move towards routine services being available seven days a week when it published Everyone Counts: Planning for patients 2013/14.[56] To enable this process, the Seven Days a Week Forum was established to support commissioners and providers throughout the transition. The forum recommended adopting 10 evidence-based clinical standards to address variation in care, which included a standard on patient experience that focused on involvement and engagement with patients in the delivery of their care.

Analysis found no notable differences by day of attendance, though there was some evidence that experiences differ by time of attendance.

Scores were above average for people attending in the morning between 5am and 9am for three of the eight themes: attention from staff, dignity and respect and overall experience. This coincides with when departments are at their quietest according to data published by NHS Digital.

Scores were below average for people attending in the evening between 9pm and midnight for overall experience. According to data published by NHS Digital, the busiest time of day is between 9am and 12pm. However, there is a smaller peak in attendance at around 8pm, which drops to a low around the early hours of the morning.

## 11: Type 3 departments

This section presents a summary of results from people who had visited Type 3 departments run directly by an NHS acute trust. It is not appropriate to compare the results for Type 1 and Type 3 departments for reasons discussed elsewhere in this report.

To view the full results please see the open data section on the CQC website

**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.**

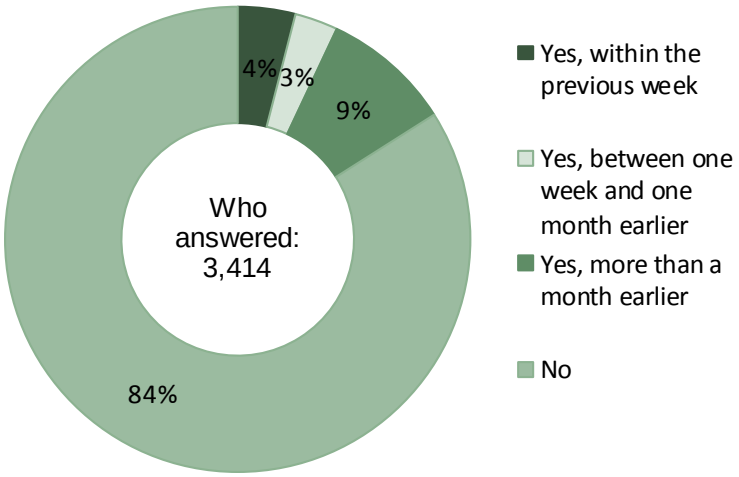
### Arrival

Nearly two-thirds (65%) of respondents said that the Type 3 department was the first place they went to, or contacted, for help with their condition, which leaves 35% who had contact with another service beforehand.

Of those people who had contacted another service first, the most common service to contact was a GP (38%) or the NHS 111 telephone service (15%).

Most people (84%) said that before their most recent visit to the Type 3 department, they had not previously been to the same one about the same condition or something related to it. Four per cent said that they had visited within the previous week.

**Q6 Before your most recent visit to the emergency department, had you previously been to the same emergency department about the same condition or something related to it?**



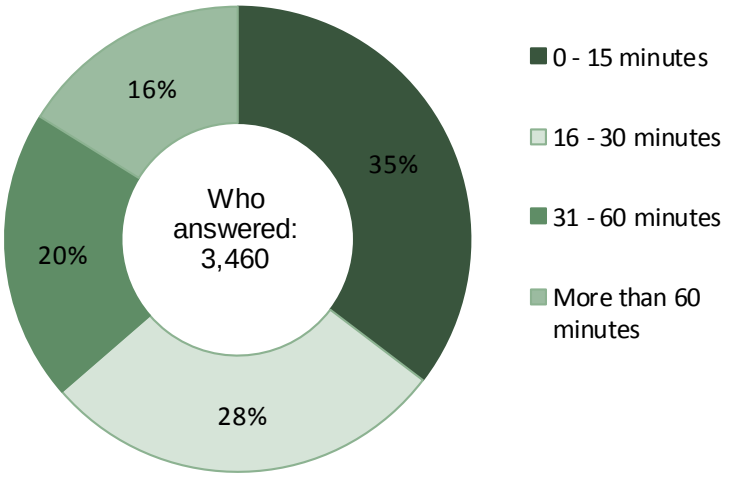

Answered by all.

**Notes:** Figures exclude people who selected the response option 'don't know/can't remember'.

## Waiting

Just under two-thirds (63%) of people waited half an hour or less before first speaking to a doctor or nurse.

**Q8 How long did you wait before you first spoke to a nurse or doctor?**

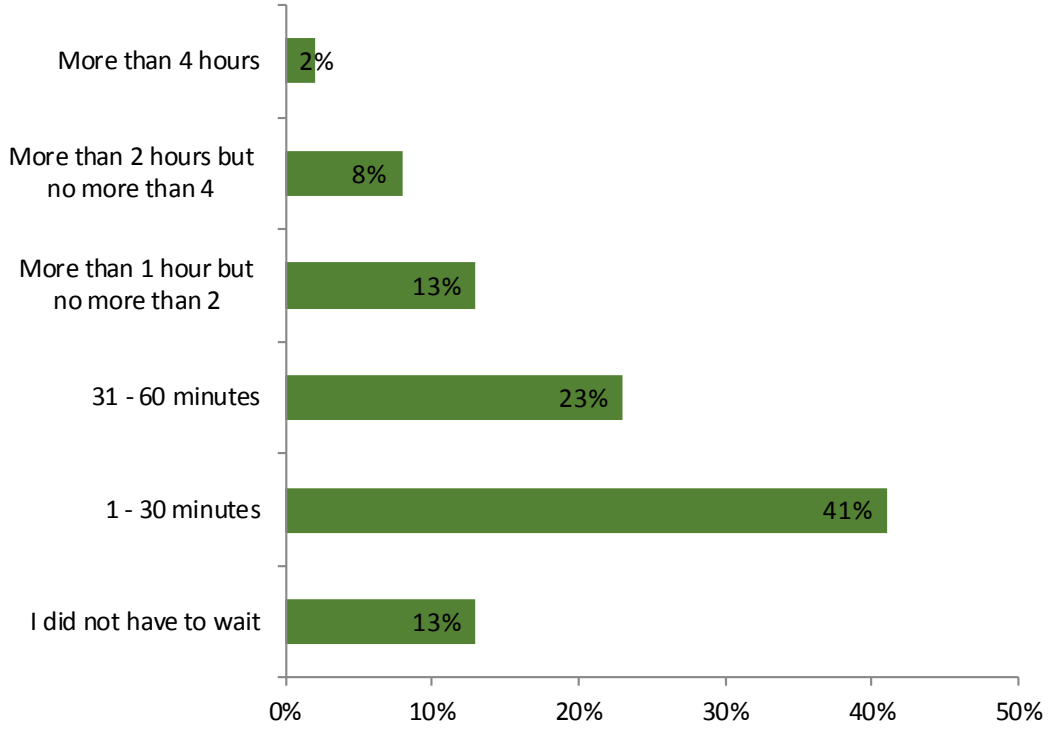



Answered by all.

**Notes:** Figures exclude people who selected the response option 'don't know/can't remember'.

Seventy-seven per cent of respondents were examined within one hour by a doctor or nurse, leaving just under a quarter (23%) who waited over an hour.

**Q9 Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?**




Number of respondents: 3,434.

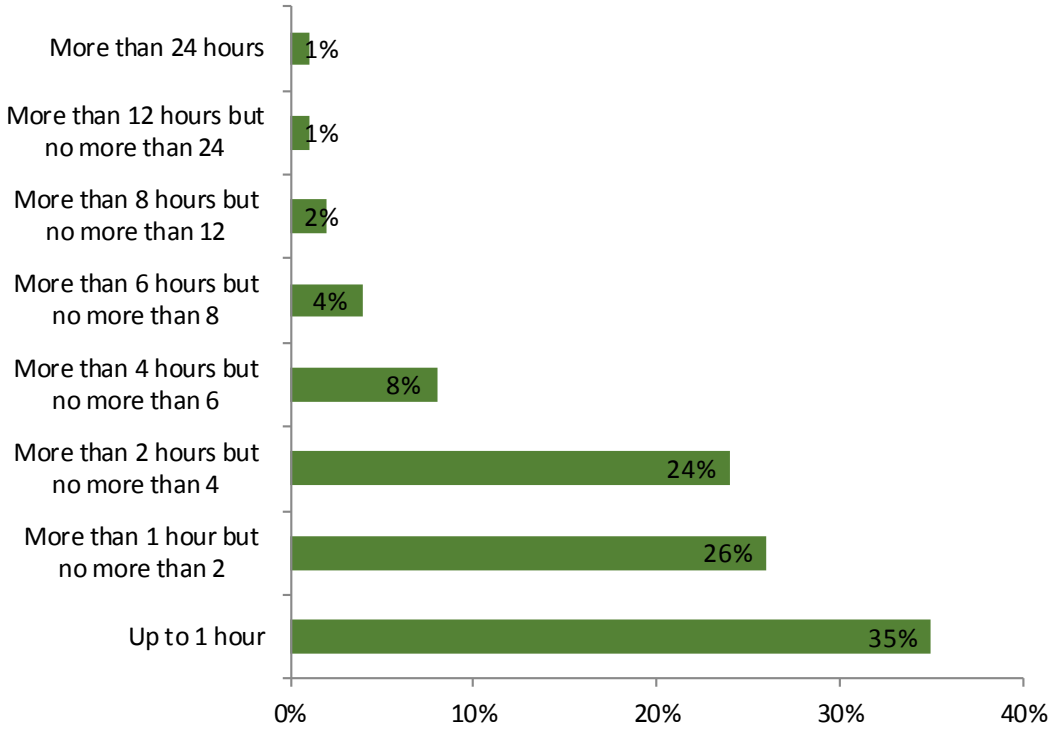
Answered by all.

**Notes:** Figures exclude people who selected the response option 'can't remember' or 'I did not see a doctor or nurse'.

Most of the people who waited to be examined by a doctor or nurse said that they were **not** told how long they would have to wait (52%). Of those who were told, 18% said the wait was shorter, 10% that it was longer and 19% said that the wait was about the same length as they were told.

Eighty-five per cent of respondents said their visit lasted less than four hours.

**Q11 Overall, how long did your visit to the emergency department last?**




Number of respondents: 3,441.

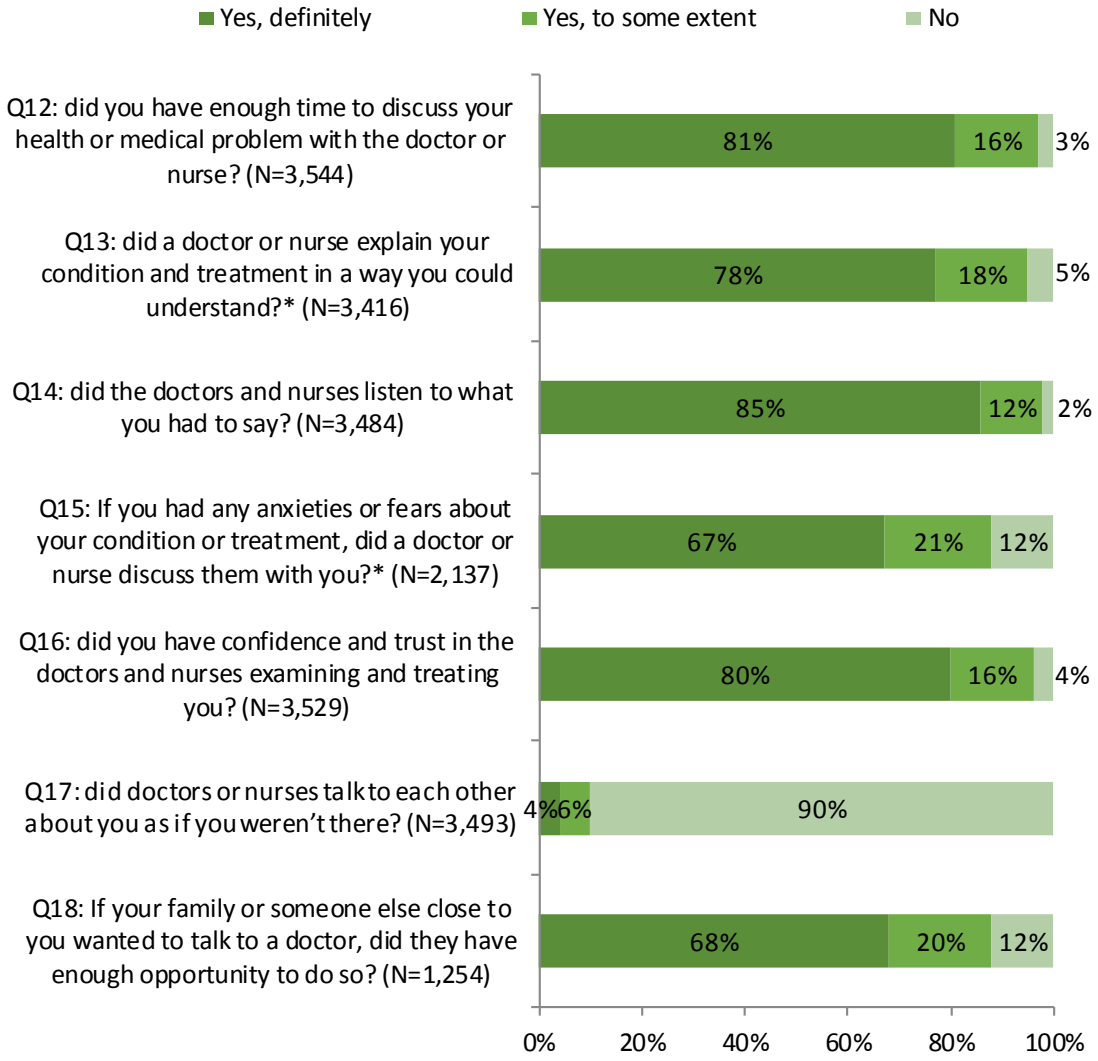
Answered by all.

**Notes:** Figures exclude people who selected the response option 'can't remember'.

## Doctors and nurses

Most respondents who saw a doctor or nurse reported experiences of good communication. For example, 81% said that they 'definitely' had enough time to discuss their health or medical problem with the doctor or nurse; 85% said that the doctors and nurses 'definitely' listened to what they had to say; and 90% said that the doctors or nurses did **not** talk to each other about them as if they weren't there.

**Q12-Q18 In the emergency department…..**




Answered by those who saw a doctor or nurse.

**Notes:** N= is the number of respondents for each question
*First response option for Q13 and Q15 is 'Yes, completely'

## Care and treatment

Most people responded positively to questions asking about involvement in care, with 74% saying that they were 'definitely' involved as much as they wanted to be in decisions about their care and treatment; 20% were 'to some extent' and 6% said they were not.

Involvement in care is supported by providing information and clear communication. Most respondents (84%) said that they were given the 'right amount' of information about their condition or treatment. Eleven per cent did not get enough, 5% were not given any and 1% received 'too much'. Respondents were asked if one member of staff said one thing and another said something quite different. Most (88%) said that this did not happen, leaving 5% who said this 'definitely' happened and 7% who said this happened 'to some extent'.

Of those who felt distressed, most (64%) said that a member of staff 'definitely' helped to reassure them. This leaves 22% who responded 'to some extent' and 6% 'no'.

Of those respondents who needed attention, 63% said that they were 'always' able to get a member of medical or nursing staff to help them and 25% said that that they 'sometimes' could. Six per cent said that they could not find a member of staff to help them, and 6% said that they had a member of staff with them at all times.

Most respondents (88%) were 'definitely' given enough privacy when being examined or treated, leaving 10% who were 'to some extent' and 2% who said they were not.

## 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.

Less than half of respondents (45%) said that they had any tests (such as X-rays, scans or blood tests).

Of these people, most (87%) said that a member of staff 'completely' explained why they needed any tests in a way they could understand. Nine per cent said this was explained 'to some extent' and 4% said that it was not.

Most (86%) received the results of tests before leaving. Of these people, most (87%) said that a member of staff 'definitely' explained the results of the tests in a way they could understand, leaving 10% who said this was explained 'to some extent' and 2% said it was not.

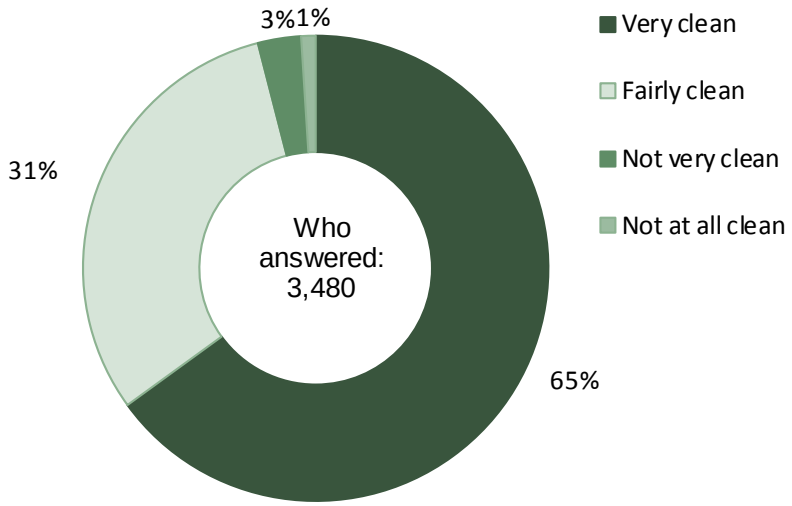
## Pain management

Sixty-four per cent said that they were in pain while in the Type 3 department. Of these people, 63% said that hospital staff 'definitely' did everything they could to help control their pain, 23% felt they did 'to some extent' and 14% that they did not.

## Environment and facilities

Most respondents described the Type 3 department as being 'very clean' (65%) or 'fairly clean' (31%).

**Q33 In your opinion, how clean was the emergency department?**




Answered by all.

**Notes:** Figures exclude people who selected the response option 'can't say'.

The majority of respondents (95%) did not feel threatened by other patients or visitors, which leaves 4% who were 'to some extent' and 2% who 'definitely' were.

Of the people who wanted to get something to eat or drink, just under two-thirds (64%) said that they were able to get suitable food or drinks, and 23% were not. The remainder were either told not to eat or drink (6%) or were unsure if they were allowed to (8%).

## Leaving

Most people (87%) went home at the end of their visit, with 10% being admitted to hospital. A small minority went to stay with a friend or relative (1%) or went to stay somewhere else (2%).

People who were not admitted to hospital were asked about their experiences of leaving the emergency department.

All patients should be involved, as much as they would like to be, in decisions around leaving the department and should receive the right information and support. This will help them to adhere to any medication prescribed, as well as enable them to be actively involved in their own self-care and to self-manage their conditions.

Almost a third (32%) were prescribed new medication(s). Of these people, most (93%) said that a member of staff 'completely' explained the purpose of the medication they were to take home in a way they could understand. The remainder were told 'to some extent' (6%), and 1% were not told.

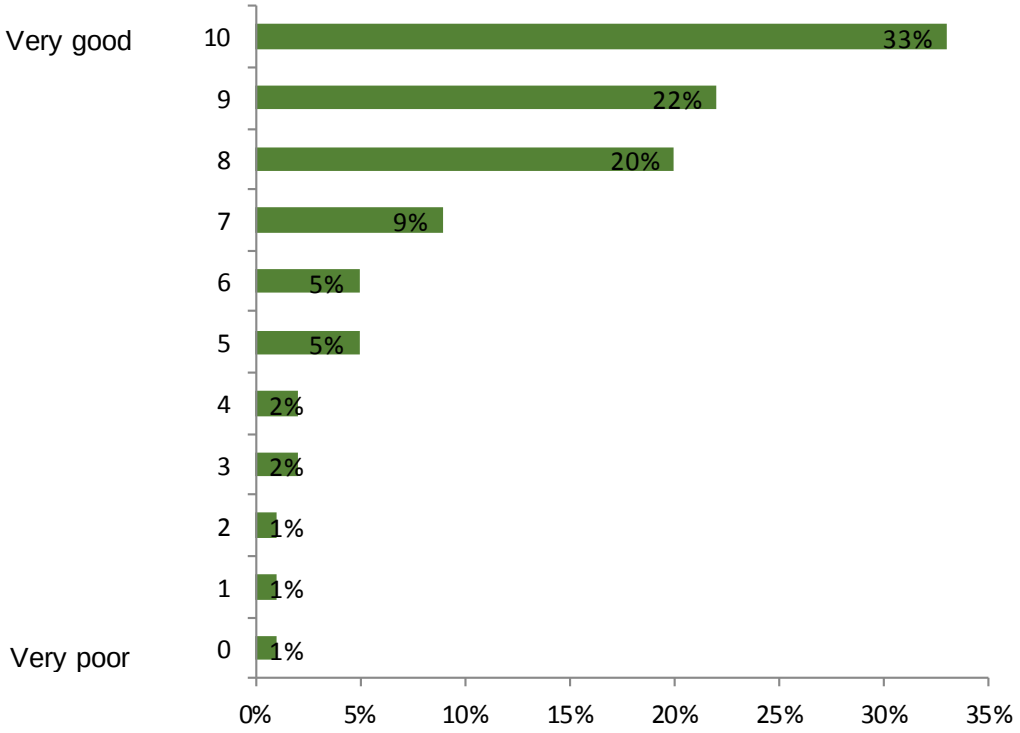
Just over half (55%) said that they were 'definitely' told when they could resume usual activities such as when to go back to work or drive a car, leaving 22% told 'to some extent' and 23% who were not told this. Just over half (57%) were 'completely' told about any danger signals regarding their illness or injury to watch out for, leaving 21% told 'to some extent' and 22% who were not told this. While most people (78%) said that hospital staff told them whom they should contact if they were worried about their condition or treatment after leaving, this leaves more than a fifth (22%) who did not receive this information.

## Overall

Most respondents (86%) were treated with respect and dignity 'all of the time', 11% said this was 'some of the time' and 3% said they were not.

When asked to evaluate their overall experience on a scale of 0 to 10 (where 0 is 'I had a very poor experience' and 10 is 'I had a very good experience') three quarters (75%) gave a score of '8' or above.

**Q45 Overall...**




Number of respondents: 3,445.

Answered by all.

# Appendix A: Survey methodology

This appendix describes the survey methodology covering questionnaire design, sampling, fieldwork and analysis.

## Questionnaire design

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, NHS England, 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 D.

In summary, the following changes were made to the questionnaire used in 2016:

- three new questions were added to reflect interest in people's route to attending the emergency department
- one question was removed as it overlapped with the new questions above
- throughout the questionnaire, the term "A&E" was replaced with "emergency department" to reflect the inclusion of people who attended Type 3 departments.

For more detailed information, please see:

- the development report for the Emergency Department Survey
- the questionnaire for the 2016 survey.

## Survey method

As with most surveys in the NHS Patient Survey Programme, the emergency department 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 reminders.

## Sampling and fieldwork

People aged 16 and over were eligible for the survey if they attended a Type 1 or Type 3 emergency department in an NHS trust between 1 and 30 September 2016. Trusts drew a stratified sample from their records of 1,250 people who had been seen at the trust during the sampling period. The sample size is sufficient to allow analysis of results at individual trust level.

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 emergency department
- anyone who had a planned attendance at an outpatient clinic run within the emergency 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.

If a trust did not have a Type 3 department, its sample was drawn from its Type 1 service only. Trusts that had both a Type 1 and Type 3 department sampled 950 people who used Type 1 services and 300 people who used Type 3 services.

The 2016 survey included 49 trusts that had both a Type 1 and Type 3 service, with 88 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.

Fieldwork for the survey (the time during which questionnaires were sent out and returned) took place between October 2016 and March 2017.

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

## Comparability with previous years

Changes to the sampling and analysis methodology for the 2016 survey mean results are **not comparable** with other surveys (carried out in 2003, 2004/5, 2008, 2012 and 2014) for the several reasons:

- Changes were made to the sampling approach: the sample size was increased from 850 to1,250; the sample month for the 2016 survey was September, rather than January, February or March in 2014 and different strata were used to sort the sample in 2016.
- The survey scope has increased: previous surveys have focused on major A&E departments (Type 1) only. This survey also includes Type 3 departments run directly by the acute trust.
- The method used to weight the results for England has changed.
- As discussed in the policy context section, the provision of urgent and emergency care services has changed over recent years, and is still evolving. This means that it would not be fair to compare the results from the 2016 survey with earlier surveys, as the landscape has changed.

# 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 2016 Emergency Department 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 (Q46-Q53) 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%.

## Subgroup analysis methodology

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 on either composites of questions, or individual questions, illustrated in the charts. This kind of model takes into account trust clustering, as trusts are likely to have a big impact on reported patient experience at England 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 the likelihood of differences between groups observed in the results arising from a population where there were no actual differences. They relate to the demographic factor as a whole rather than to comparison between specific categories within the factor.

Differences that are equivalent to at least 0.1 standard deviations from the overall mean of the target variable are treated as being noteworthy in this report. Composites were created with questions relating to NHS patient experience framework. See appendix G for the charts.

# Appendix B: 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 Indictors

These indicators have been designed to provide national-level accountability for the outcomes that the NHS delivers and to drive transparency, quality improvement and outcome measurement throughout the NHS. They do not set out how these outcomes should be delivered; it is for NHS England to determine how best to deliver improvements by working with clinical commissioning groups (CCGs) to make use of the tools available.

Data from the NHS Patient Surveys are used to monitor Domain 4 'Ensuring that people have appositive experience of care'. This looks at the importance of providing a positive experience of care for patients, service users and carers.

For more information about the NHS Outcome Framework, please visit NHS Digital (formerly the Health and Social Care Information Centre) and the GOV.UK websites:
http://content.digital.nhs.uk/m/nhsof
www.gov.uk/government/publications/nhs-outcomes-framework-2016-to-2017

## 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 emergency 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.

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 provider organisation level, from 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/

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:
www.content.digital.nhs.uk/catalogue/PUB22832

NHS Digital also publishes more detailed data on A&E attendances, which is broken down by age and diagnosis.
www.content.digital.nhs.uk/catalogue/PUB23070

HES is a data warehouse containing details of all admissions, outpatient appointments and A&E attendances at NHS hospitals in England. For more information on HES data, please see:
http://content.digital.nhs.uk/hes

## Patient experience

NHS England publishes results from the Friends and Family Test (FFT). 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/

# Appendix C: Comparisons with other surveys

While Scotland and Northern Ireland have a programme of patient surveys, this does not currently include a survey specifically of emergency department services, though the inpatient surveys include a limited number of questions on A&E. There is currently no similar survey undertaken in Wales.

The surveys in Scotland and Northern 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).

Although the measures are not directly comparable with the equivalent question in the emergency department questionnaire, placing the overall question next to each other might provide useful context in this one area.

## 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 emergency department services, their inpatient survey includes seven questions on time spent in the emergency department.

The Scottish Inpatient Experience 2016 is a postal survey, which was sent out in January 2016 to a random sample of people aged 16 years or over who had an overnight hospital stay between April and September 2015.

**Overall, how would you rate the care and treatment you received during your time in A&E?**

| | |
|---|---|
| Excellent | 51% |
| Good | 37% |
| Fair | 9% |
| Poor or Very Poor* | 3% |

* results for 'poor' and 'very poor' amalgamated in published results

More information on the Scottish Care Experience Survey Programme is available here:
www.gov.scot/Topics/Statistics/Browse/Health/careexperience

## Northern Ireland

As in Scotland, there is no survey specifically of emergency department services in Northern Ireland, though two questions on time spent in the A&E were included in the last inpatient survey in 2014.

The Inpatient Patient Experience Survey was conducted as a postal 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 March/April 2014.

**During your time in A&E would you say your care and treatment was…**

| | |
|---|---|
| Excellent | 45% |
| Good | 37% |
| Fair | 12% |
| Poor or Very Poor* | 6% |

* results for 'poor' and 'very poor' amalgamated in published results

More information on patient surveys undertaken the Northern Ireland is available here:
www.health-ni.gov.uk/topics/doh-statistics-and-research/department-health-commissioned-surveys

## Other research

There are other surveys carried out in the UK by various organisations. While results are not directly comparable because of different methodologies, these other surveys may be of interest as they provide further information on urgent and emergency care. A selection are summarised below:

### Healthwatch reports

Local Healthwatch organisations and Healthwatch England have undertaken research to look at the decision-making processes of why people choose to attend A&E. Their work suggests some people are unaware of alternatives to their major A&E department. For more information, please see:
www.healthwatch.co.uk/accident-and-emergency-opinions

### Monitor

In 2013/14, Monitor carried out a review into the closure of walk-in centres. This included a face-to-face interview survey looking at people's use of walk-in centres, and their reasons for attending. For more information, please see:
www.gov.uk/government/publications/nhs-walk-in-centre-services-in-england-review

### The Patients Association and The Royal College of Emergency Medicine

Between September 2014 and February 2015, the Patients Association and the Royal College of Emergency Medicine ran an open access survey exploring how patients with urgent healthcare needs had accessed accident and emergency services. This survey was available to patients and the public on the Patients Association website.

The survey asked a range of questions to ascertain the experiences of patients with an urgent healthcare need who had recently used an A&E department, their awareness of alternatives, and their preferred treatment location. A total of 924 responses were received.

The report calls for NHS England to ensure that the public is not only fully informed about appropriate use of services (such as out-of-hours GPs, walk-in centres and the NHS 111 service) but also to ensure that these services have sufficient capacity and are available when required. For more information, please see: www.patients-association.org.uk/reports/report-time-to-act-urgent-care-and-ae-the-patient-perspective/

## International research

This section highlights surveys of emergency departments carried out by other countries. While results are not directly comparable because of different healthcare systems, and different survey methodologies, these other surveys may be of interest and a selection are summarised below.

### Emergency Department Patient Experience of Care Survey (EDPEC) - Centres for Medicare & Medicaid Services (CMS)

This American survey is currently under development. Currently, three draft versions of the survey are being tested: two versions for patients admitted to the hospital and one for patients discharged to the community. The surveys ask patients about their experiences of arriving at the emergency department, during care, and after being admitted to the hospital or discharged. For more information, please see: www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS/ed.html

### Patients' experiences with emergency care in Saskatchewan hospitals

This Canadian emergency department survey was carried out between 18 January and 14 March 2011 in 14 of the most active emergency departments in the province.

Less than a quarter (21.6%) of patients rated their overall care experience as excellent. For more information, please see: https://hqc.sk.ca/Portals/0/documents/ed-survey-2011.pdf

# Appendix D: Main users of the survey data

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

## Care Quality Commission (CQC)

CQC will use the results from the survey in the regulation, monitoring and inspection of NHS trusts in England. Survey data will be used in CQC Insight, an intelligence tool that indicates potential changes in quality of care to support decision-making about our regulatory response. Survey data will also form a key source of evidence to support the judgements and inspection ratings published for trusts.

## Department of Health

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 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 respondents data that is contained within this report.

For more information, see the following link:
www.gov.uk/government/publications/nhs-outcomes-framework-2016-to-2017

## NHS England

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/.

## NHS Improvement

NHS Improvement oversees NHS trusts and independent providers that provide NHS-funded care. It supports providers to give patients consistently safe, high-quality, compassionate care within local health systems. NHS Improvement will use the results of the emergency department survey to inform quality and governance activities as part of its Oversight Model for NHS Trusts.

For more Information about NHS Improvement, please see: https://improvement.nhs.uk/.

## 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.

# Appendix E: Quality and methodology

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

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## 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 F: Further information and feedback

## Further information

The results for England and trust level results are available on CQC's website. You can also find a 'technical document' here, which describes the methodology for analysing the trust level results and a Quality & Methodology report:
www.cqc.org.uk/emergencydepartmentsurvey

The trust results from previous emergency department surveys are available at the link below. However, please note that results from the 2016 survey are **not comparable** with previous surveys. For more information on this, please see the statistical release or the Quality and Methodology report:
www.nhssurveys.org/surveys/296

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:
www.nhssurveys.org/surveys/957

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/content/surveys

More information about how CQC monitors hospitals is available on CQC's website at:
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 Emergency Department Survey 2016. The guidance above should help answer any questions you have about the programme. However, if you wish to contact the Team directly please contact Paul Williamson, User Voice Development Manager, at 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 Paul Williamson, User Voice Development Manager, at 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.

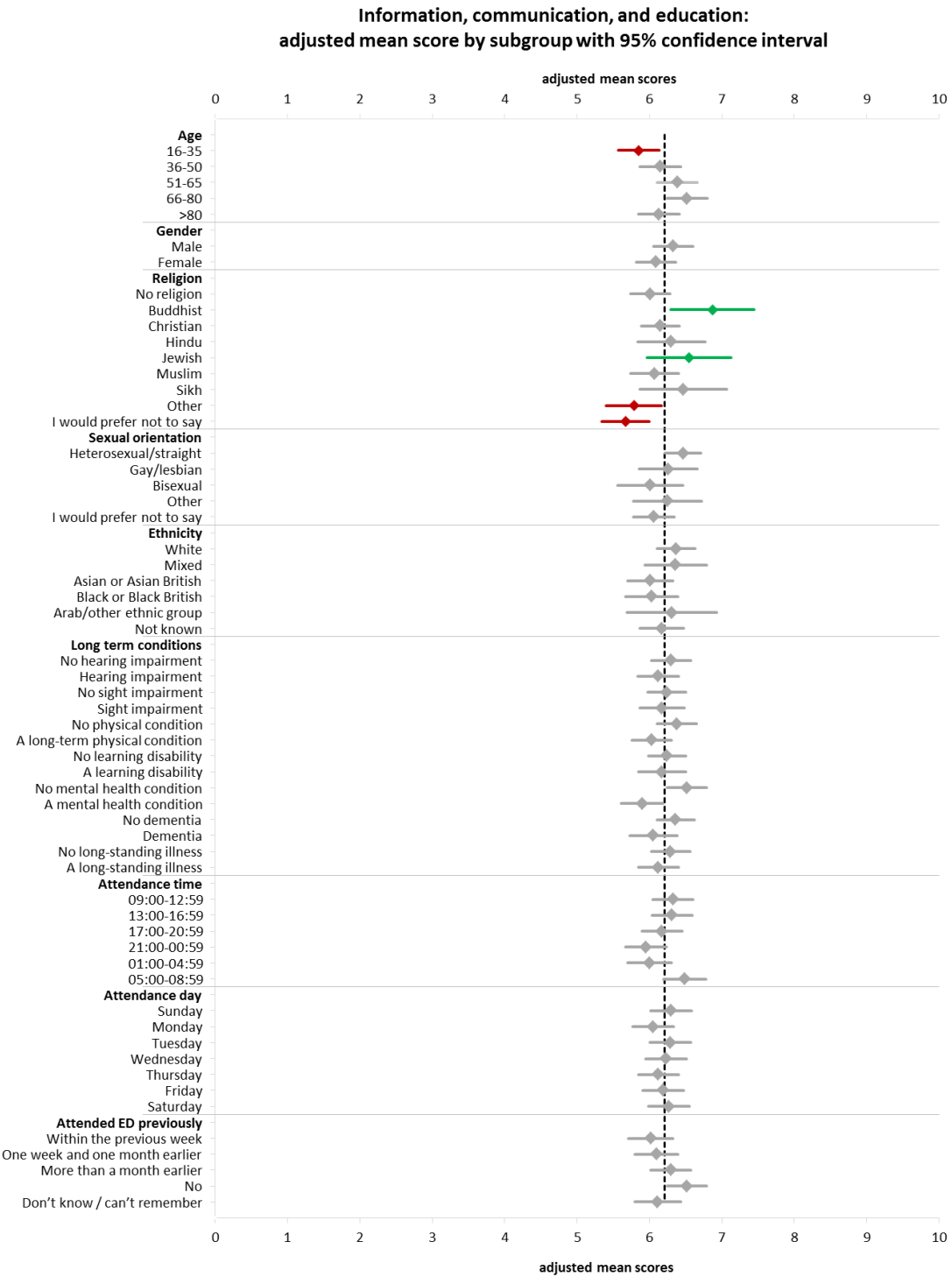
# Appendix G: Subgroup analysis charts

## Interpreting the graphs

This appendix provides the graphs underlying the subgroup analysis, the results for which are provided in section 10.

In the charts, the dotted line shows the average score for the composite, and those highlighted in red or green are more than 0.1 standard deviations away from the mean. Findings noted in this report are restricted to those that do not cross the mean line meaning we can be confident they are above or below the mean score.

For more detailed information on the methodology, please see the Quality and Methodology report.


Information, communication, and education:
adjusted mean score by subgroup with 95% confidence interval
adjusted mean scores
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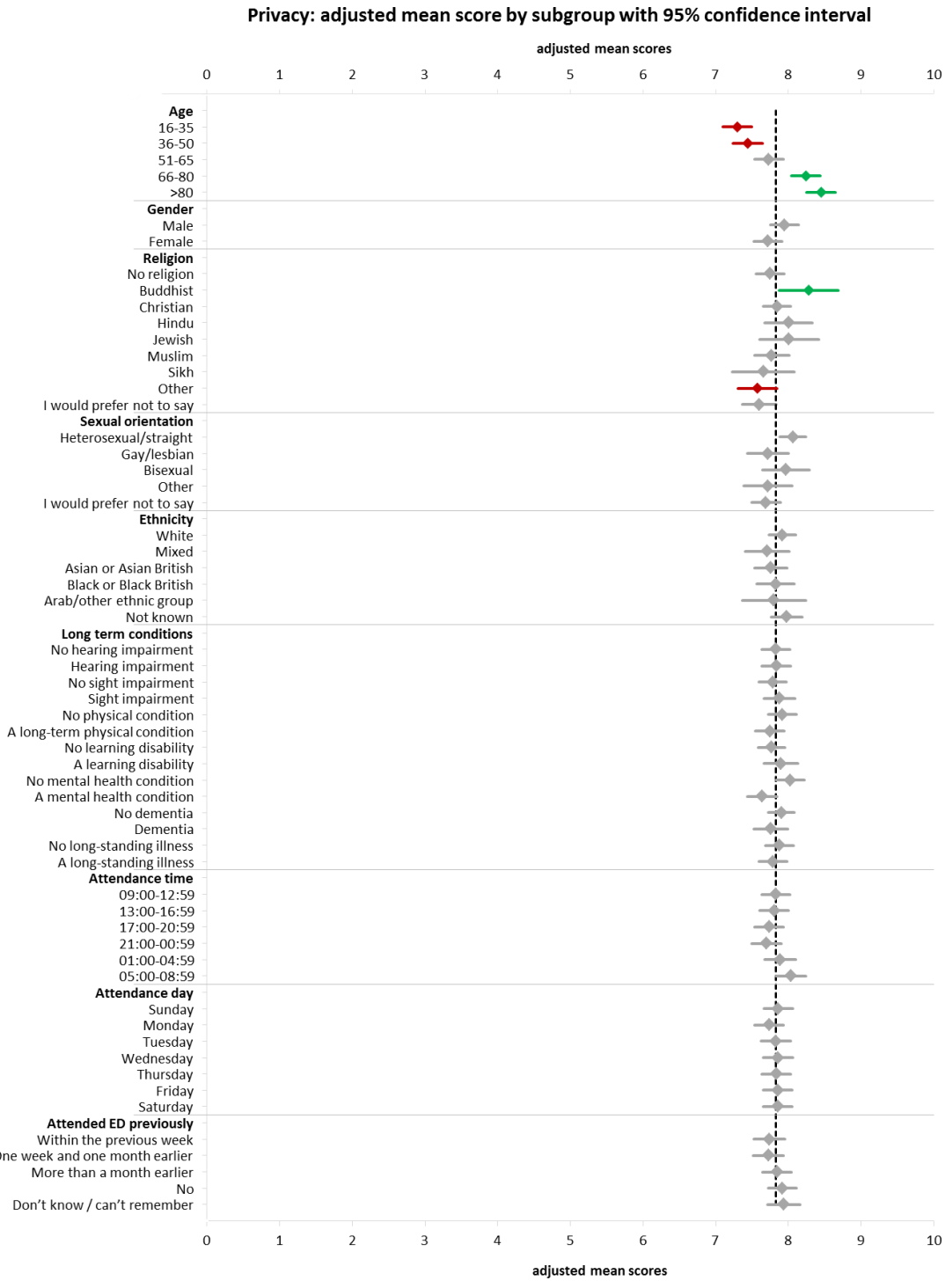
Age
16-35
36-50
51-65
66-80
>80
Gender
Male
Female
Religion
No religion
Buddhist
Christian
Hindu
Jewish
Muslim
Sikh
Other
I would prefer not to say
Sexual orientation
Heterosexual/straight
Gay/lesbian
Bisexual
Other
I would prefer not to say
Ethnicity
White
Mixed
Asian or Asian British
Black or Black British
Arab/other ethnic group
Not known
Long term conditions
No hearing impairment
Hearing impairment
No sight impairment
Sight impairment
No physical condition
A long-term physical condition
No learning disability
A learning disability
No mental health condition
A mental health condition
No dementia
Dementia
No long-standing illness
A long-standing illness
Attendance time
09:00-12:59
13:00-16:59
17:00-20:59
21:00-00:59
01:00-04:59
05:00-08:59
Attendance day
Sunday
Monday
Tuesday
Wednesday
Thursday
Friday
Saturday
Attended ED previously
Within the previous week
One week and one month earlier
More than a month earlier
No
Don't know / can't remember
adjusted mean scores


Privacy: adjusted mean score by subgroup with 95% confidence interval
adjusted mean scores
0
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Age
16-35
36-50
51-65
66-80
>80
Gender
Male
Female
Religion
No religion
Buddhist
Christian
Hindu
Jewish
Muslim
Sikh
Other
I would prefer not to say
Sexual orientation
Heterosexual/straight
Gay/lesbian
Bisexual
Other
I would prefer not to say
Ethnicity
White
Mixed
Asian or Asian British
Black or Black British
Arab/other ethnic group
Not known
Long term conditions
No hearing impairment
Hearing impairment
No sight impairment
Sight impairment
No physical condition
A long-term physical condition
No learning disability
A learning disability
No mental health condition
A mental health condition
No dementia
Dementia
No long-standing illness
A long-standing illness
Attendance time
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01:00-04:59
05:00-08:59
Attendance day
Sunday
Monday
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Wednesday
Thursday
Friday
Saturday
Attended ED previously
Within the previous week
One week and one month earlier
More than a month earlier
No
Don't know / can't remember
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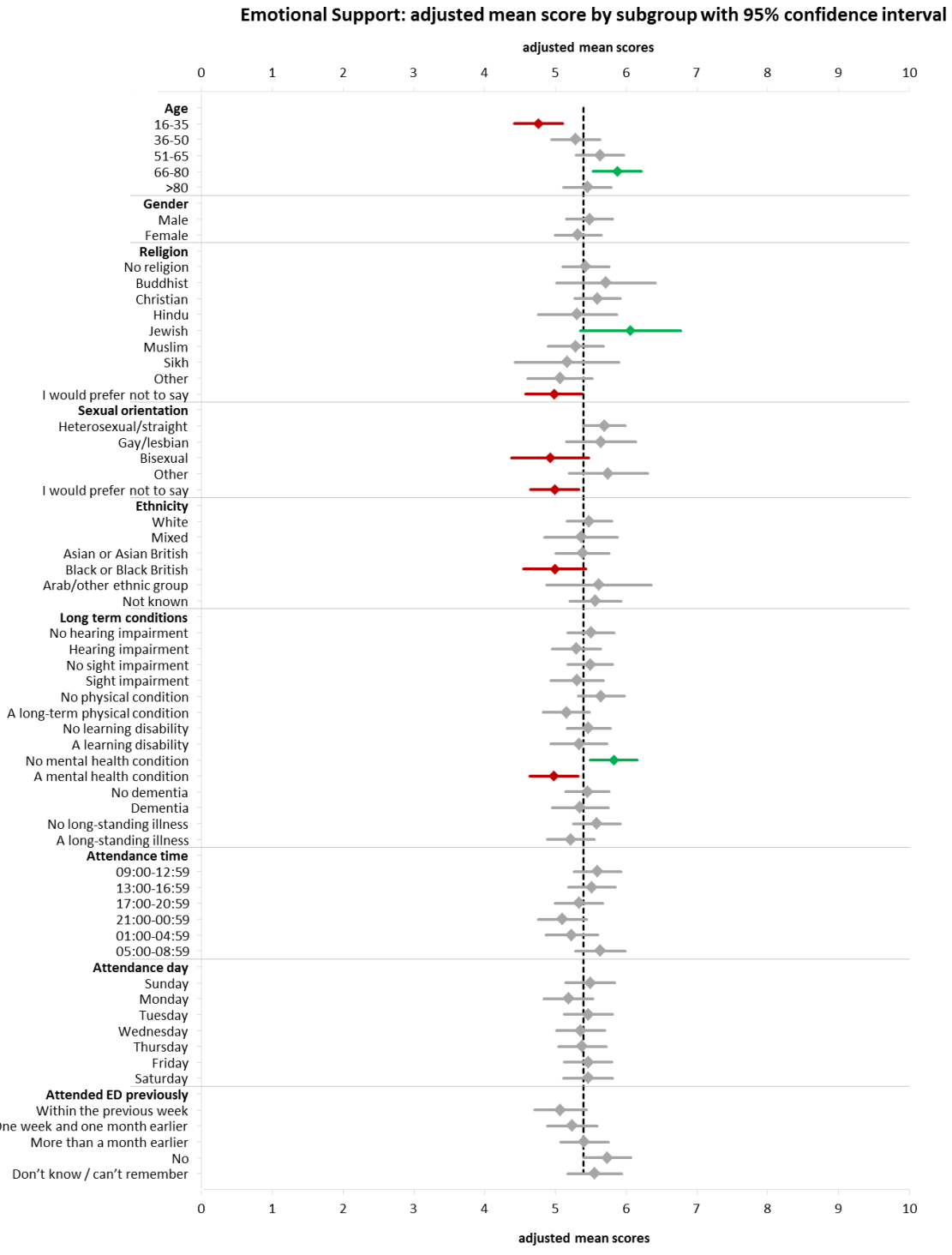
adjusted mean scores


Emotional Support: adjusted mean score by subgroup with 95% confidence interval
adjusted mean scores
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Age
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36-50
51-65
66-80
>80
Gender
Male
Female
Religion
No religion
Buddhist
Christian
Hindu
Jewish
Muslim
Sikh
Other
I would prefer not to say
Sexual orientation
Heterosexual/straight
Gay/lesbian
Bisexual
Other
I would prefer not to say
Ethnicity
White
Mixed
Asian or Asian British
Black or Black British
Arab/other ethnic group
Not known
Long term conditions
No hearing impairment
Hearing impairment
No sight impairment
Sight impairment
No physical condition
A long-term physical condition
No learning disability
A learning disability
No mental health condition
A mental health condition
No dementia
Dementia
No long-standing illness
A long-standing illness
Attendance time
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Attendance day
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Attended ED previously
Within the previous week
One week and one month earlier
More than a month earlier
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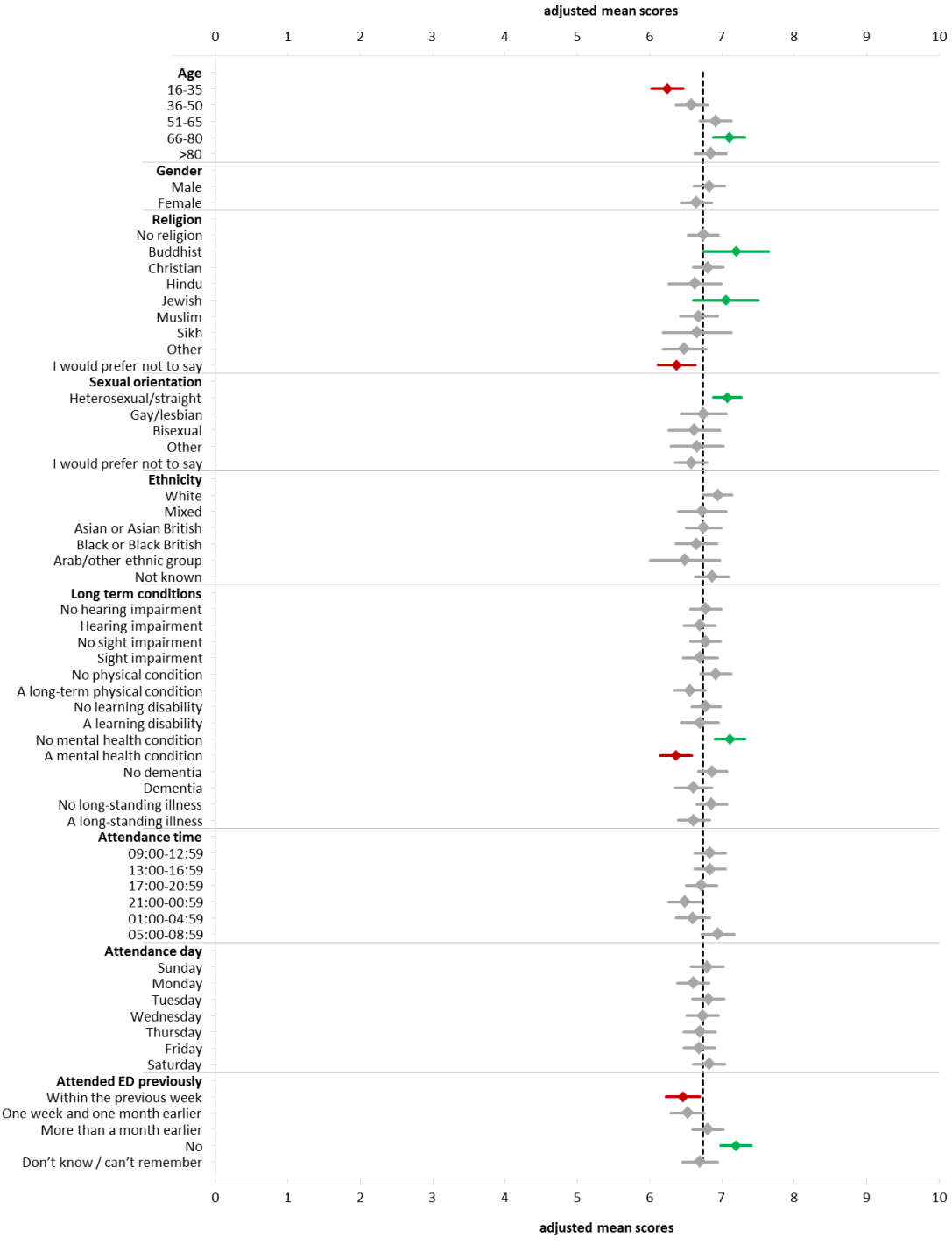
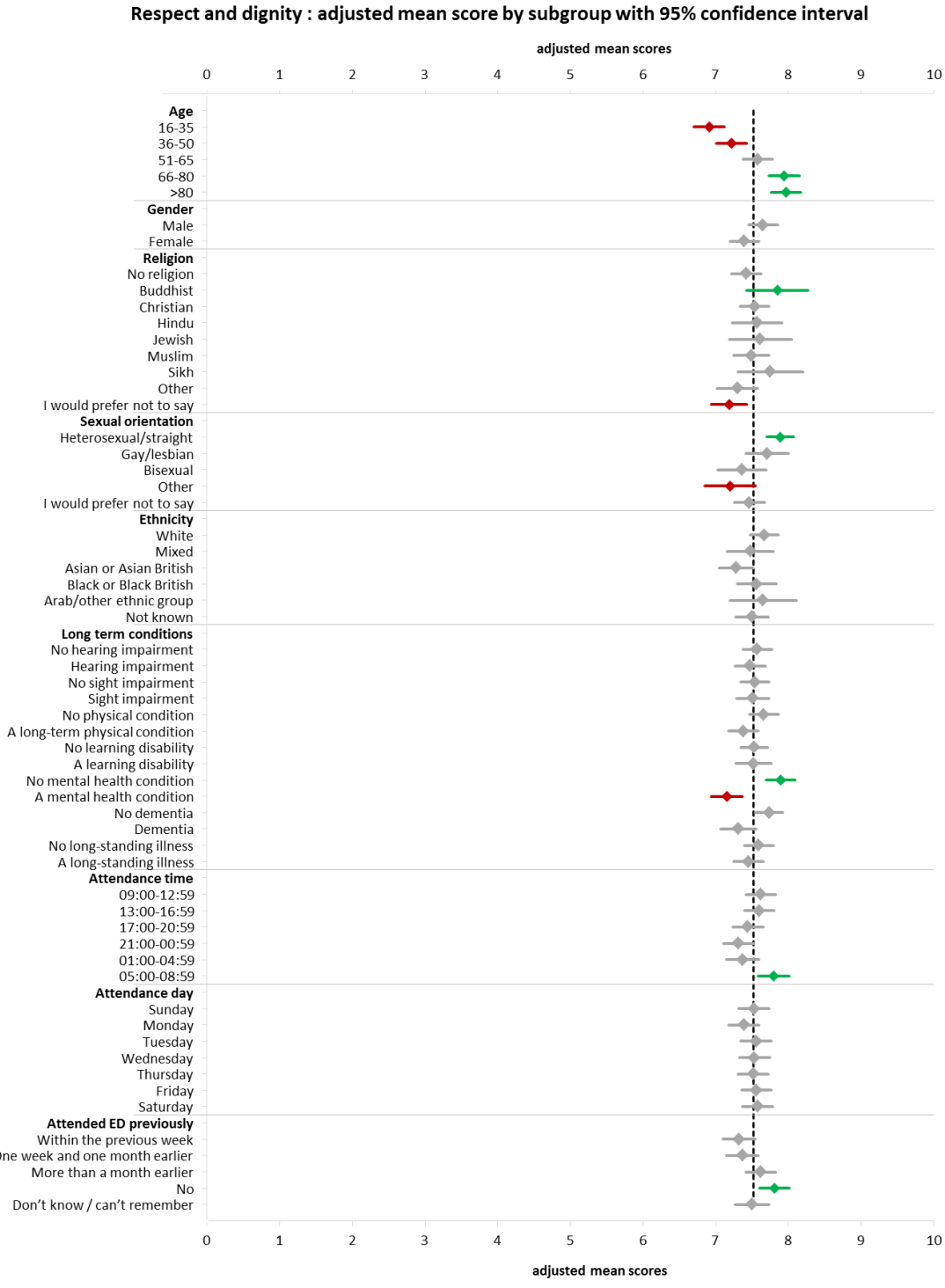
adjusted mean scores

**Involvement & decision making: adjusted mean score by subgroup with 95% confidence interval**




Respect and dignity : adjusted mean score by subgroup with 95% confidence interval
adjusted mean scores
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Gender
Male
Female
Religion
No religion
Buddhist
Christian
Hindu
Jewish
Muslim
Sikh
Other
I would prefer not to say
Sexual orientation
Heterosexual/straight
Gay/lesbian
Bisexual
Other
I would prefer not to say
Ethnicity
White
Mixed
Asian or Asian British
Black or Black British
Arab/other ethnic group
Not known
Long term conditions
No hearing impairment
Hearing impairment
No sight impairment
Sight impairment
No physical condition
A long-term physical condition
No learning disability
A learning disability
No mental health condition
A mental health condition
No dementia
Dementia
No long-standing illness
A long-standing illness
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Attendance day
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Attended ED previously
Within the previous week
One week and one month earlier
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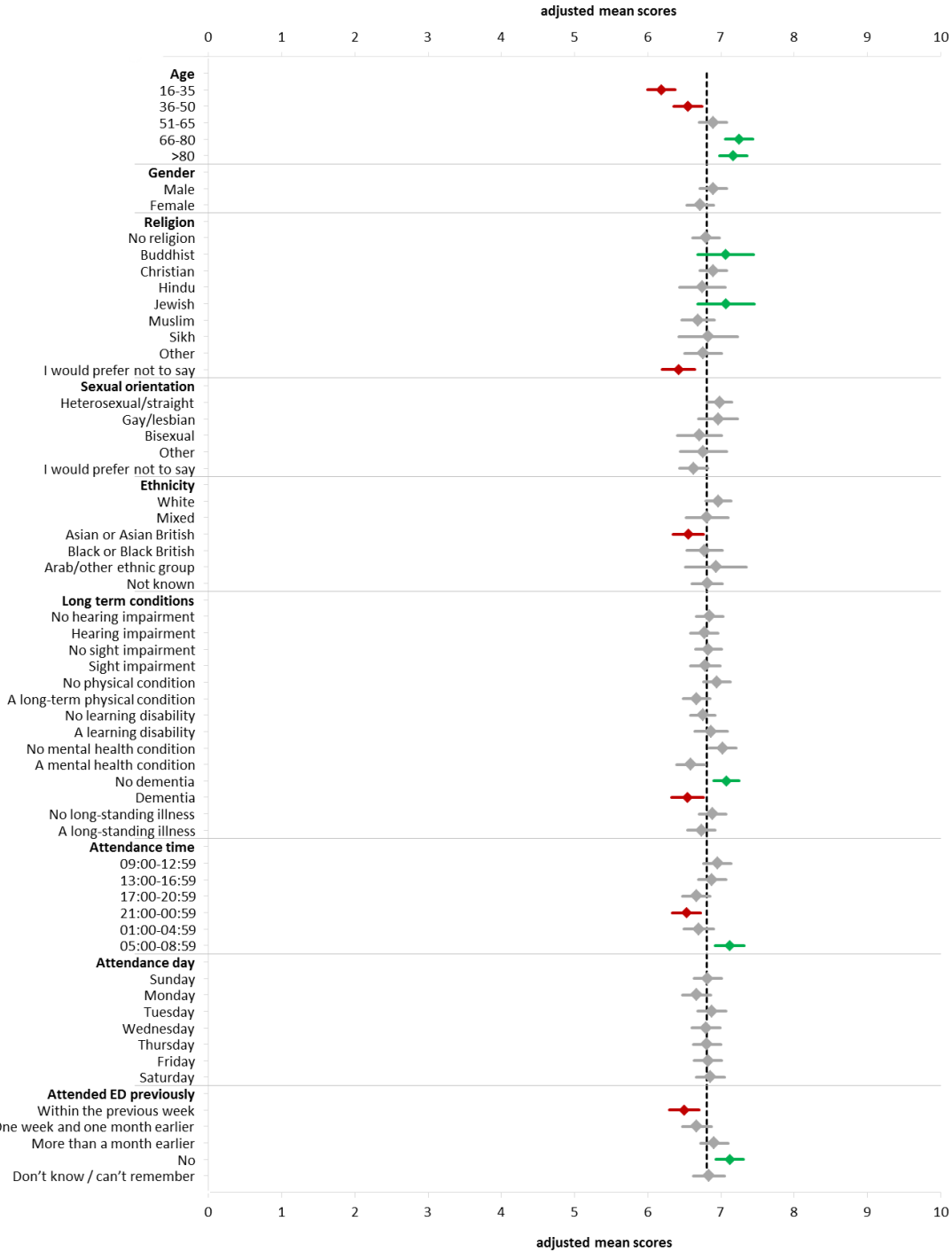
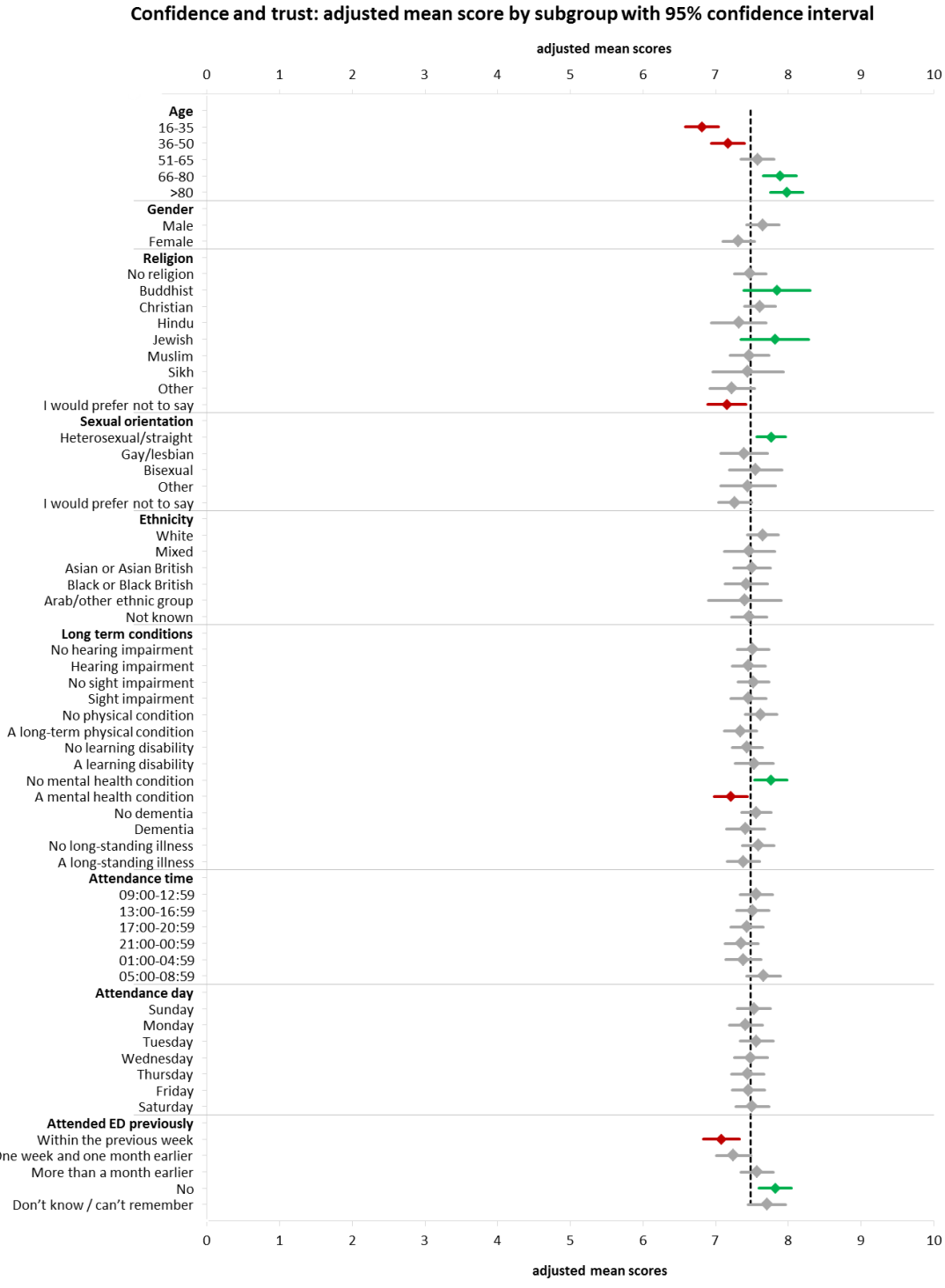
adjusted mean scores

**Overall experience: adjusted mean score by subgroup with 95% confidence interval**




Confidence and trust: adjusted mean score by subgroup with 95% confidence interval
adjusted mean scores
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Long term conditions
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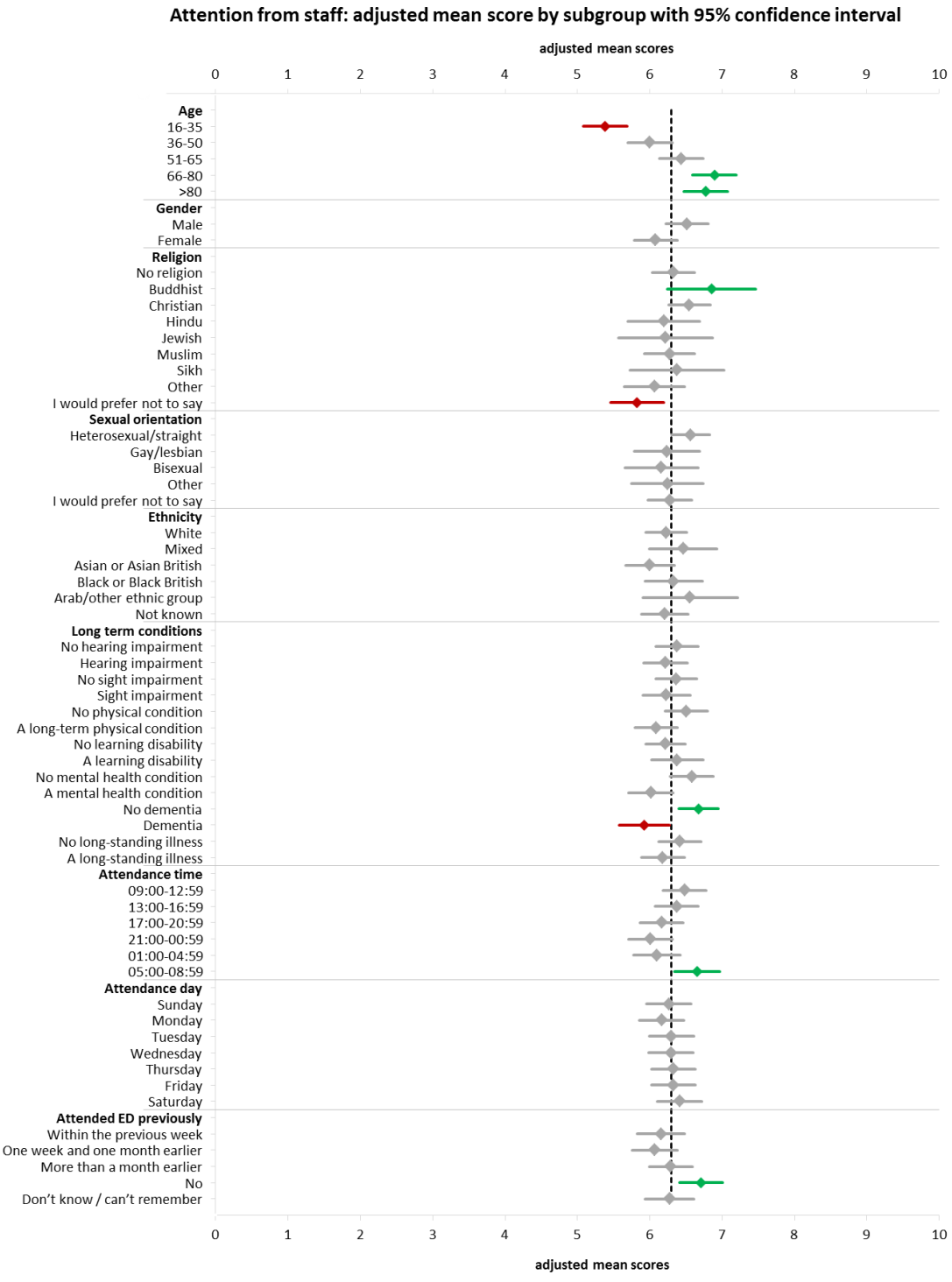
Attention from staff: adjusted mean score by subgroup with 95% confidence interval
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Within the previous week
One week and one month earlier
More than a month earlier
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Don't know / can't remember
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adjusted mean scores

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