

## A&E Survey

How and why patients decide to go to  
Accident & Emergency

June 2014



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# Foreword

Healthwatch West Sussex is the independent consumer champion for health and social care across West Sussex. Our role is to hear what local people have to say about local health and social care services. We use people's feedback to help improve services, challenging and working with the organisations who commission and deliver them. Healthwatch West Sussex seeks to engage with people in local communities from a wide range of backgrounds, including those who are socially isolated or seldom heard.

Each year, well over a hundred thousand people visit an Accident and Emergency (A&E) department within West Sussex. For many, it is a vital, life-saving service, and it is important that A&E provision works effectively. More than this, it's often said that Accident and Emergency is a barometer for the state of the health and social care system as a whole – problems found here often reflect wider issues.

Healthwatch West Sussex receives comments about a wide range of areas, but more about A&E than any other hospital department. What we hear suggests that some consumers are confused about where else they can go to get urgent treatment. Others find it difficult to get appointments elsewhere when they need them.

This report aims to understand attendance at Accident and Emergency from the perspective of the people who go there. It looks to understand why they are there, and how that decision was made. The report finds that while most people do attempt to use A&E responsibly, more can be done to provide clear information on alternatives, to increase the availability of other services, and to improve the provision from NHS 111.

I'm grateful, on behalf of Healthwatch West Sussex, to all the members of the public who filled out a questionnaire, and for the dedicated work of the Authorised Representatives who made the survey possible.

*Frances Russell, Chair of Board for Healthwatch West Sussex*

# Executive Summary

## Aims & methodology

- In response to concerns about mounting pressure on Accident and Emergency services locally and nationally, Healthwatch West Sussex carried out a survey to find out about why people went to A&E, and how they had made the decision to do so.
- The survey involved 367 people attending A&E departments at St. Richard's, Worthing and Princess Royal Hospitals during late January and early February 2014.

## Key findings

- Over half the sample came from only nine postcode districts, with RH16 making up 15.5% of the sample. There was a strong relationship between certain locations and the proportions of respondents considering their conditions to be urgent.
- The majority of respondents appeared to gauge the severity of the patient's condition appropriately. However, one in four respondents were unsure, implying that they may have been unable to make an informed decision about where to seek treatment, or that they lacked confidence in advice received from other sources.
- Respondents at Worthing Hospital tended to be less sure how serious the patient's condition was, and were more likely to have been advised by a friend/relative to come to A&E than at other hospitals.
- There was no evidence that health professionals were unnecessarily referring people to A&E. Conversely, non-experts such as friends and relatives were more likely to act cautiously, advising people to go to A&E.
- People with an injury were likely to go directly to somewhere where they could receive treatment for their wounds directly. GPs were less likely to be considered as an option in these circumstances.
- Patients attending A&E with an illness were more likely than those with other types of condition to be unsure how serious their condition was. They tended to expect tests to be carried out, and were more likely to have sought advice from a GP or an advice line.
- A&E did not appear to be seen as a location reserved for treating urgent or serious conditions. Irrespective of the severity of the condition, respondents tended to seek advice or treatment at whatever point it became apparent this was necessary. Their choice over where to go was dictated by which services were known or perceived to be open at that time.
- The majority of respondents had heard of NHS 111 and the Out of Hours service, but fewer were aware of Walk-in Centres and Minor Injuries Units. Very few had heard of Urgent Care Clinics.

- Awareness of facilities varied by postcode district. This may reflect the distribution of services around the county, but may also suggest a need for targeted promotion within particular localities and communities.
- 17.8% of people said they would not consider using NHS 111. Reasons cited included long waiting times and poor quality information.
- There was also evidence that people may be receiving clearer advice from GPs and other health professional than from NHS 111.
- The proportion of those who said they would not consider accessing a GP was significantly higher at Princess Royal Hospital than at other hospitals. Attendees at Princess Royal were more likely to rate their condition as not at all/not very serious, but also to give urgency as the main reason for attending.

# Acknowledgements

Healthwatch West Sussex would like to thank:

- All members of the public who completed the questionnaire
- The Authorised Representatives who volunteered their time and energy to developing the project and conducting surveys
- Viv Nuttall for her expertise and help in questionnaire design
- Tony Reynolds and Lesley Bright for their help with the pilot study
- The staff of the A&E departments at St. Richard's Hospital, Worthing Hospital and Princess Royal Hospital
- Sheree Fagge, Chief Nurse at Brighton and Sussex University Hospitals NHS Trust
- Caroline Davies, Deputy Chief Nurse at Brighton and Sussex University Hospitals NHS Trust
- Sandra Ellard, Deputy Director of Nursing and Safety at Western Sussex Hospitals NHS Foundation Trust

# Introduction

This study was proposed in the light of mounting concern about pressure on Accident and Emergency departments. The issue is prominent in national<sup>1</sup> and local<sup>2</sup> media and concerns have been raised in Parliament<sup>3</sup>.

While care should be taken when using statistics without content (such as the number of attendees), a number of statistics published by NHS England<sup>4</sup> suggest that local A&E departments may be under a degree of pressure. The target for 95% of A&E patients to be seen within four hours was missed by Brighton and Sussex University Hospitals NHS Trust (BSUH) in both of the last two quarters of 2013-14, while Western Sussex Hospitals NHS Foundation Trust (WSHT) missed the target on five out of six successive weeks during late November 2013 and early January 2014. Between November 2013 and March 2014, ambulances were forced to queue for more than thirty minutes on 300 occasions at WSHT and 2195 occasions at BSUH.

The issue of pressure on A&Es has been discussed at the Horsham and Mid Sussex Urgent Care Task Force. In addition, key figures from both BSUH and WSHT indicated they would value a survey, including the Chief Executive Officer and Chief Nurse of BSUH, the Senior Medical Consultant at Princess Royal Hospital, and the Deputy Director of Nursing and Safety at WSHT.

Over recent months, Healthwatch West Sussex has received more comments about Accident and Emergency than any other hospital department.<sup>5</sup> While some of this concern is focused on the performance of A&E departments, wider questions have been raised about the level of demand for these services, with the perception that some people attend unnecessarily. Comments made to Healthwatch West Sussex indicate that some consumers may be confused about the provision of alternatives, despite efforts to raise awareness of the most appropriate source of treatment for different conditions.

A survey of the patient experience of GP surgeries undertaken by Healthwatch West Sussex<sup>6</sup> identified difficulties obtaining appointments, suggesting that some patients are being forced to go elsewhere for treatment. Concerns were also raised about Out of Hours provision. Both factors may be leading to increased attendance at A&E departments.

Despite the prominence of these concerns, little research has been conducted locally to understand why patients go to A&E departments, or what attempts are made to access other sources of treatment and advice first. We hope that this report can provide a patient-centred view of the reasons for attending A&E, and an explanation of how these decisions are reached.

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<sup>1</sup> Trigg (2013); Campbell & Mason (2013); Smith (2014)

<sup>2</sup> Argus (2014); Mid Sussex Times (2013); West Sussex County Times (2013)

<sup>3</sup> House of Commons (2013)

<sup>4</sup> NHS England (2014)

<sup>5</sup> Healthwatch West Sussex (2014a)

<sup>6</sup> Healthwatch West Sussex (2014b)

# Methodology

## Aims

The aim of the study was to understand how people make decisions about whether to come to Accident and Emergency departments.

## Objectives

- To assess the nature of conditions which prompt visits to A&E, including:
  - the types of illnesses and conditions
  - how long patients have been suffering
  - how serious patients consider their conditions to be
  - what treatments patients think are needed
- To measure awareness of other sources of treatment
- To record the sorts of actions patients take before coming to A&E, such as:
  - consulting sources of information
  - visiting other treatment providers
- To understand the reasons why patients chose to come to A&E

## Collecting data

Data was collected through the use of questionnaires which were predominantly administered by experienced Authorised Representatives who had received detailed guidance and specific training. They were overseen by Healthwatch West Sussex's Research Officer.

In order to capture a full breadth of activity and attendances at A&E, fieldwork took place over nine days between Saturday 25<sup>th</sup> January and Sunday 2<sup>nd</sup> February 2014, at a range of times between 10am and midnight. Interviews took place in the waiting rooms of A&E departments at three locations:

- St. Richard's Hospital, Chichester
- Worthing Hospital
- Princess Royal Hospital, Haywards Heath

Figure 1 (below) gives details of the fieldwork conducted. Overall, it is felt that this gave sufficient coverage to accurately capture activity across all locations, times and days during the period. However, it is important to recognise that the data gathered will reflect the fieldwork coverage, as well as patterns of patient attendance. For this reason, it is correlations between variables, rather than absolute frequencies for dates and times, which are the focus of the subsequent analysis.

		Number of survey periods
Hospital	Princess Royal	13
	Worthing	6
	St. Richard's	6
Time period	10am - 2pm	6
	2pm - 6pm	9
	6pm - 10pm	6
	10pm - midnight	4
Day	Saturday*	5
	Sunday*	4
	Monday	5
	Tuesday	2
	Wednesday	4
	Thursday	1
	Friday	4

Figure 1: Breakdown of surveying periods.

\* Fieldwork took place over nine days; totals therefore include two Saturdays and Sundays, but only one of each weekday.

Given the short time period over which fieldwork was conducted, it should be stated that the findings of this survey must be considered a snapshot, rather than being representative of A&E usage at other times. The weather during the week of fieldwork was unseasonably wet<sup>7</sup> which may have affected patterns of need and attendance to some degree. However, overall attendance figures for the week were broadly comparable with those for previous years (see Figure 2 below).<sup>8</sup>

However, although the level and types of demand for A&E treatment may vary between time periods, the perceptions and decision-making processes which members of the public use when seeking treatment are likely to be remain relatively stable, and therefore bear examination.

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<sup>7</sup> Met Office (2014)

<sup>8</sup> NHS (2014)

Weekly attendances at A&E		
Week ending	Princess Royal Hospital	Western Sussex Hospitals NHS Foundation Trust
2 <sup>nd</sup> February 2014	552	2,412
3 <sup>rd</sup> February 2013	596	2,485
5 <sup>th</sup> February 2012	517	2,284
30 <sup>th</sup> January 2011	524	2,272

Figure 2: Total number of attendances in the week. Figures for Western Sussex Hospitals NHS Foundation Trust include A&E departments at both Worthing Hospital and St Richard's, and were taken from NHS (2014). Data for Princess Royal relates solely to that hospital, and was supplied by Brighton and Sussex University Hospitals Trust.

Significant consideration was given to the needs of patients and medical staff. Authorised Representatives took great care to ensure that surveys did not interfere with or delay treatment or instructions from hospital staff. Interviews were not carried out with anyone under the age of eighteen, although accompanying adults were interviewed where this was possible.

Individuals who appeared to be too unwell, distressed or otherwise preoccupied were not disturbed, and extreme sensitivity was shown to anyone who preferred not to participate. Informed consent was sought from all participants, with detailed information being made available before interviews took place. It was made clear that patients' treatment would not be affected by their decision whether to participate in the survey or not, nor by any responses they might give.

Care was taken during and after interviews to guard the confidentiality of people's data, for example, by ensuring that participants could not be overheard. No details were shared with hospital or medical staff. Individuals were given the option of completing the survey themselves if they wished to, and the questionnaires were designed with this need in mind. While only a small number of people took up this option, it did convey the advantage of allowing a larger number of people to be surveyed during particularly busy periods.

## Analysis

The survey data was analysed using the software packages SPSS and Microsoft Excel<sup>9</sup>. In addition, open-ended responses were sorted according to their themes. The aim of the analysis was to identify relationships which existed between variables.

A number of commonly hypothesised relationships were examined. Many of these were drawn from discussions and ideas generated by volunteers belonging to Healthwatch West Sussex's *Enter & View Group* during planning meetings, while others reflect ideas commonly expressed in the media. Some were more speculative.

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<sup>9</sup> Both univariate and bivariate methods of analysis were conducted.

Correlations are reported where they were found to be statistically significant at the 95% confidence level.<sup>10</sup> This equates to a one in twenty chance that the relationship was merely due to random chance. In view of the large number of these tests which were performed, it was inevitable that some false positives would occur. Therefore, care was taken with results only slightly below the  $p=.05$  significance level, especially where the strength of the correlation was relatively weak, or where no credible hypothesis to explain the relationship was available. In general, correlations which did not exist at a statistically significant level were not reported, except where the absence of a relationship was of particular interest.

In a number of cases, the sample size was not large enough to produce a reliable test of significance. This usually occurred where some categories had only a small number of responses. Where possible, variables were recoded into fewer categories and the test reconducted. Where this was not possible, correlations were dismissed, although in a few cases, the finding is explicitly stated, along with a desire for further research.

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<sup>10</sup> Significance levels and measures of correlation strength are reported in footnotes. For a full appendix of results, see Healthwatch West Sussex (2014c).

# Findings

## Fieldwork context

As mentioned in the *Methodology* section, it is important to recognise that the times, dates and locations of interviews will reflect the fieldwork conducted, as well as the patterns of patient attendance during the period.

### Location

During the fieldwork, 367 surveys were carried out. The largest share (44%) occurred at Princess Royal Hospital. Fewest interviews were conducted at St. Richard's Hospital (24%, equating to 86 surveys). The total achieved at Worthing Hospital falls approximately halfway between these amounts.

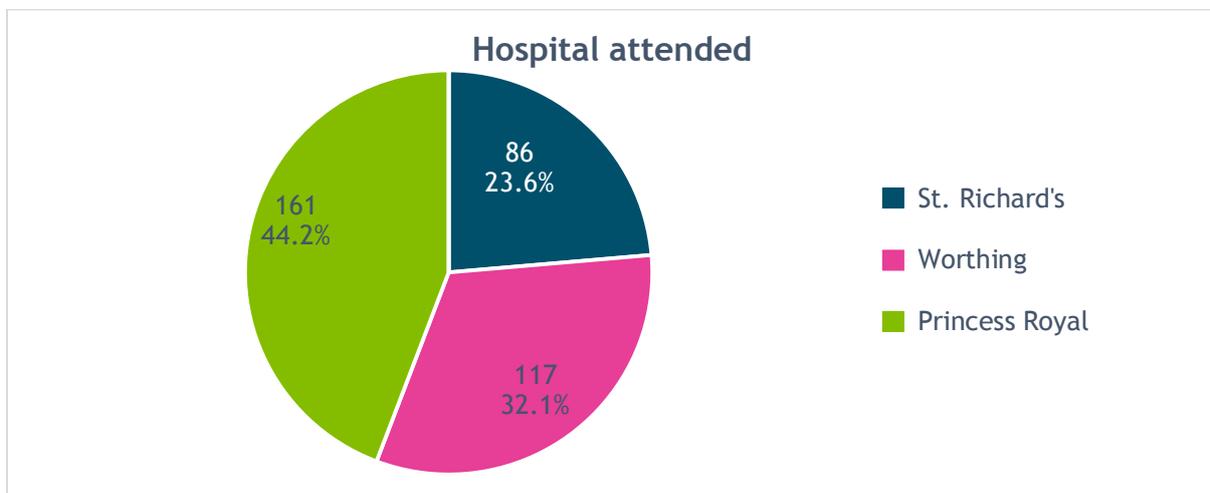


Figure 3: Hospital attended.

### Times and days

The majority of surveys were completed on or just after the weekend, with Monday having the most recorded interviews (25.0% of the sample), followed by Saturday (19.5%) and Sunday (15.9%). Fewer were captured on other weekdays, with the least being conducted on Thursday (6.0%).

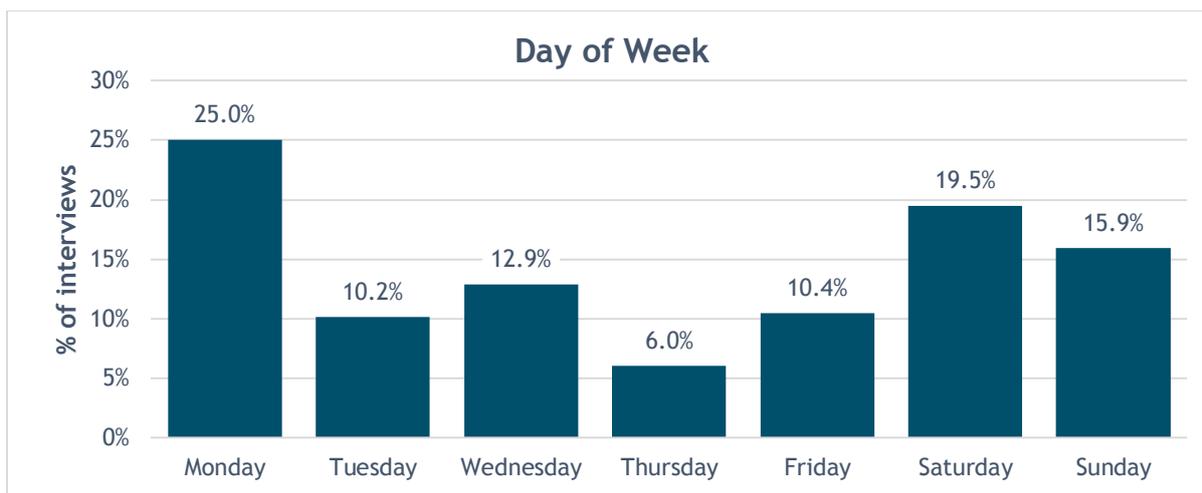


Figure 4: “Day on which interview took place”. Fieldwork took place over nine days; totals therefore include two Saturdays and Sundays, but only one of each weekday.

There was a relatively even spread of interviews throughout the day. Figure 5 shows the interview times rounded to the nearest hour. Perhaps unsurprisingly, fewest were conducted in the earliest and latest parts of the day, while the most were carried out around 3-4pm.

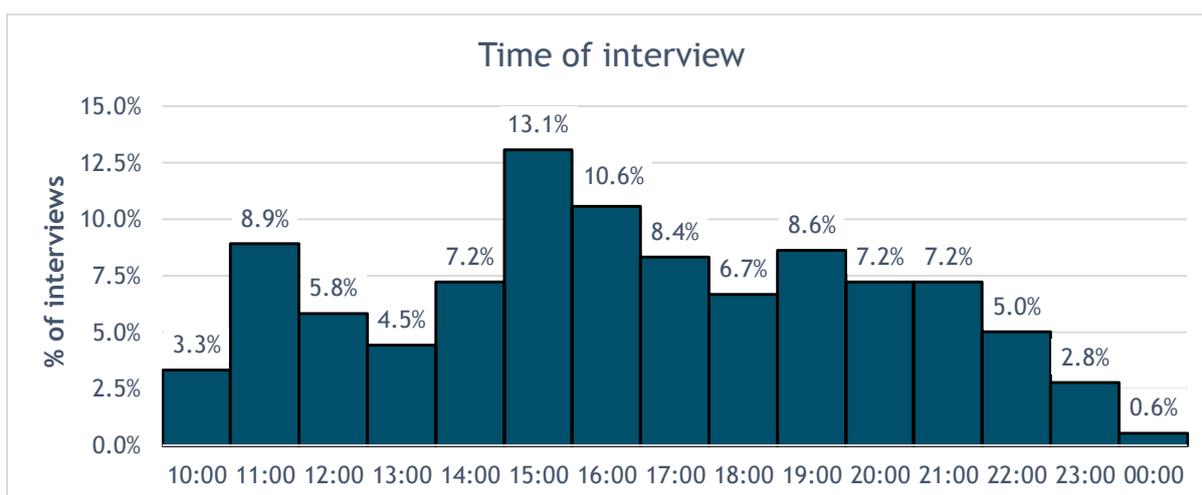


Figure 5: “Time of interview”, rounded to the nearest hour (e.g. the 11:00 time slot includes interviews occurring between 10:30-11:29).

### Peak/off-peak times

Overall, slightly fewer than half of surveys (45.7%) were conducted during weekday working hours. These are defined as running from 10am, when the earliest interviews took place, to 6pm on Monday to Friday.<sup>11</sup> Figure 6 shows separate figures for the proportions of interviews taking place after 6pm on a weekday and those at the weekend.<sup>12</sup>

<sup>11</sup> These may be considered hours when most people could expect their GP practices to be open. Interviews with Practice Managers suggested that over half of GP practices offered appointments later than 6pm on at least some days, while 30% offered some weekend appointments (Healthwatch West Sussex, 2014).

<sup>12</sup> The subsequent analysis in this report refers only to peak and off-peak times, which includes any interview taking place in a timeslot of 6pm or later, as well as any interviews on a Saturday or Sunday.

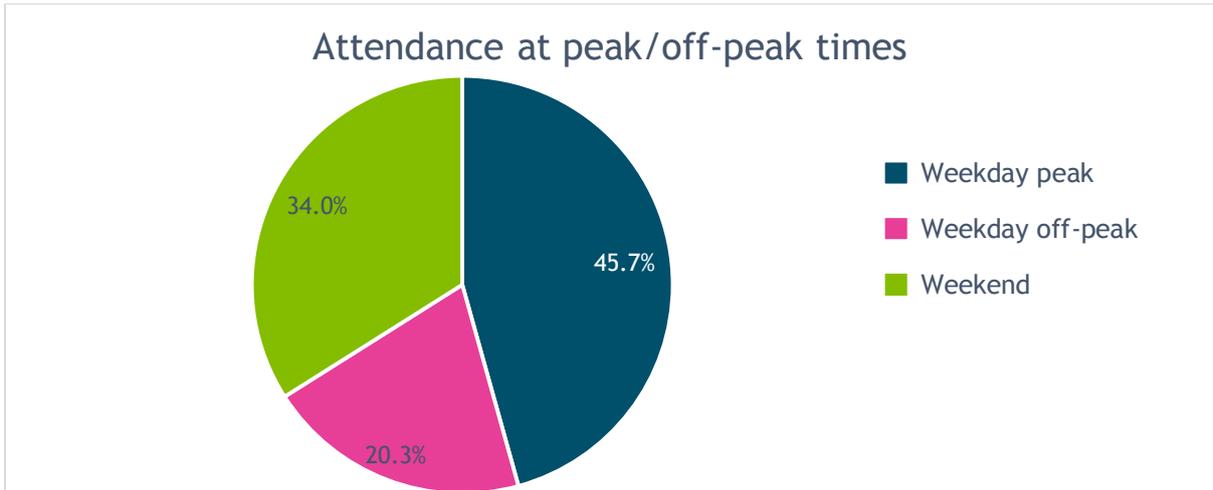


Figure 6: Interviews conducted at peak and off-peak times. Peak hours are defined as 10am to 6pm. No interviews were carried out before 10am. 'Weekend' includes interviews taking place at any time on a Saturday or Sunday.

## Details about the patient

The majority (62.7%) of those interviewed were the patient themselves, while 21% were accompanying a child. Interviewees were balanced almost equally between genders, with 50.6% being female.

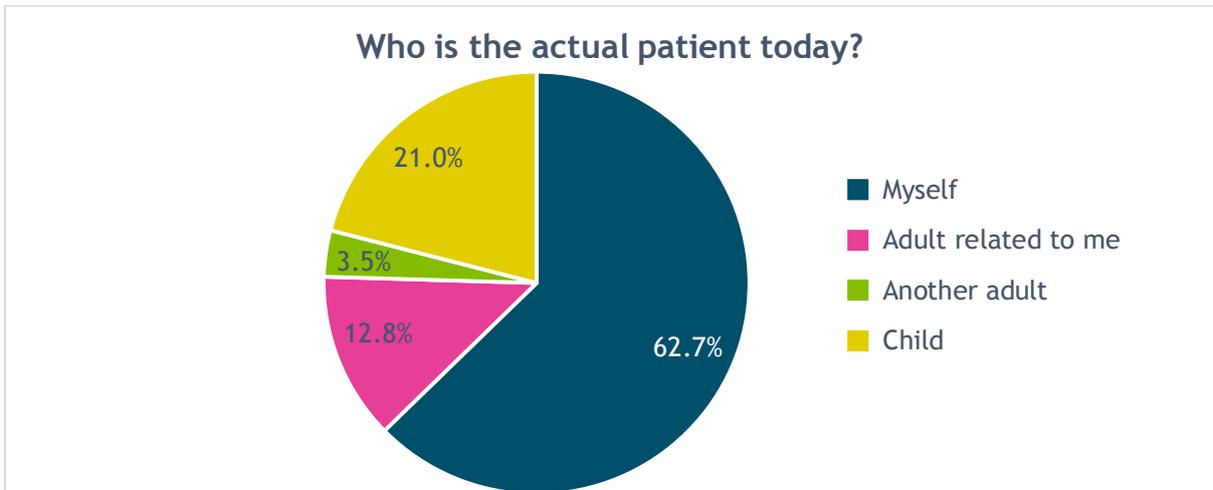


Figure 7: "Who is the actual patient today?"

## Age

The most common age groups for patients surveyed were 25-44 and 45-64, making up 26.8% and 22.1% of the sample respectively. Almost a quarter (23.5%) of patients were aged under 18. There were fewer patients at the older end of the age spectrum, with only 14.5% of the sample being aged 65 or over.

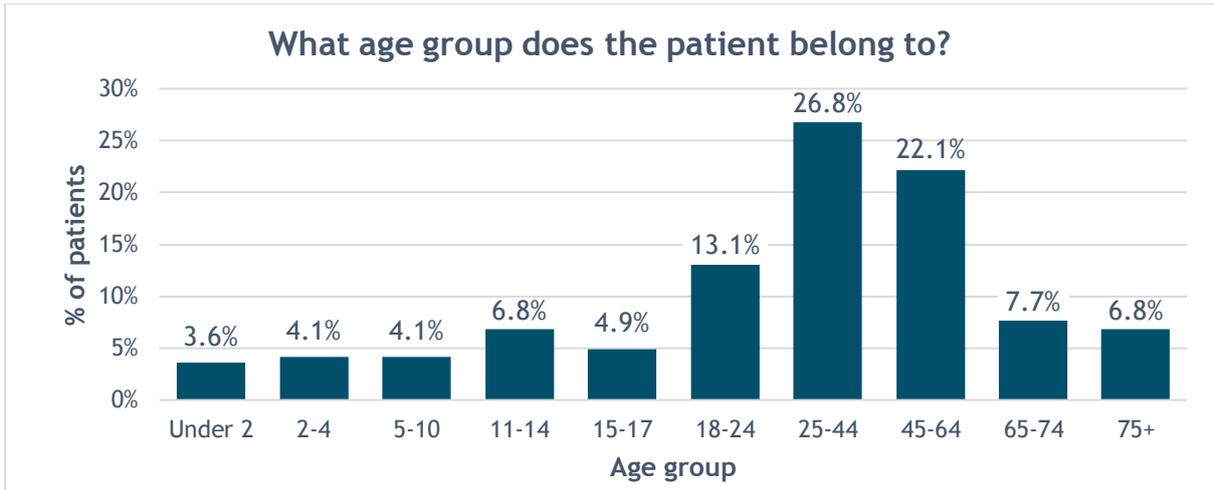


Figure 8: “Which age group does the patient belong to?” The graph shows the percentage of the sample belonging to each age group, which may be different to the proportions attending A&E.

This finding may be misleading, as some age brackets were considerably wider than others. Figure 9 corrects for this, showing the relative likelihood of each age group attending A&E.<sup>13 14 15</sup> It can be seen that the age groups relatively most likely to attend A&E were children aged under 2 and all age groups between eleven and twenty four. Adults were successively less likely to come to A&E, with each age group having a lower relative likelihood figure, and those aged 75+ being least likely to attend.<sup>16</sup>

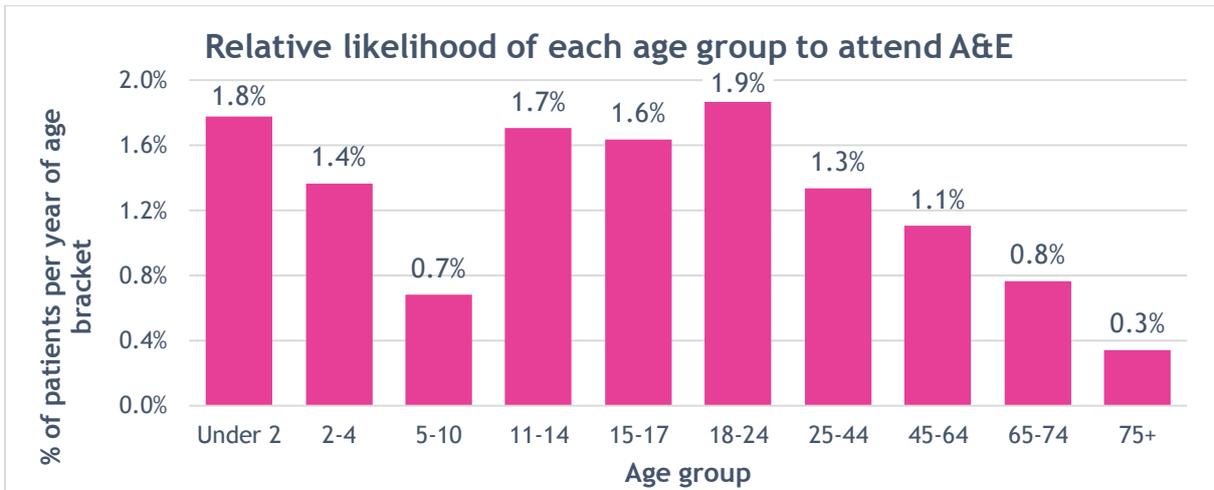


Figure 9: Relative likelihood of each age group to attend A&E. See footnotes 12-14 for calculation method.

<sup>13</sup> This is calculated by dividing the percentages in Figure 8 by the number of years that each age group spans. For example, 23.5% of the sample belonged to the age group 25-44, a span of twenty years. 23.5% is divided by 20 to give the relative likelihood of 1.3% for that age group.

<sup>14</sup> It is more difficult to calculate a precise figure for the 75+ group, as the category has no defined upper limit. While the survey did not ask for the precise age of patients, it was possible to identify one person aged 93. For this reason, the age band was considered to range from 75 to 95.

<sup>15</sup> Note that the calculations made in Figure 9 do not take any account of the population structure of the county.

<sup>16</sup> It should be noted that as surveys were only carried out with people in A&E waiting rooms, persons arriving in ambulances (i.e. those experiencing the most severe conditions) were seldom included in the sample.

## Travelling to A&E

### Transport used

Over two thirds (72.4%) of patients had been driven to A&E by another person, and in a further 17% of cases, the patient had driven themselves. It was generally not possible to interview people who had arrived by ambulance, as they tended not to be sent to waiting rooms. Consequently, only 2.8% of those interviewed had arrived by ambulance. However, in these cases, it is likely to have been a paramedic, rather than the patient, who will have made the decision that A&E was the appropriate location.

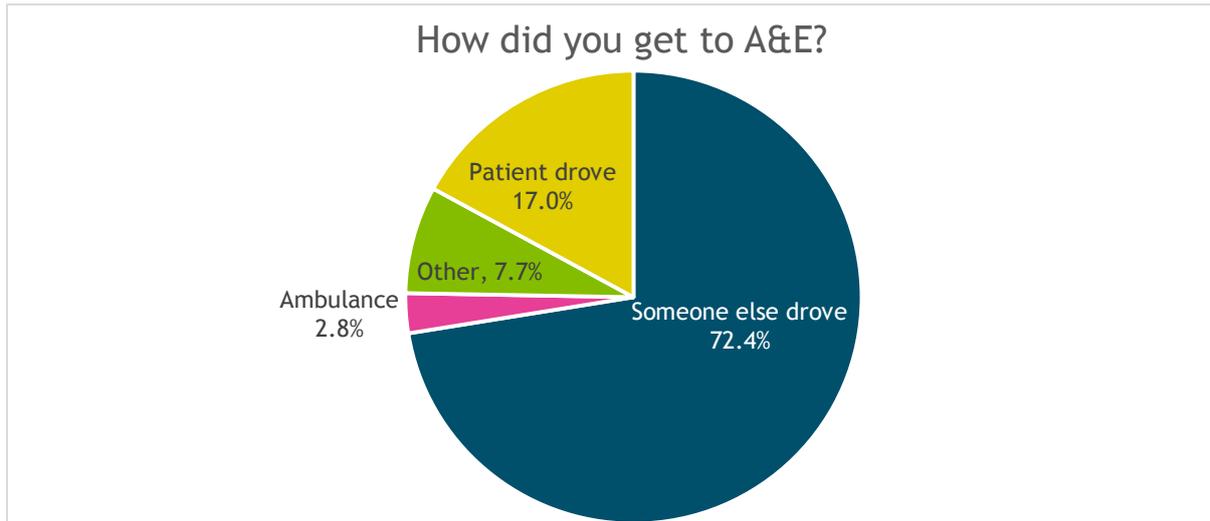


Figure 10: Transport used by patients in getting to A&E department. Smaller circle gives a breakdown of the 10.6% of responses which are combined into 'Other' in the larger circle. The percentages given in the smaller circle are as a proportion of the whole sample.

### Journey time

Over half of respondents took less than twenty minutes to travel to A&E, with 36.3% taking between 10-19 minutes. Very few (2.9%) had travelled for more than 45 minutes.

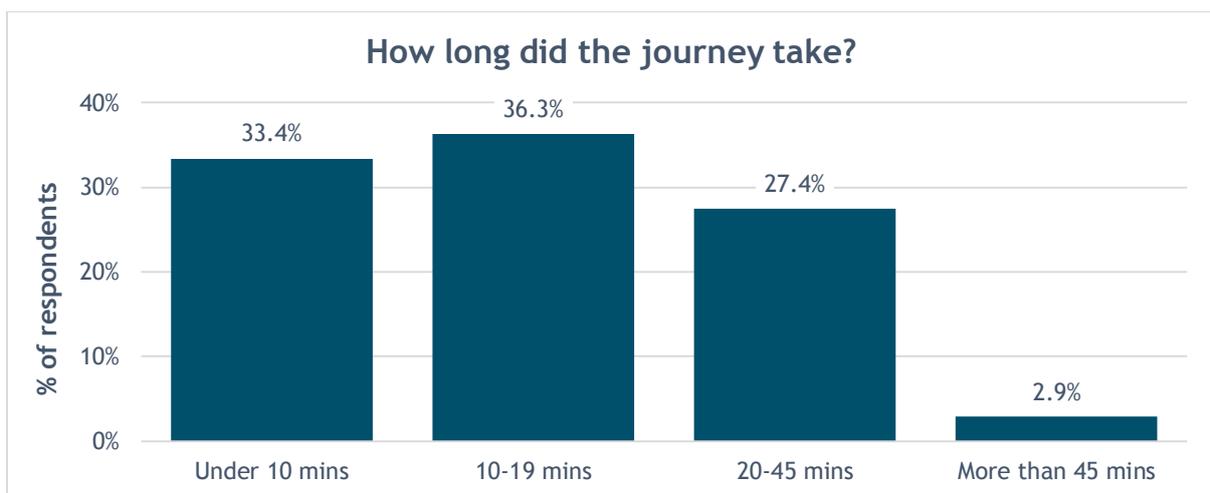


Figure 11: "How long did the journey take, in total?"

## Participants home addresses

Just over a third of participants' homes were in the BN postcode area (39.0%), while a similar number lived in the RH area (37.0%). Fewer (17.9%) had a PO postcode.

Fifty specific postcode districts were recorded during the survey. Of these, nine districts accounted for more than half the sample, each one occurring in at least 3.5% of cases. These are shown in Figure 12 below. The most frequently occurring district was RH16, making up a sizeable 15.5% of the sample, while RH15 (9.1%) and BN11 (6.7%) were also recorded frequently.

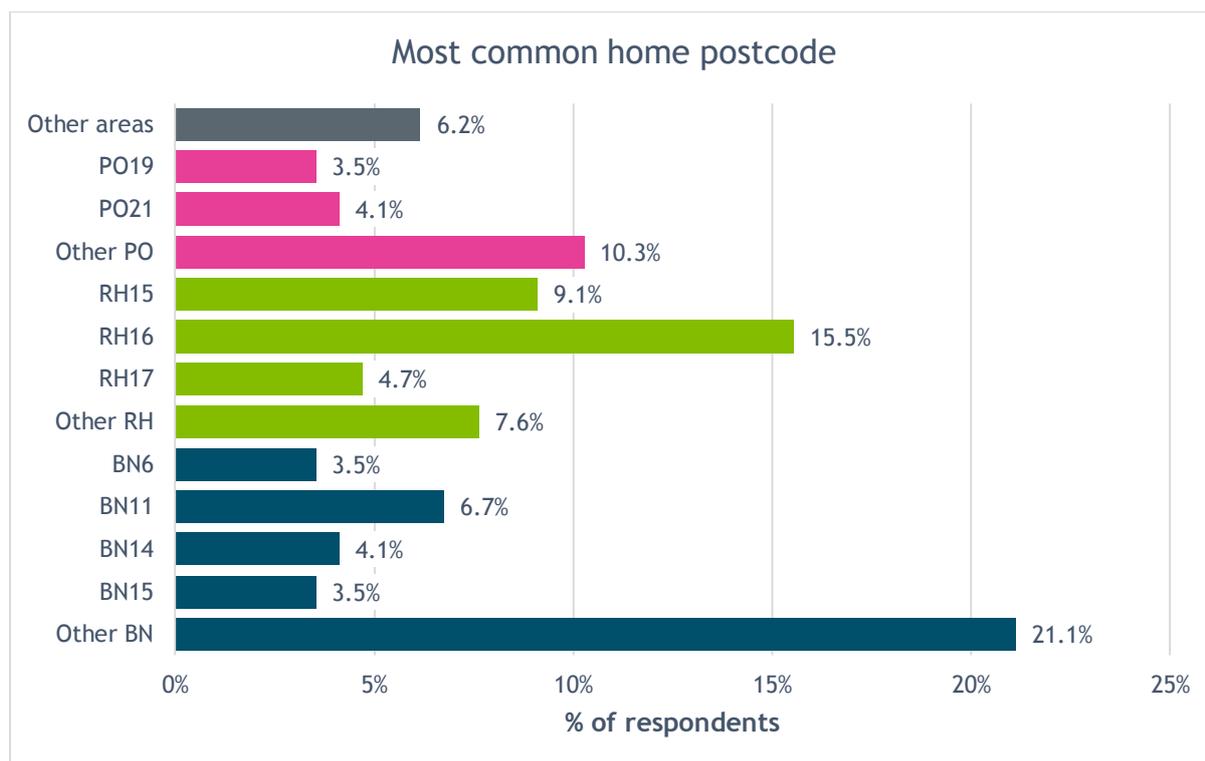


Figure 12: "What is the first part of your home postcode?" The response is for the participant, which may differ from the home address of the patient. Districts representing less than 3.5% of the sample have been combined into the 'other' categories. 'Other areas' includes all postcodes from areas GU, ME, NR and TN.

To a large degree, this pattern is understandable, reflecting some of the major population centres areas of the county. It must also be recognised that some locations, such as Horsham, Crawley and Shoreham-by-Sea, are served in part by other facilities not included in the sample; which may explain why they do not show up as prominently in the data.

However, it is notable that the area around Littlehampton forms a smaller proportion of the sample than might be expected, given its population size<sup>17</sup> and the fact that both the major treatment locations served by the area were included in the sample. The proportion of respondents who came from the RH16 area was relatively high, even when the larger number of interviews taking place at Princess Royal Hospital is taken into account. It may be worth investigating why this is the case.

<sup>17</sup> Population figures taken from Brinkhoff (2014), which are drawn from the 2011 Census.

## The condition or problem

### Type of problem

More than half of patients (55.9%) had come to A&E because of an injury, while 17.5% classified their problem as an illness. Figure 13 (below) shows the descriptions selected by the respondent, which may differ from those given in a medical assessment.

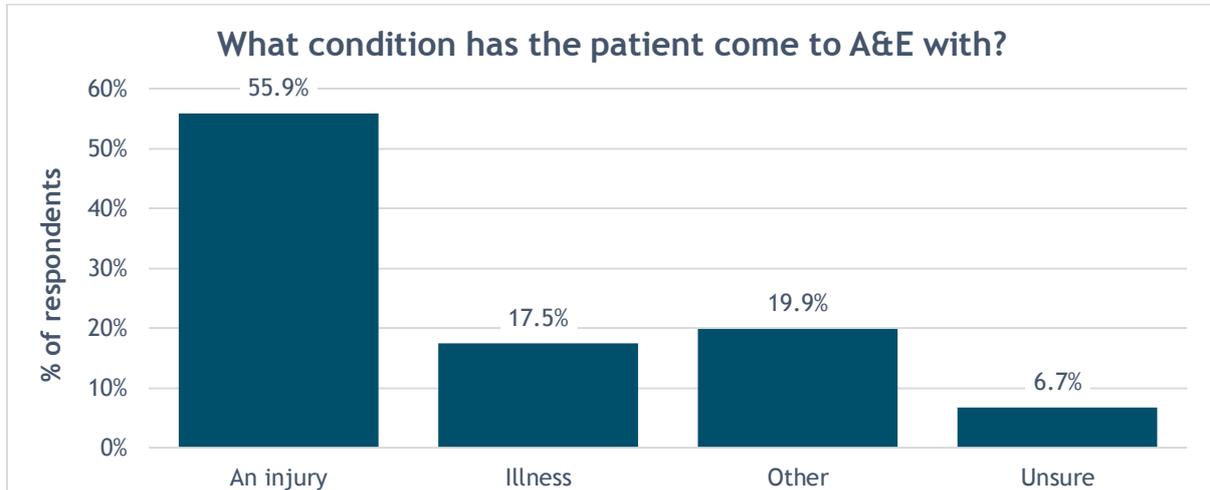


Figure 13: "Is the patient here because of an injury, an illness, or another condition?" Classifications were selected by the respondent.

Although optional, around two thirds of respondents also gave further details of the condition. Figure 14 summarises the main themes.

Examples of problems reported	
Injuries	<ul style="list-style-type: none"> <li>• Specific accident or incident (107) (e.g. Fall, sports injury)</li> <li>• Named part of body (15)</li> </ul>
Illnesses	<ul style="list-style-type: none"> <li>• Specific identified condition (16) (e.g. kidney stones, mental health problem)</li> <li>• Infection or swelling (14)</li> <li>• Specific symptom (11) (e.g. breathing difficulties, rash)</li> </ul>
Other/unsure	<ul style="list-style-type: none"> <li>• Longstanding condition/follow-up to previous treatment (11)</li> <li>• Wanting a check or diagnosis (6)</li> <li>• Dental (5)</li> </ul>
Appearing in all categories	<ul style="list-style-type: none"> <li>• Pain (27)</li> </ul>

Figure 14: Summary of main trends in reported conditions. Numbers in brackets show the number of cases; these include a small number of responses which fit well into these themes but which were classified differently by the respondent. Cases have not been counted in more than one category (although for some, this would have been possible).

Some age groups were statistically more likely than others to have come to A&E with an injury. <sup>18</sup> The vast majority of those aged 5-10 or 11-14 came with an injury (86.7% and 92.0% respectively). 65-74 year olds are less likely to present with an injury than those who are in younger or older age groups, while children under 2 were the least likely.

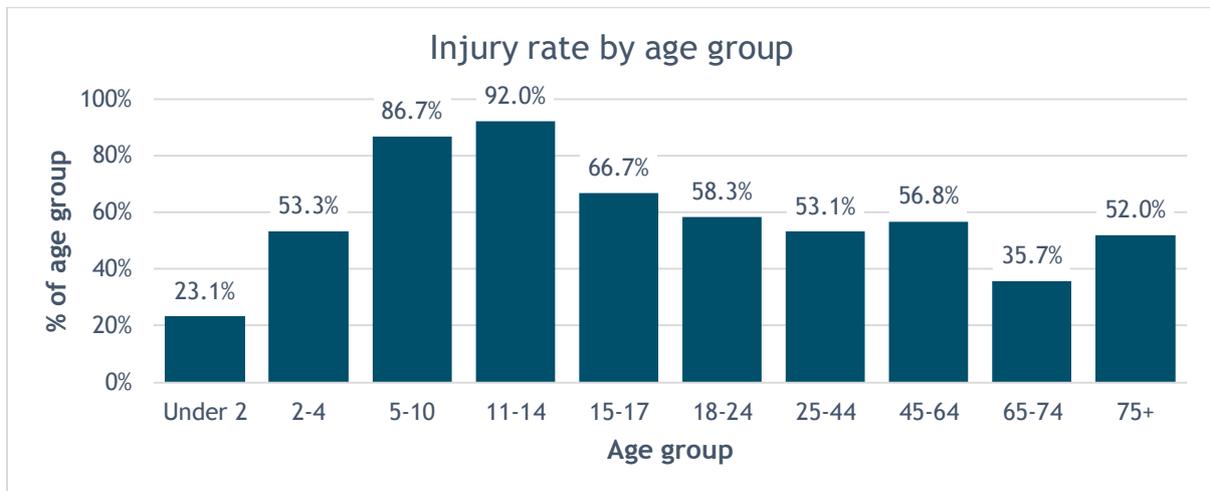


Figure 15: The proportion of each age group coming to A&E with an injury.

### Duration of the problem

A third of patients (35.5%) had been suffering from their *current* problem or condition for less than four hours, and a further 18.6% for between four and twelve hours. One in six patients (16.1%) had attended A&E with a problem persisting for more than seven days.

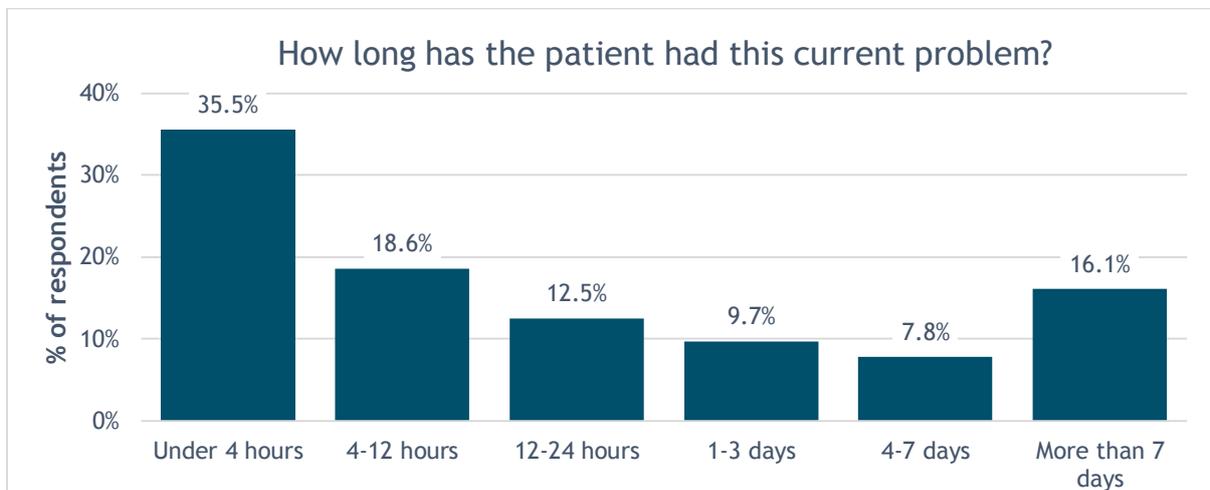


Figure 16: “Approximately how long has the patient been suffering from this current problem? (If the issue is reoccurring or longstanding, how long has the current episode been occurring?)”

<sup>18</sup> p=.000, phi coefficient .290

The amount of time patients waited before coming to A&E depended on the type of problem. Almost half of people coming with an injury (48%) came to A&E within four hours, compared to only 9% of those with an illness. Most commonly, patients in the illness category had either waited between four and twelve hours (23.4%) or more than seven days (20.7%).<sup>19</sup>

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*“I’ve had a cough since Christmas. I made an appointment with my GP but the condition has worsened rapidly.”*

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However, there was no statistically reliable correlation between the amount of time waited and the perceived severity of the condition (see below for details of this variable). This suggests that A&E is not viewed as a location to be reserved for treating urgent conditions. It appeared that respondents would seek advice or treatment at whatever point they realised it was necessary, irrespective of the severity of the condition. Their choice over where to go was then dictated by which services are known or perceived to be open at that point. The finding also highlights the difference between ‘serious’ and ‘urgent’, showing that even less serious conditions can require treatment without delay.

### Recurring problems

The significant majority of patients (78.5%) had not experienced their current problem before. Of those who had, more had sought treatment from A&E (13.6%) than a GP (9.0%) or elsewhere. No correlations with other variables were found, suggesting that participants with pre-existing conditions tended to act in a similar manner to those with new conditions.

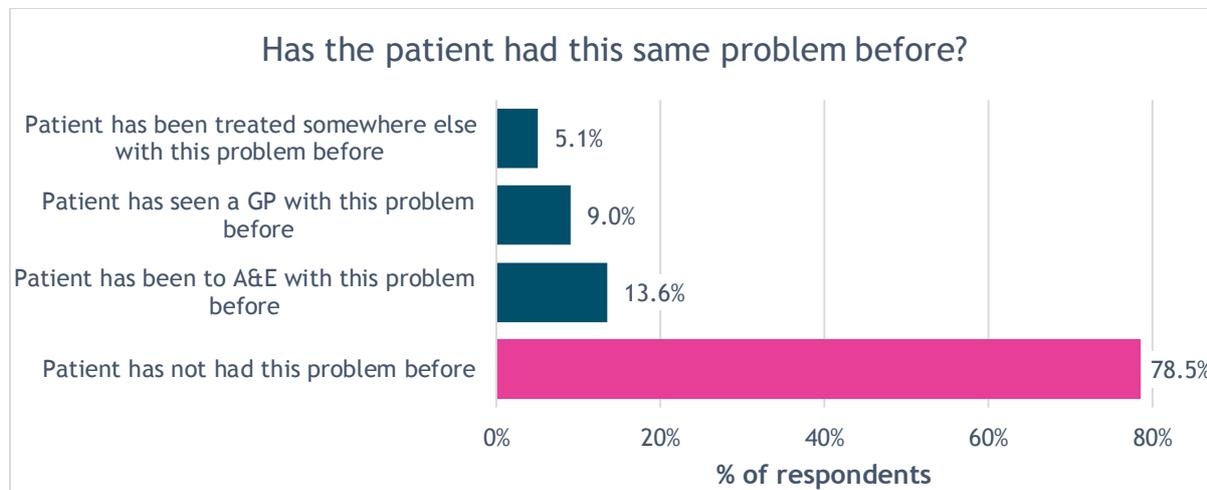


Figure 17: “Has the patient had this same problem before?” Figures do not total 100% as it was possible to have sought previous treatment from more than one location.

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<sup>19</sup> Injury  $p=.000$ , Cramer’s  $V = .313$ . Illness  $p=.000$ , Cramer’s  $V .294$ .

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*“I was discharged from hospital two days ago... but no home assessment was done. [A family member] had tried to get necessary support before discharge but this didn't happen.”*

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### Perceived seriousness of the problem

Respondents were asked to rate how serious they considered the patient's condition to be. The most frequent response was 'fairly serious' (38.6%). The smaller number considering the condition to be 'very serious' may be partially explained as it was generally not possible to interview people who had arrived by ambulance.

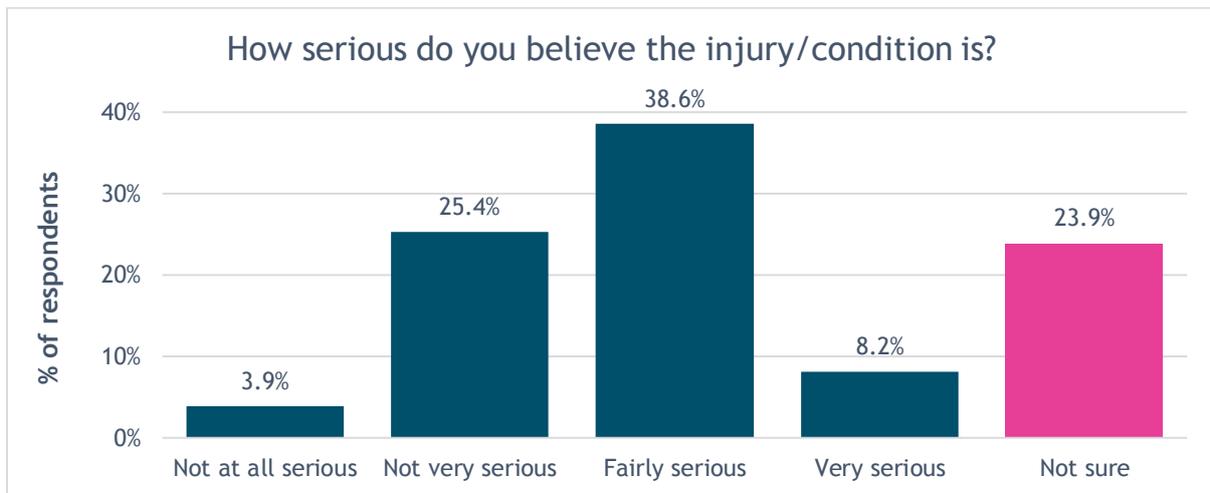


Figure 18: “How serious do you believe the injury/condition to be?”

However, it is noteworthy that almost a quarter of respondents were unsure whether the condition was serious or not. It is also striking that 3.9% did not consider the patient's problem to be 'at all serious'. Both of these figures suggest that some of those attending the department may not have been able to make an informed decision that A&E was the most appropriate location from which to seek treatment. It may also suggest that some people lacked confidence in the advice received from other sources.

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*“I'm not sure what the problem is and needed it checked out.”*

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Figure 19 (below) gives some examples of the types of problems reported under the different levels of severity. While some responses lacked the detail to gauge their seriousness (e.g. 'animal bite', 'sports injury'), there were relatively few cases where the problem appeared to contradict the degree of seriousness ascribed to it.

Injuries to fingers and arms tended to be seen as less serious than injuries to feet and legs. Most people who cited a specific or pre-existing medical condition viewed it as fairly or very serious. The problems described by people who were unsure of the severity tended to match more closely with the sorts of issues described as “fairly serious” by other respondents.

Both *Injury* and *Illness* variables were correlated with perceived severity, with illnesses being more likely to be considered serious. 38.2% of respondents described injuries as *not at all/not very serious*, compared with only 11.1% of illnesses. Patients with illnesses were also more likely to be unsure how serious they were. <sup>20 21</sup>

Types of problems reported		
Not very/at all serious	Injuries	<ul style="list-style-type: none"> <li>• Injuries to fingers or arms</li> <li>• Fingers trapped</li> <li>• Rusty nail puncture</li> </ul>
	Medical	<ul style="list-style-type: none"> <li>• Possible kidney stones</li> <li>• Burn from saucepan</li> </ul>
	Infection	<ul style="list-style-type: none"> <li>• Ear infection</li> </ul>
Fairly/very serious	Injuries	<ul style="list-style-type: none"> <li>• Injuries to feet and legs</li> <li>• Vehicle accident</li> <li>• Cut from a chisel</li> <li>• Suspected fracture</li> </ul>
	Medical	<ul style="list-style-type: none"> <li>• Deep Vein Thrombosis</li> <li>• Swallowed a battery</li> </ul>
	Infection	<ul style="list-style-type: none"> <li>• Infection after an operation</li> </ul>
	Pain	<ul style="list-style-type: none"> <li>• Chest pain</li> <li>• Severe stomach pain</li> <li>• Allergic reaction</li> </ul>
Not sure	Medical	<ul style="list-style-type: none"> <li>• Breathing problems</li> <li>• Headache and dizziness</li> <li>• Chemical spilt in eye</li> </ul>

Figure 19: Examples of conditions for different levels of perceived severity.

Perceptions of severity also differed slightly between hospitals, as shown in Figure 20. <sup>22</sup>

Hospital	Relatively more likely to rate the seriousness as...
Princess Royal	Not at all/not very serious
St. Richard's	Fairly/very serious
Worthing	Not sure

Figure 20: How perceived seriousness varied by hospital

<sup>20</sup> Injury  $p=.000$ , Phi coefficient = .255

<sup>21</sup> *Illness* uses a recoded variable which combined 'not at all serious' and 'not very serious' into one category, in order to avoid an unreliable Chi-Square test.  $p=.000$ , Phi coefficient = .209

<sup>22</sup>  $P=.024$ , Cramer's V = .158

## Treatment expected

Respondents were asked what treatment *they* thought the patient might need. The most common answer was an X-ray (given by 37.2%), followed by stitches (11.1%). 18.3% expected some sort of test, including a blood test. Relatively few respondents (4.2%) expected the patient to be admitted to hospital. Overall, 28.6% elected to tick “don’t know” rather than give a response.

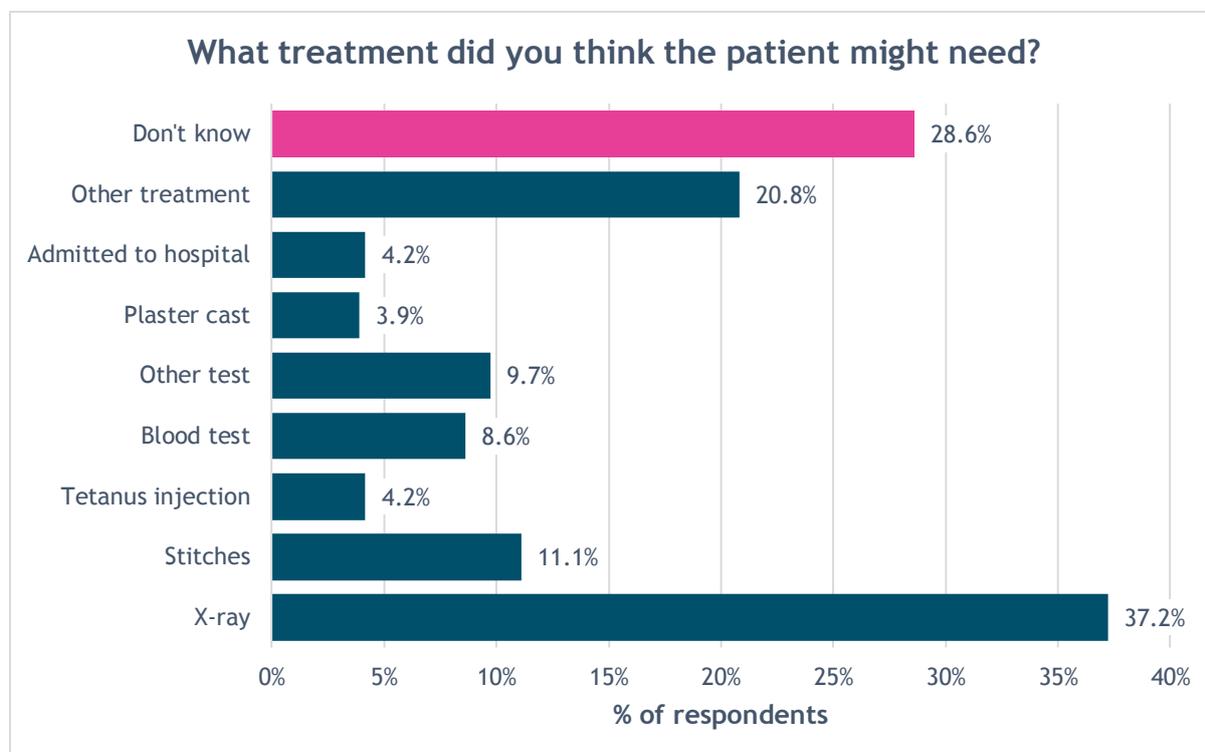


Figure 21: “What treatment did you think the patient might need today?” Figures do not total 100% as it was possible to select more than one treatment. Respondents were not barred from selecting “don’t know” along with other options.

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*“I’m hoping to have my wrist x-rayed.”*

---

Perhaps unsurprisingly, different treatments tend to be expected for different conditions, as shown in Figure 22. While those coming with an injury inevitably seek direct attention to their wounds, people coming with an illness were relatively more likely to expect some sort of tests to be conducted. However, while some of these tests were described as urgent, other expected treatment such as taking urine samples and prescribing antibiotics, might easily have been obtained at other locations such as a GP practice. There was evidence that a small number of respondents have come to A&E after several months of failure to diagnose or treat their condition elsewhere.

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*“I’ve had the problem for year and a half. I feel I should have got care sooner then I wouldn’t feel so bad now... There are bits where the service has let me down, and other bits have worked well.”*

---

Condition	Treatments more likely to be expected
Injuries <sup>23</sup>	X-ray Stitches Tetanus Plaster cast
Illness <sup>24</sup>	Blood test Other test Other treatment

Figure 22: Treatments relatively more likely to be expected by patients coming with injuries and illnesses

There was some evidence that the treatment expected was associated with the actions taken by respondents before coming to A&E (see below for details of this variable).

Treatment expected	More likely to have	Less likely to have
X-ray <sup>25</sup>	Waited	Phoned an advice line
Stitches <sup>26</sup>	Come straight to A&E	—
Other tests <sup>27</sup>	Phoned an advice line	Come straight to A&E
Don't know <sup>28</sup>	Phoned an advice line	—

Figure 23: How the treatment expected influenced what participants had done before coming to A&E.

15.7% of respondents from Princess Royal Hospital expected to receive some 'other test' around three times as many as people attending Worthing Hospital and St. Richard's.<sup>29</sup>

## Making the decision about where to go for treatment

### Awareness of other treatment facilities

Four out of five respondents (79.9%) had heard of NHS 111, with a similar proportion being familiar with the Out of Hours service. Fewer people, just more than half, were aware of Walk-in Centres and Minor Injuries Units. Only 18.0% of the sample had heard of Urgent Care Clinics.

<sup>23</sup> X-ray p=.000, Phi coefficient =.437. Stitches p=.000, Phi coefficient =.254. Tetanus p=.001, Phi coefficient =.181. Plaster cast p=.001, Phi coefficient =.175.

<sup>24</sup> Blood test p=.000, Phi coefficient =.276. Other test p=.001, Phi coefficient =.170. Other treatment p=.045, Phi coefficient =.106.

<sup>25</sup> Waited p=.049, Phi coefficient =.104. Advice line p=.004, Phi coefficient =-.151

<sup>26</sup> P=.000, Phi coefficient =.213

<sup>27</sup> Advice line p=.011, Phi coefficient =.135. Come straight to A&E p=.002, Phi coefficient =-.167

<sup>28</sup> P=.002, Phi coefficient =.164

<sup>29</sup> p=.001, Phi coefficient =.191

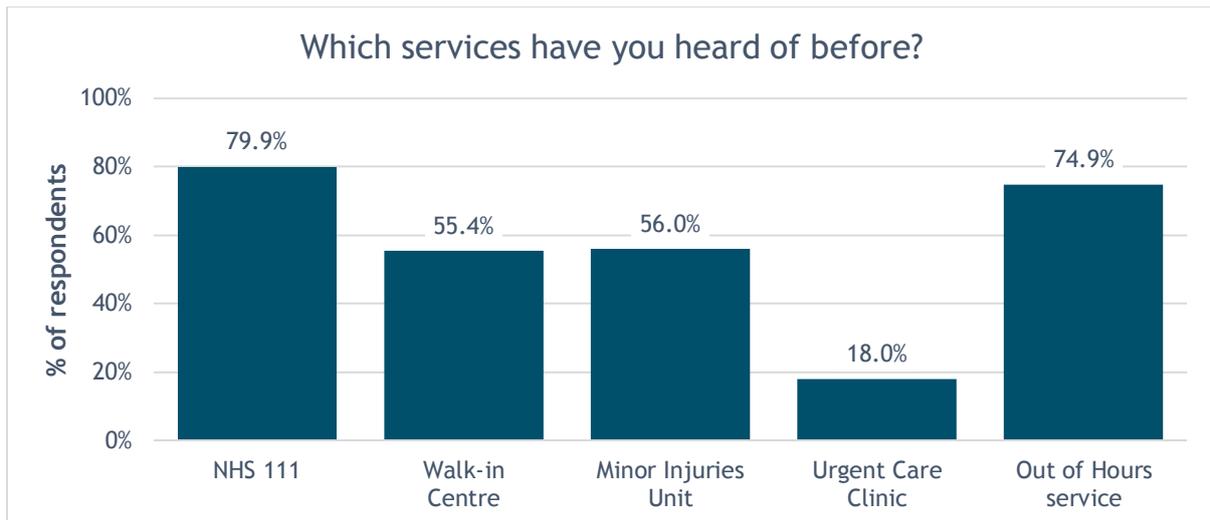


Figure 24: “Which of the following services have you heard of before?” Figures do not total 100% as it was possible to select more than one option.

Women were more likely than men to have heard of NHS 111 (79.5% compared to 68.8%).<sup>30</sup> No other services showed any statistically significant variations by demographic variables.

As might be expected, awareness of Minor Injuries Units varied considerably by area.<sup>31</sup> 78.6% of respondents in the PO21 area were aware of this facility, compared with only 25.0% of respondents with BN15 postcodes.<sup>32</sup> No statistical relationship existed for the other types of service.<sup>33</sup> While it is to be expected that awareness of particular facilities would be higher among those living nearest to them, there may be particular localities and communities with lower rates of awareness of nearby facilities, and in which targeted promotion may prove worthwhile.

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*“I’m not resident here, so don’t know the available facilities.”*

*“I didn’t know what else to do.”*

---

<sup>30</sup>  $p=.023$ , Phi Coefficient = -0.123

<sup>31</sup> as measured by the “most common home postcodes” variable.

<sup>32</sup>  $p=.001$ , Cramer’s V = .310

<sup>33</sup> A similar statistical correlation existed for the hospital attended, which was correlated with awareness of both Walk-in Centres and Minor Injuries Units. However, it is likely that the underlying correlation is with home postcode, as most people will travel to the nearest A&E department.

## Actions before coming to A&E

A third of respondents (32.3%) had come directly to A&E, while a similar proportion (30.1%) had waited to see if the condition improved. In total, 38.8% of respondents had sought medical advice from at least one medical professional.<sup>34</sup> This figure increases to at least 47.8% when other people with medical training such as first aiders are included.<sup>35</sup>

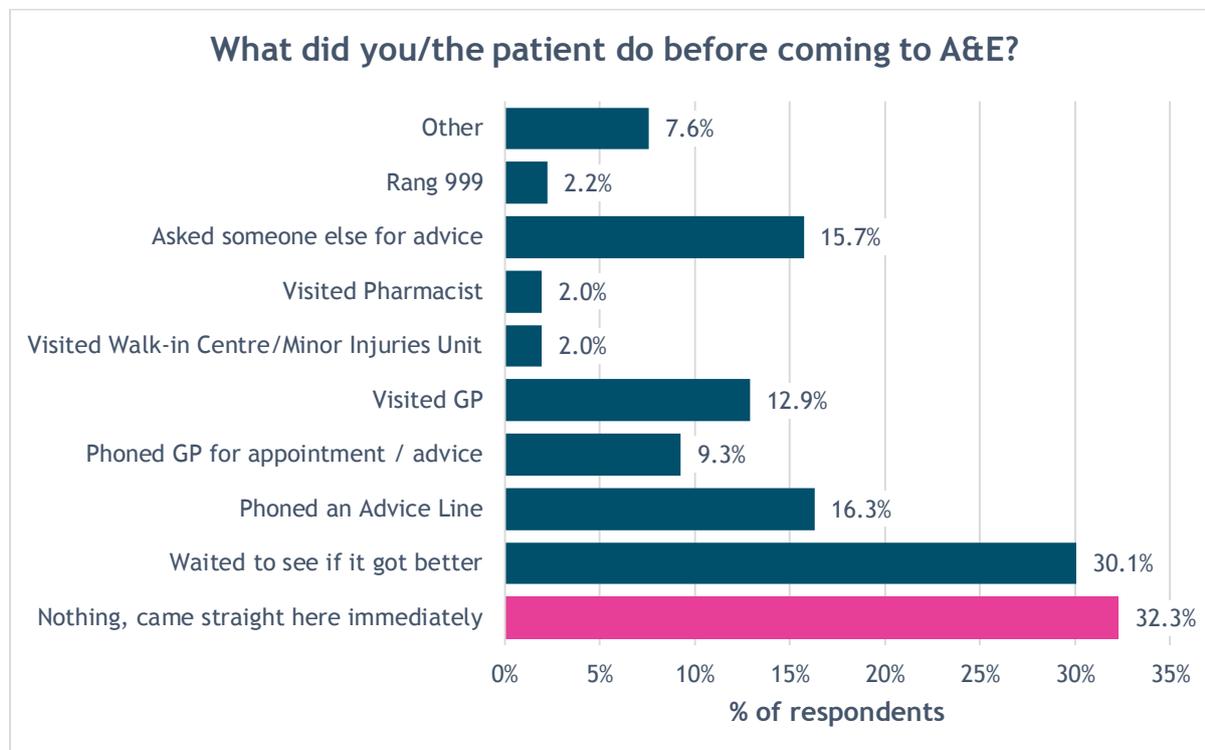


Figure 25: “What did you / the patient do before deciding to come to A&E?” Figures do not total 100% as it was possible to select more than one option.

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*“I tried an ice pack but it started to bleed. The Pharmacist wouldn't look at the wound. The GP surgery was shut and 111 was an answerphone.”*

---

No relationship was found to exist between the actions taken before coming to A&E and the perceived severity of the condition. This would appear to rule out the suggestion that people with less serious conditions would be likely to seek help from other sources such as a GP or pharmacist before coming to A&E.

However, the type of condition did affect the actions respondents were likely to have taken before coming to A&E (see Figure 26 below). Those with an illness or other problem were relatively more likely to have taken advice from a GP or Advice Line. People with an injury were more likely to have sought treatment directly, but it is noticeable that GPs did not tend to be considered as an option in these circumstances.

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<sup>34</sup> Staff from a GP practice, Walk-in Centre, Minor Injuries Unit, Advice Line, pharmacist or 999.

<sup>35</sup> This figure includes ‘Asked someone else’ where the detail given identifies someone with medical training such as a first aider, school nurse, former nurse etc.

Condition	More likely to have	Less likely to have
Injury <sup>36</sup>	Come straight to A&E Waited to see if it improved Visited Walk-in Centre	Visited GP Phoned an Advice Line
Illness <sup>37</sup>	Visited GP Phoned GP	-
Other <sup>38</sup>	Other Phoned an Advice Line	Come straight to A&E
Unsure <sup>39</sup>	Phoned an Advice Line	Waited to see if it improved

Figure 26: The influence on the type of condition on the actions taken before coming to A&E.

Correlations were found between the amount of time people waited before coming to A&E and some (but not all) of the actions they had taken; while some of these correlations are almost tautological (for example, short waiting times and coming directly to A&E), others bear more consideration.<sup>40 41 42</sup>

Figure 27 shows the differences in (median) average waiting times for respondents who had taken different courses of action before coming to A&E. This shows that people who consulted a GP had waited notably longer than those who had sought advice from an advice line or other source.

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*“I rang the GP but couldn't get an appointment for a week.”*

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<sup>36</sup> *Came straight to A&E* p=.001, Phi coefficient =.176. *Waited* p=.018, Phi coefficient =.125. *Walk-in Centre* p=.023, Phi coefficient =.121. *Visited GP* p=.000, Phi coefficient =-.214. *Advice line* p=.000, Phi coefficient =-.209.

<sup>37</sup> *Visited GP* p=.000, Phi coefficient =.203. *Phoned GP* p=.035, Phi coefficient =.112.

<sup>38</sup> *Other* p=.000, Phi coefficient =.205. *Advice Line* p=.043, Phi coefficient =.107. *Came straight to A&E* p=.014, Phi coefficient =-.130.

<sup>39</sup> *Advice Line* p=.004, Phi coefficient =.154. *Waited* p=.016, Phi coefficient =-.127.

<sup>40</sup> Correlations with ‘*Problem duration*’ were as follows: ‘*Nothing, came straight to A&E*’: p=.000, Phi coefficient .466; ‘*Waited to see if it improved*’: p=.000, Phi coefficient =.324; ‘*Visited GP*’: p=.000, Phi coefficient =.401.

<sup>41</sup> The Chi-squared statistic for correlation between ‘*Phoned GP*’ and ‘*Problem duration*’ variable was not reliable due to small expected values in some of the cross tabulations. However, the values for the calculations did suggest that a correlation may exist, although it would require a larger dataset to test this.

<sup>42</sup> Other variables within the set had no statistically significant correlation.

Median time taken before coming to A&E	
Came straight to A&E	Under 4 hours
Phoned an advice line	4-12 hours
Asked someone else	4-12 hours
Waited to see if it improved	12-24 hours
Phoned GP	4-7 days
Visited GP	4-7 days

Figure 27: Median time waited by respondents who had taken each course of action before coming to A&E for respondents

One possible implication of the previous three paragraphs may be that people’s decision about where to seek advice is dictated by what is available in the timeframe they feel it is needed. This may be evidence that those able to wait for advice from a GP tend to do so, while those who are not willing or able to wait may be forced to seek advice from an advice line or from someone else. In cases where respondents come to A&E relatively quickly, it would either appear that respondents feel confident in their choice of A&E, or that they have been advised by someone such as a first aider soon after the condition has emerged.

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*“I know what needs to be done.”*

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### Advice received from others

Over two thirds of people (71.3%) received advice that they should go to A&E from another person. Receiving advice was not related to the type of condition, its perceived severity or the amount of time waited before coming to the department. This suggests again that patients are selecting A&E as their treatment location on the basis of the availability of treatment, rather than viewing A&E as a place for only serious or urgent conditions.

The proportions of respondents who had been advised to come to A&E by another person are shown in Figure 28. Advice was most commonly received from a Friend or relative (34.0%) followed by ‘Other’, a GP or NHS 111, with relatively few from other services.

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*“I visited the GP today but wasn't happy with what they said...”*

*“I have standing instructions from my consultant to attend A&E if certain circumstances occur.”*

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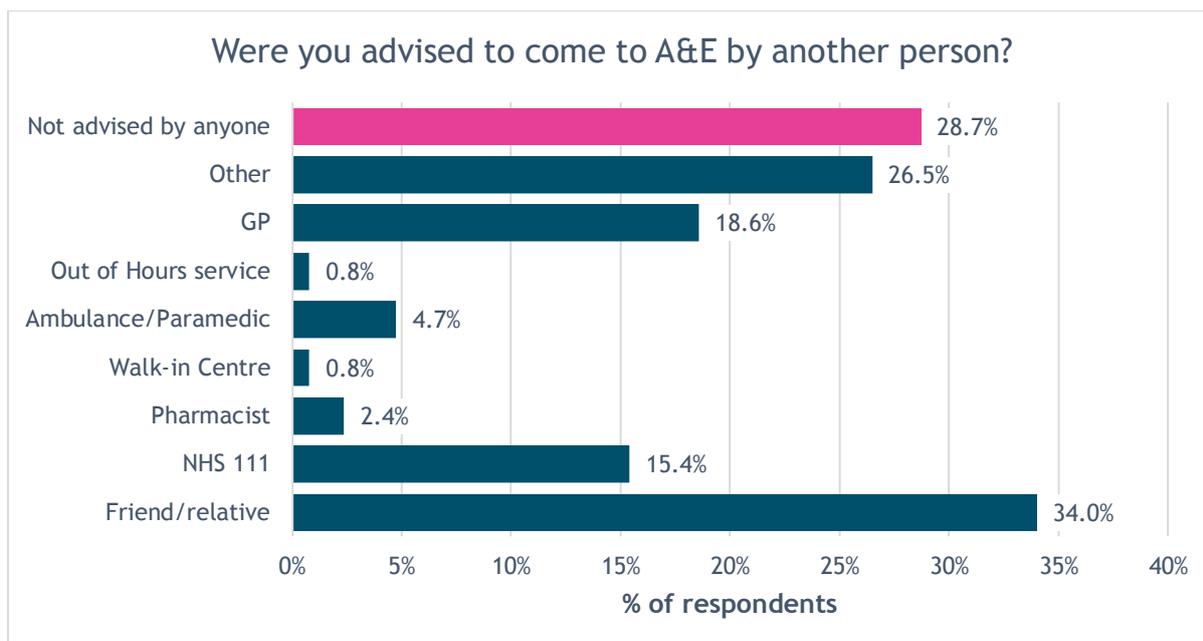


Figure 28: “Were you / the patient advised to come to A&E by another person?” Figures do not total 100% as it was possible to select more than one option. “Not advised by anyone” was not given as an option on the questionnaire, but represents respondents who did not tick any other option in the category, after incomplete questionnaires had been discounted.

While it is not statistically reliable to give breakdowns for specific services, overall, of those who had visited or consulted a health professional, 62% had been advised to go to A&E.<sup>43</sup> This compares to 86% of those who had asked for advice from someone else.<sup>44</sup> This suggests that health professionals are more likely to have either attempted to treat the condition themselves, or assessed it as not needing A&E treatment. Friends, relatives and ‘others’ may be inclined to be more cautious when called upon to give advice. However, in other situations, it may have been easily apparent (e.g. to someone with basic first aid training) that A&E treatment was needed.

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*“I had an accident at work. I waited until I got home, when my partner advised me to go to the hospital.”*

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In view of this potentially over-cautious advice, it is noteworthy that attendees at Worthing Hospital were more likely to have been advised by a friend or relative to come to A&E than at other hospitals.<sup>45</sup> There may be a number of reasons for this, but it may be worthwhile investigating whether other sources of medical advice in the area are as readily available and are being utilised as fully.

<sup>43</sup> GP, advice line (such as NHS 111), paramedic, pharmacist or staff at a Walk-in Centre or Minor Injuries Unit.

<sup>44</sup> A friend/relative, or ‘someone else’.

<sup>45</sup> P=.001, Cramer’s V =.198.

% of respondents advised to come to A&E by a friend or relative		
St. Richard's	Worthing	Princess Royal
20.5%	36.6%	17.5%

Figure 29: Proportion of respondents attending each department who had been advised to come to A&E by a friend or relative

Respondents who had called NHS 111 were almost twice as likely to say they didn't know what treatment to expect, compared to the sample as a whole (48.7% against 28.3%).<sup>46</sup> No such correlation existed for other forms of medical advice, and this may imply that people who are unsure about a condition receive clearer information from a GP or other health professional than they do from NHS 111.

*"I phoned 111 and was told to see the GP. I waited a couple of days for someone to visit - no-one came, so I phoned the hospital and a consultant advised me to come to A&E."*

### Services respondents would not consider

Survey participants were asked if there were any services which they would not consider accessing. Over 70% said they would consider accessing all services. (A number clarified that they would be prepared to do so when appropriate, but that in their particular circumstances, A&E was the appropriate location.)

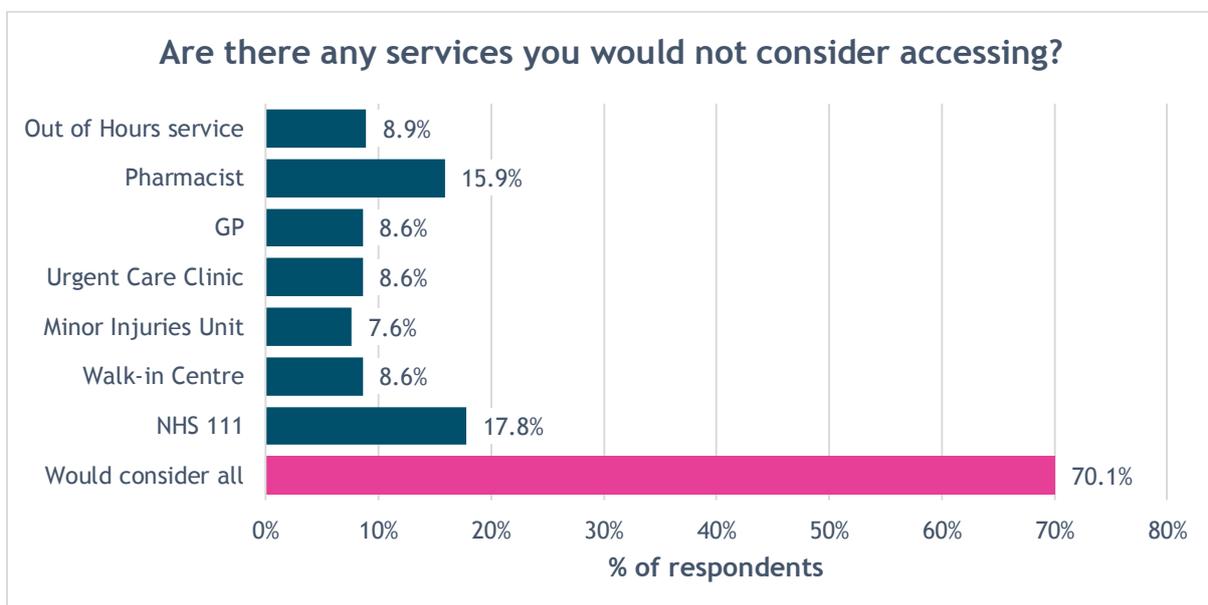


Figure 30: "Are there any of the following services which you would not consider accessing?" Figures do not total 100% as it was possible to select more than one option.

<sup>46</sup> P=.003, Phi coefficient =.159

However, this means that almost a third of people did indicate at least one service which they were not prepared to visit. Of these, NHS 111 was cited most often (17.8% of all respondents), followed by Pharmacists (15.9%). The majority of other services, including GPs and Out of Hours services, were rejected as options by around eight percent of the sample.

Figure 31 summarises the main reasons given as to why they would not consider services; these are illustrated with selected quotations. NHS 111 was mentioned more often than all other services, and it is clear that the advice line was viewed negatively by a significant minority of participants. A number of answers cited a general lack of confidence stemming from previous bad publicity. Other responses were based on direct previous experience, with the sentiment that the service hadn't been able to help before, or had simply directed the caller to A&E. Others felt that they were not given any information they could not have located themselves on the internet.

Reasons given for not considering services	
Ineffectiveness of NHS 111 (29)	<ul style="list-style-type: none"> <li>• “Tried NHS 111 before. Took too long. Showed they did not know much.”</li> <li>• “NHS 111 has long waits to answer the phone and always tells you to go to A&amp;E.”</li> <li>• “Felt when I rang NHS 111 last [time] they were reading the same computer screen that I was.”</li> <li>• “NHS 111 has had such bad publicity failing to deliver.”</li> <li>• “Useless.”</li> </ul>
Not appropriate in circumstances (19)	<ul style="list-style-type: none"> <li>• “Possible fracture so needed full A&amp;E X-ray.”</li> <li>• “Only go to GP as he understands my illness.”</li> <li>• “Not ill apart from this problem.”</li> </ul>
Awareness (15)	<ul style="list-style-type: none"> <li>• “Didn't know about NHS 111 or Out Of Hours.”</li> </ul>
Availability (12)	<ul style="list-style-type: none"> <li>• “If you want the GP you have to phone [at] 8am and can't always get through.”</li> <li>• “I went to the Minor Injuries Unit, but it was just shutting.”</li> </ul>

Figure 31: “For any services you would not consider, please explain why not”. Summary of main trends in explanations. Numbers in brackets give the number of answers fitting each theme, with some responses being included in more than one category. Some quotes have received minor corrections.

14.0% of those who were attending Princess Royal Hospital said they would not consider accessing a GP, significantly more than for Worthing (4.7%) or St. Richard’s Hospitals (2.9%).<sup>47</sup> There was no reliable evidence that this reflected an underlying reluctance to use GPs in certain home postcode areas, although the quantity of data available made it difficult to perform robust analysis, so this possibility cannot be entirely discounted and should perhaps be examined further.

<sup>47</sup> p=.006, Cramer’s V=.180

## Main reasons for attending A&E

Participants were asked what their main reasons were for coming to A&E at that particular time. Almost two thirds (64.5%) said that the condition was urgent, while 22.3% cited a referral by another person. It is notable, however, that more than one in ten respondents gave reasons of convenience (15.4%), unavailability of alternatives (10.2%) or lack of awareness of other options (13.9%).

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*“I waited a month and decided it was too painful. I could be driven here today by a friend as they were free.”*

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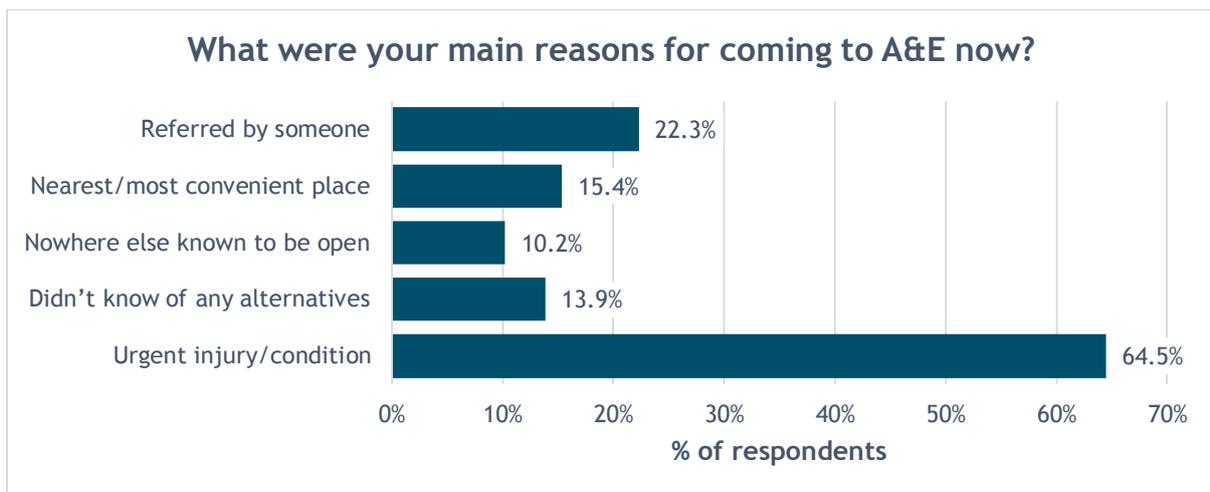


Figure 32: “So what were your MAIN reasons for coming to A&E now?” Figures do not total 100% as it was possible to select more than one option.

Clearly, it is the responsibility of service commissioners to take operational decisions on whether it is more efficient to provide treatment in A&E departments or at other locations. What the data does show, however, is that people’s main concern is to be able to access treatment reliably when they feel it is needed. If commissioners wanted to encourage consumers away from A&E departments towards other locations such as GPs and Walk-in Centres, there is likely to be scope to do so. But this would rely on improving awareness about these alternatives. It may also be important to give members of the public confidence that treatment will be available at the time they are seeking it.

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*“I would have gone to the Minor Injuries Unit but the X-ray machine had broken down.”*

---

The sincerity of the main reasons cited was confirmed by their correlation with other related variables. For example, 15.7% of those coming during off-peak hours gave the reason that nowhere else was known to be open, compared to only 2.0% who said this during peak hours.<sup>48</sup> Likewise, of those who said the condition was urgent, 55.0% rated the condition as fairly or very serious, compared to 32.3% of those who did not select this option.<sup>49</sup>

There was a relatively strong relationship between certain home postcodes and giving ‘urgent condition’ as the main reason for attending.<sup>50</sup> ‘Urgent condition’ was also correlated with the hospital attended (see Figure 33).<sup>51</sup> The reason for these differences is unclear. One possibility implied by the high number of sports injuries in the sample is that the location of certain sports clubs and other sources of risk may be a factor. Taking both these findings together, it may be fruitful to conduct further research on the prior locations of A&E attendees.

% of respondents giving “urgent condition” as a main reason for coming		
St. Richard’s	Worthing	Princess Royal
55.4%	40.2%	77.8%

Figure 33: Proportion of respondents attending each department who gave a main reason for attending as “Urgent injury or condition”.

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*“I’ve been to A&E with my son many times.”*

*“Although there are other services available, they are never efficient.”*

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<sup>48</sup> P=.000, Phi coefficient =.230

<sup>49</sup> p=.001, Phi coefficient =.239

<sup>50</sup> p=.000, Cramer’s V =.348

<sup>51</sup> p=.000, Phi coefficient =.337

# Conclusions

It should be emphasised that this survey, running over only one week, can only give a snapshot of the demand for A&E services. Conditions on other weeks, and at other locations, may be very different. For example, the data collected during the week showed little evidence that A&E services were stretched beyond capacity, or that pressure on other services was driving significant numbers of elderly people towards A&E. However, this survey was not designed to evaluate these types of issues, and should not be regarded as doing so.

## Most people try to use A&E responsibly

One commonly held perception of A&E departments which was not supported by the data does demand comment - that of the irresponsible user of A&E. In general, most people appeared to have made some attempt to use A&E services responsibly, or at least, effectively. Excluding those who were unsure, over 60% of people thought the patient's condition was fairly or very serious.<sup>52</sup> Around half of respondents had taken at least one form of action before attending A&E, and a similar proportion had taken advice from someone with at least basic medical or first aid training. 30% of people had waited to see if the condition got better before coming to A&E. Moreover, among many of those who had rated their condition as not very or not at all serious, it was evident that treatment was required, and that it may have been unwise to delay seeking this for too long.

## People just want to be treated

Taking the data as a whole, the message it conveys is perhaps an obvious one - that people's main concern was to receive treatment at whatever point it became apparent this was necessary. In the case of injuries, the need was often clear immediately. Illnesses were more likely to emerge over a longer period of time, making the decision about where and when to seek treatment less clear cut. It is likely to be in these types of conditions where good quality advice may prove most helpful, if it can be found.

A&E did not appear to be seen by the public as a location reserved for treating urgent or serious conditions. Rather, people appeared to select the most appropriate location which was open at the time that they were seeking treatment. Official advice tends to list other locations such as Minor Injuries Units as more suitable for conditions such as sprains, cuts, broken limbs, burns and infections, and GPs as more suitable for many illnesses. A&E is described as being reserved for "life-threatening emergencies"<sup>53</sup> while the advice for those who are unsure is to consult NHS 111.

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<sup>52</sup> While many of those who were unsure came with conditions which appeared to be similar in the nature of their severity.

<sup>53</sup> For example, NHS Choices (2014), Sussex Community NHS Trust (2014).

In practice, however, a number of respondents commented that they felt unable to obtain treatment elsewhere, either because their GP was closed, because no appointments were available, other facilities were closed or none existed in their area. There was also evidence that a small number of people had come to A&E after several months of failure to diagnose or treat their condition elsewhere.

### Awareness and understanding of alternatives

Awareness of many of the alternative services was relatively low, with little more than half of respondents having heard of Walk-in Centres or Minor Injuries Units. 14% of respondents said their main reason for coming to A&E was that they didn't know of any alternatives.

Moreover, recognising the name of a facility is not the same as knowledge of its location or understanding the treatments offered. Many of the respondents interviewed were confused about where else they could go for their particular condition. This is not helped by the variety of names used for facilities, or the variations in provision. The message given on the NHS Choices website<sup>54</sup>, for example, that "Urgent care centres provide a variety of services but vary in different areas" simply is not clear and consistent enough, particularly for someone seeking urgent help.

A similar problem is the poor quality of information available on websites such as NHS Choices and of the provider Trusts. While some pages were clear and comprehensive, too many lacked basic details such as opening times, or gave no information about the facility at all. A number of links to other webpages did not work at all, while others referred to defunct bodies such as NHS Direct or Primary Care Trusts.

If service commissioners wish to increase the use of these facilities, a key need will be to produce clearer, more accurate and up-to-date information about what is available, where and when. The role that GPs can play in treating injuries could also be explained more fully. These steps would be most effective if further research is carried out to identify the particular communities and sections of the public who would most benefit from it. However, it is likely that many people would prefer treatment facilities which are open, rather than information about locations which are frequently closed when needed.

### Availability of alternatives

A related point concerns the availability of alternative services, many of which are only open between the hours of 9-5, and not at all during the weekend. Over half the interviews with respondents occurred during times when these services were closed. A further 17% arrived shortly before closing time.<sup>55</sup> Even when opening times were published online, it was not clear whether someone arriving shortly before a service closed would be treated or not. This may combine with an uncertainty about how quickly patients will be seen, leading some people towards services which are known to be open at all times of day.

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<sup>54</sup> NHS Choices (2014)

<sup>55</sup> Between 2:30-4:30pm.

The differing opening times of other services may be adding further confusion about which service is appropriate for different conditions. The clarity of the message about whether it is appropriate to go to A&E is somewhat undermined if it changes depending on whether other facilities are open or not! While it is implied that many people should wait for a GP appointment, in reality, many people said that they find it difficult to obtain GP appointments quickly enough.<sup>56</sup> Adding to this is the tendency of other parts of the Health Service to suggest A&E as a fall-back for when their own facilities are closed.<sup>57</sup> Each of these points serves to strengthen the impression of A&E as the most reliable (if not necessarily the quickest) place to receive treatment.

A final point here is that there is a very real difference between presenting clear advice that, for some conditions, it is appropriate and safe to wait to be treated, and the perception that services just aren't open. While many people do need to be treated relatively quickly, for others, clearer information may be enough to reassure them that it's okay to wait, particularly if they are able to feel confident that they would be able to obtain a GP appointment at the first available opportunity.

### Concerns about NHS 111

NHS 111 showed up among the alternatives to A&E as being viewed negatively. While the service was more widely known than other options, more than one in six respondents said they would not consider using the service, twice the rate for other options. Some respondents cited long waiting times. While the same comment is also made about other services, the inherent disadvantage of NHS 111 is that it cannot provide treatment, only advice. Many respondents felt there was little point in waiting, particularly if they would then have to queue a second time at whichever facility they were directed towards. However, people may be more inclined to seek advice from NHS 111 if services worked in a joined-up manner. On being referred to a treatment provider, patients could be given a place in a virtual queue so that their previous waiting time was taken into consideration. In addition, information which had been given could be forwarded automatically to save having to repeat this on arrival at the facility.

Another issue identified was the lack of clear information received from NHS 111. The quality of advice is a concern, because almost a quarter of respondents were unsure whether the patient's condition was serious or not.

Respondents who had used NHS 111 were almost twice as likely to say they didn't know what treatment to expect, compared to the sample as a whole, suggesting that the information being given is more generic than that from other sources such as GPs. One person commented that the operator was looking at the same webpage that they were!

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<sup>56</sup> Healthwatch West Sussex (2014b)

<sup>57</sup> This is not to suggest that particular services are referring people to A&E rather than providing treatment themselves. No GP practice was named more than twice as having made a referral.

People with illnesses appeared more likely to need good advice, but these conditions were more likely to be difficult to diagnose accurately over the phone. While the need for NHS 111 operators to be cautious in the face of uncertainty is understandable, it is debatable whether the service will be viewed as worth consulting if it is unable to give callers specific information.

In many cases, the perceptions of NHS 111 were based on prior experience, and suggests that the service has work to do in order to improve its reputation after some high-profile difficulties in its early days.

### Specific locations

While the more frequent occurrence of the more populated postcode districts was to be expected, the proportion of respondents attending Princess Royal Hospital from the RH16 postcode district was still higher than in other comparable areas.

Differences were also evident between the different hospitals. The proportion of people saying they would not consider accessing a GP was considerably higher at Princess Royal Hospital than at the other locations. Attendees were more likely to rate the patient's condition as being less serious, and many more people attended the department expecting to receive some 'other test'. Taking these findings together, it may be worth conducting further research into the provision in this area, as there is a clear sense that some people are using the department differently to attendees in other areas.

Respondents at Worthing Hospital were more likely to have been advised by a friend or relative to come to A&E than at other hospitals. One reason for this may be that there are relatively few alternatives, although the A&E department at Worthing Hospital does include a 'see and treat' area for handling minor injuries.<sup>58</sup> However, it may be worthwhile investigating whether there is scope for increasing uptake of services such as GPs and NHS 111 in this area.

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<sup>58</sup> Western Sussex Hospitals NHS Foundation Trust (2014)

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For support with a complaint about an NHS provided service, please contact our Independent Complaints Advocacy Service (ICAS):

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Email: **[icas@westsussexcab.org.uk](mailto:icas@westsussexcab.org.uk)**

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