Urgent care in London engagement programme

Phase 2 – Deliberation Report

March 2023

Contents

Executive summary

There is a national ambition to transform urgent and emergency care (UEC). London wants to improve people's experiences of receiving care through ensuring that policy and change proposals are more transformative and innovative, working with Integrated Care Systems (ICSs), healthcare professionals, as well as citizens to shape services. This is a complex agenda, with multiple interests and issues that need to be considered as part of any pathway redesign and therefore requires the involvement of both Londoners and staff in a deliberative process.

Imperial College Health Partners and Ipsos were commissioned by NHS England and Improvement (London region) to design and deliver a dialogue and deliberation engagement process to understand public, patient and staff expectations around urgent care services, in particular the trade-offs these may create, to inform future decision making. Building on previous public deliberation exercises in London, this work continues to develop a different type of relationship with Londoners, understanding people's hopes, fears, and expectations in relation to how care is provided across the Capital.

Methodology

The programme of engagement was designed and delivered in two phases over the course of ten months in 2022. Phase 1 (engage) focused on gathering and synthesising key insights and issues in relation to urgent care to inform Phase 2 (Dialogue and Deliberation), the design and delivery of a dialogue and deliberation with staff and citizens, supplemented with parallel engagement with diverse communities that may be most impacted by future change. The work was supported by an independent Oversight Group, made up of 13 people, established to advise on the design and delivery of the engagement programme (all phases).

This report focuses on Phase 2 – Deliberation, which was split into three strands: public workshops, NHS staff workshops, and parallel engagement with marginalised communities through advocacy groups. The three strands of work covered four areas along the urgent care pathway: initial access via the digital 'front door'; triage; streaming and redirection; and scheduled urgent care.

Within each area, different options to the care pathway were presented to public participants and then explored and deliberated. The public participants were then asked to develop a set of expectations based on each of the four areas of the urgent care pathway. Staff participants were then presented with the public expectations along with a summary of the information presented on the four areas, and asked to build on the public expectations and develop their own based on what they think would be feasible to take forward. The findings from the public deliberations were also presented to advocacy groups who were asked to reflect and consider on the expectations for the groups they advocate for.

The findings from deliberations across all strands and participants groups are summarised below.

Initial access via the digital 'front door'

What if the only way for patients to access urgent care services is by starting the journey with a digital device or a phone? The care offered might end up being face to face, but the starting point ("front door") is virtual.

NHS 111 first

- Initial access to urgent care will be though NHS 111, with phone and online services available.
- NHS 111 will provide remote advice or direction to the most appropriate service for the patient's need (talk before you walk)

Digital assessment for walk-ins to ED

- Walk-in patients will be required to check in at the front door of urgent care services.
- This will likely be via a digital device, where patients will be asked a series of questions about their symptoms/situation

Whilst open to the digital approach, both public and staff participants and patient advocates highlighted key risks and groups for whom this approach might not work for. This includes individuals who may not be able to report symptoms through a digital device (including patients with communication needs, older people, people with dementia, people with frailty, homeless people or those without NHS numbers, and those in mental health crisis).

Other risks and downfalls considered included, but were not limited to, lack of human contact which could impact patient safety, the system being easily manipulated, a risk that people may fall through the cracks, data privacy issues, and too much reliance on overly cautious algorithms which could lead to more patients being directed to the Emergency Department (ED).

Public, staff and patient advocates' discussions concluded that there was general support for the approach for the majority of patients. However, there was a consensus that a 'one size fits all' approach will not work due to a range of risks (described above) and there will need to be alternative options available for people who cannot access the system digitally and/or have communication needs, as well as someone always physically present to help those who need it with completing a digital assessment.

Public and staff participants discussed that the success of the 'digital front door' would rest upon several factors including technology, efficiencies and capacity within NHS 111, flexibility within the system, patient expectations successfully managed and public education.

Public expectations on initial access via the digital 'front door'

The public participant expectations on initial access via the digital 'front door' are presented in the Figure below.

Figure ES.1. Public participant final expectations on the digital 'front door'

If the digital 'front door' is taken forward across London, we feel it could…

- Lead to better management of patient demand for NHS services whilst benefitting patients (e.g. you may be seen more quickly)

- Provide greater access to care at home (e.g. convenience) and require people to attend a health service in-person only when they need to
- Be improved over time, as technology advances (e.g. use voice commands when accessing online/ be accessible in different languages)

To ensure this approach is acceptable and trustworthy the following must be in place:

- The interface should be user friendly. The interface should be able to handle multiple conditions at one time to take account of co-morbidities
- There should always be an option for the most vulnerable (e.g. elderly, hard of hearing, young children, homeless people, people with mental health issues, etc.) or anyone who is distressed to walk-in / access face-to-face triage
- There should be an alternative option / back up if the system crashes / internet goes down
- There should be a designated assistant to help those who need support navigating the digital front door (e.g. assistant present in health service settings, e.g. A&E, interpreter services) as well as a help button / virtual assistant for those accessing at home
- There needs to be well-publicised 24 hour access points for those with limited access to digital communications (e.g. in public libraries, supermarkets, railway stations, etc.)
- Clear guidance on what to do if a health problem changes/ gets worse, supported by ongoing reassurance
- Ongoing and hard-hitting education campaign for the public to communicate how to access the digital front door, confirm the approach is safe (e.g. risk averse, data is secure) and trusted (e.g. run by highly skilled/ trained staff), and what to do if you have difficulty accessing digitally. This campaign should be regularly tested to ensure it is working
- Digital front door platforms should be regularly evaluated and updated to improve effectiveness.

Staff expectations on initial access via the digital ‘front door’

The staff participant expectations on initial access via the digital ‘front door’ are presented in the Figure below.

Figure ES.2. Staff participant final expectations on the digital ‘front door’

The **~~digital~~ virtual front door**

Making the right decision for all patients

- The **algorithm has to be on the cautious side** because the people creating the programme carry the risk in the first instance. If the digital first approach is **too risk-averse, too many people could still end up in the ED**. We need to be clear about whether the digital front door will be the full 111 algorithm triage or if there will be a tailored option
- **Not all patients will find this straightforward**. There is a risk that patients who **underestimate their symptoms** (men in 40s) or those not able to provide the necessary information (**frail people**) may ‘fall through the cracks’, and those who **need a carer** with them for any follow-up triage call (e.g. through NHS111)

- We also need to think about the impact of a digital front door on vulnerable people who **come into ED as a safe place** to be - do we need to consider how social care services are linked into the digital front door? Also **anxious patients**/ those in **MH crisis** may still walk into ED
- How do we ensure we don't leave behind groups because of the force of getting caught up in the service change?
- Need to reduce steps and times forms are filled

Ensuring hand offs are successful

- Services downstream need to be fully linked in and have capacity - ideally digitally - including Out-of-Hours (OOH), pharmacies, Primary Care
- We need to consider hand-off for locums, e.g. pharmacists
- There is a risk that patients will go back into 111 if they didn't get the outcome they wanted and these people may still go to A&E if unhappy. Important to be right first time to ensure carers can assist people to the right place
- NHS111 coding for urgency currently doesn't fit in with how GPs work (i.e. it gives option for two-hour or six-hour urgency, whereas GP can be same day / next day)
- Will services have to accept or will the algorithm have the power to transfer to a service?
- Need to overcome a lack of coordination and IT systems not talking to each other

Evaluation and assurance – make sure it works and communicate this

- Patients and staff will need to be reassured about the effectiveness and accuracy of the digital front door
- We need to understand how we can manage patient and public expectations too. Many people will still present and want treatment for minor issues. More advice about self-care too, to help reduce demand on services. Important to manage expectations before they come for treatment
- An opportunity for support in choosing the right options and join the UTC virtually, an adjunct to walk into A&E
- Who is accountable for mistakes made by an algorithm?
- Is it reasonable to be transparent about the number of appointments/ capacity available?

Comms and education will be paramount

- Need to empower people to understand where they should go

Triage

Effective triage has an important role to play in supporting the NHS to manage demand, but we know it's complex! Could adopting any of the approaches below help?

1. Increasing use of digital triage, where patients input their symptoms online / over the phone and an algorithm determines the urgency and most appropriate service

2. Involving more senior clinicians in the triaging process e.g. experienced doctors, GPs and consultants

3. Introducing a standardised triaging tool which enables staff to assign a clinical priority to patients, based on presenting signs and symptoms

Public participants and staff recognised that digital triage has the potential to lead to better demand management, though they flagged risks associated with the perceived removal of the human element through the use of algorithms. They also flagged the potential for patients to manipulate the digital system.

The involvement of more senior clinicians in the triage process was initially very attractive to all participant groups as it was felt to provide greater assurance and efficiency within the triage process. However, participant groups recognised workforce limitations related to this option and the need to provide senior clinical input at later stages in the care pathway (e.g. treatment), identifying key skills that matter above the specific role or type of healthcare professional (e.g. good interpersonal skills, confidence, compassion).

Digital triage was perceived to present new opportunities for digitally literate patients, much like other services used in everyday life, which could save their time and be more convenient. In some breakout rooms there was a general lack of trust in automated approaches to triaging including concerns about the ability to identify nuances in patient needs (e.g. level of pain or discomfort), risk of being sent to the wrong department and concerns about what would happen if the system crashed. Some participants felt that digital triage placed too much onus on a patient's ability to communicate their needs or symptoms, which could be challenging for certain groups.

Public participants and patient advocates also questioned the feasibility of digital triage for certain patient groups. Driven by a preference to speak to a healthcare professional, some public participants - and patient advocates - felt that there should be an option to speak to a healthcare professional within digital triage as well as alternative options (e.g. walk-in) for vulnerable people.

Interpersonal skills and experience within triaging were the key characteristics mentioned by public participants when discussing important characteristics required for triaging staff. Public participants also noted an expectation that senior clinicians would input to support those in triaging roles.

Staff participants acknowledged in an ideal world senior clinicians would be heavily involved in the triage process. However, similarly to the public, staff participants reflected on the feasibility and challenges associated with having more senior clinicians in triage functions and the need for further training to refresh their skills and knowledge.

Staff found the standardised triaging tool more appealing than public participants and thought it could more effectively streamline patient journeys, better manage demand, and help reassure patients.

Public expectations on triage

The public participant expectations on triage are presented in the Figure below.

Figure ES.3. Public participant final expectations on triage

We expect the urgent care triage process to…

- Have input from senior clinicians / qualified healthcare professionals when required, e.g. for complex conditions (recognising workforce limitations)
- Utilise technology to support the triage process, such as digital triage and/or use of a standardised triaging tool (either process must be rigorously tested to ensure it is safe, can be trusted and minimises risk to patient safety) and where appropriate an option for video call triaging to see physical symptoms / injuries
- Continue to offer an option for human/ face-to-face contact for vulnerable patients (e.g. small children, older people, people with learning disabilities, those with pre-existing conditions), those who may not be able to access digital services, and those where further explanation or reassurance is needed after a triage decision (e.g. if the decision does not meet the patient's expectations)

These expectations should be underpinned by the following:

- Communicating to the public about how senior clinicians and other trained staff are involved in safe triaging to ensure confidence and trust in the system, e.g. senior clinicians working alongside triaging staff to provide support as needed
- Communicating to the public that digital and face to face triaging follow the same approach / tool
- Ensuring, where possible, those who work in triaging are qualified and experienced healthcare professionals with access to a senior clinician if needed. However, recognising workforce constraints limit the availability of these roles, triage staff need to have the following essential skills:
    - ➢ Extensive experience in triaging
    - ➢ Some form of clinical expertise / training
    - ➢ Excellent interpersonal (e.g. calm, confident), customer service (e.g. compassionate) and communication (e.g. reassuring) skills as well as the ability to effectively manage a patient’s expectations
- Sharing of patient records across the system to ensure the triage process has information about a patient’s history (e.g. to help minimise the risk of missing underlying issues or the patient having to repeat their story)
- Regular, standardised and accredited training

- Regular testing and updates to digital triaging platforms

Staff expectations on triage

The staff participant expectations on triage are presented in the Figure below.

Figure ES.4. Staff participant final expectations on triage

How feasible is it for the system, across London, to meet the public expectations about triage from the perspective of your role/service?

What would need to be in place to help you, and your colleagues, feel confident about implementing or working alongside…

Digital triage:

- Unsure if digital triage can be equal to face-to-face triage. A **video option** for triagers would add to a clinician's ability to triage better. Some patients cannot explain their symptoms but they are able to show you. Also, a staff member is able to observe behaviour and tone – which is especially important in mental health.
    - In an ideal world we'd have visual triage for all, but we recognise the constraints
    - We can limit use of this to where it's really needed (e.g. ambulance example - use for assessing open fractures)
    - We can also have patients send images, as another option - which may be more feasible than video
- Digital/online may be more **feasible for certain groups of patients**, e.g. younger patients may be more comfortable
- Staff can also triage remotely from a wider range of places

However…

- We need to offer alternative options for those that <u>cannot</u> access digital – and that do not <u>want</u> to access digital
- Some people also need to have **two-way interaction** (**reassurance** and compassion achieved through talking to a person). This feels **achievable** to offer to some patients where it is needed.
    - There are examples where video consultations do work for triage, and we've seen it's possible through the pandemic
    - Suggest we have a pre-screening of some kind to identify who really needs the F2F option, e.g. certain mental health issues, vulnerable groups, elderly
    - Sometimes the patient just needs to speak to a person for that reassurance. If this reassurance is given remotely – it <u>needs to be fast</u> to give faith (long call backs – can mean people aren't reassured and just go to A&E)
    - Reassurance in the triage outcome can also be supported by giving patients <u>clear expectation of timeframe</u> and next step (e.g. "I will call you within 3 hours", example from optometry)
- Video may not be feasible to introduce everywhere from the system side – e.g. some GP appointments are only available via telephone
- Not every patient will have access to video technology at their end either – e.g. especially the elderly who are less likely to have access to a smartphone

More senior clinicians triaging:

- Senior staff can do triage more quickly and efficiently
- When we should rely on more senior staff triaging: more complex cases, as back-up/escalation (if person triaging needs second opinion)
- If involve more senior staff, should be permanent staff rather than reliance on agency staff – as **training** is important and would be a challenge if trying to train transient staff

However…

- May not be best use of resources / feels less feasible especially given workforce challenges. In some settings there is often only one senior person on shift
- Some senior staff may not *want* to add triage to their role – especially considering that training and periodic refreshes would be required
- Training and experience in triaging is key to getting comfort, making good, quick decisions (which is what a triager needs to do)
- Generally, more important than seniority, is that the triager has the right skillset and training for the role. This is feasible to do – we can train staff to confidently triage, e.g. train to use a standardised tool, to use a pro-forma, to make sure nothing is missed
- **Escalation routes** must be available to triagers to enable them to involve more senior/experienced staff where needed (and info sharing in these hand-offs is crucial)

Triage in general:

- **Data sharing and access to patient records** is critical – all staff involved in the process of a patient's care should have access to the same level of patient records, including care plans, history, previous interactions, etc., in one place – e.g. summary care record
- **Access to that data** may need to be via hand-held devices, e.g. iPads for staff triaging in-person, e.g. paramedic doing a home visit
- **Training** is very important for triage role – including not only clinical skills but interpersonal skills as managing patient expectations is important
- **Staff also need feedback** in order to learn/develop and gain confidence on their triaging
- There is an opportunity to **develop more staff**, e.g. pharmacists and optometrists, to do first stage triaging

Streaming and redirection

How can we ensure processes around streaming and redirection work effectively for both staff and patients?

Streaming

The patient is streamed within the department or to another service on the same site with the right clinical skills and diagnostic and treatment capabilities to meet their care needs in a timely way.

Redirection

The patient is redirected to a service at a different location that is more suitable for their needs e.g. pharmacy, their GP *(or an alternative GP practice which can see them sooner)* or to an emergency department.

Both streaming and redirection were broadly accepted by the public, and streaming was particularly uncontentious.

However, staff participants raised doubts about redirection including concerns about feeling the brunt of patient frustrations when they are redirected, and shared concerns about their own level of comfort redirecting patients. Staff expressed a lack of confidence that patients would agree to being redirected and also had uncertainty around who held accountability and risk as patients transit to a new service.

Public participants did discuss the potential challenges redirection poses for patients and staff including inconvenience to patients, uncertainty about what might happen during the redirection process and concerns that not everyone would be able to travel. Reassurance was key for patients to feel confident and comfortable with being redirected.

Both public and staff participants reflected on uncertainties faced by the patient when redirected given how the system currently operates. With this in mind, public and staff participants felt streaming and redirection were acceptable as long as conditions were in place. These included building in exemptions for patients at higher risk and providing support with travel, providing patients with proof or evidence to take with them to the service they have been redirected to. Public participants also discussed setting limits for how far a patient has to travel when they are redirected, providing patient choice and receiving clear instructions.

Staff participants also felt streaming and redirection needed to be consistent, have specific criteria, have input from senior clinicians and have the ability to share information to ensure these changes worked effectively.

Public expectations on streaming and redirection

The public participant expectations on streaming and redirection are presented in the Figure below.

Figure ES.5. Public participant final expectations on streaming and redirection

We expect streaming and redirection to…

- Be happening already across NHS urgent care services and not be a surprise to patients due to effective education campaign

To improve acceptability of these processes, the following conditions must be in place:

- **Patients need to be reassured about the steps being taken regarding streaming/ redirection, including:**
    - Being made aware of the reason for streaming/ redirection and why another service is more appropriate
    - Being given clear instructions on where to go, what to do if things don't go to plan/ their symptoms get worse, e.g. address, telephone number etc.
    - That the service they are redirected to is aware they are coming and able to see them. This could be via an appointment time / SMS confirmation / reference or referral number
    - That their information/ record is shared with the new service to avoid repetition of history

  - They are given clear information about how long they will wait to be seen at the new service
  - If people are being redirected, other services need to be able to cope with the demand (the whole system needs to work)
- **Patients should be given reasonable options and a choice about where they are redirected to, based on:**
  - Length of wait to be seen at other services with a commitment to a maximum wait or a confirmed appointment time
  - Ability to travel to other services, taking into consideration distance of other services, access to transport, cost of transport, length of transport, access to/ cost of parking, mobility and ability to comprehend instructions
  - The type of health professional a patient will see in other services
  - Capacity to make a decision/ choice (about the above)
  - Ability for transport to be provided in extreme situations, e.g. for most vulnerable
- **Contingency plans should be put in place for vulnerable patients to minimise dependency on one health professional, should their preferred health professional be unavailable**

Staff expectations on streaming and redirection

The staff participant expectations on streaming and redirection are presented in the Figure below.

Figure ES.6. Staff participant final expectations on streaming and redirection

How feasible is it for the system, across London, to meet the public's expectations from a staff/ service perspective?

Services will need to:

- Redirect patients early in the journey (at the beginning of their journey) – especially if resource not available at the site (ensure that they are redirected before having to wait too long)
- Provide patients with a guide / framework / road map for what they need to do if something goes wrong
- Ensure patients have the means to be redirected (relating to patient capacity, mobility, comprehension, language skills) and the ability to relay information - 'tell their story' (a workaround needed - summary report / form / letter) if the service is unable to share information - or a 'hotline' back to original service
- Develop a comprehensive criteria of is 'vulnerable' (as this is very subjective and difficult to define)
- Ability to offer options to patients – patient should have the final say as to if they are redirected and the option to wait for unscheduled care

This presents opportunities to:

- Educate patients about the variety of services through which they can access care - this helps to limit patient frustration / manage expectations - if they are making better decisions about going to the most 'appropriate' place (an information pack at point of registration)
- Save the system time

What would need to be in place to help you, and your colleagues, feel confident about implementing these approaches to streaming and redirection?

Ability to offer patients:

- Clarity on how to re-access the system should they need to AND what to do if circumstances worsen during or after redirection
- Transportation between services for those that need it or universal offer? (not agreement on this due to cost)
- A more efficient (faster) and 'appropriate' service (when redirecting based on demand). We must be careful to frame in this way

System capacity to:

- Deliver a seamless process where other services know the patient is coming AND waiting times are known upfront BUT if we give waiting / appt times this might raise expectations for patients! As much as possible provide live waiting times (an App)
- Bolster pharmacy provision – make it easier and more accepting for people to use (information campaign to raise awareness)

Staff education/ training to:

- Develop staff skilled in streaming/ redirection AND improve consistency of streaming/ redirection approach – educate pharmacists on red flag symptoms
- Build knowledge and confidence in other services
- Increase awareness about what services are available and when, as well as capacity to receive patient
- Improve communication between services – e.g. notify redirecting service that patient has arrived/ been accepted

Questions / issues for decision makers:

- Who has final say if a patient does not want to be redirected? The patient
- Staff are concerned about staff abuse and we need to protect staff
    - ➢ How do we deal with unhappy patients if being told they are to be redirected (staff may have concerns) – this relates to the importance of explaining that redirection may offer them less of a wait
- How do we deal with serial presenters who are not registered with a GP?
- How will this work if an appointment cannot be guaranteed at the other service? **What if there is NO appt available?**
- What happens to patients who arrive late (or not at all) to an appointment? Who follows this up and takes responsibility for the patient?
- How do we make streaming/ redirection seamless?
- How do we improve consistency?
- Better not to use senior clinicians (junior and early in the journey) or else tempted to 'stay and play'
- In the redesign and dissemination of this must stress that this is NOT about ED to GP – it's about the most 'appropriate' place for the patient

Scheduled urgent care

Would it be feasible and beneficial to move towards a model where more urgent care is scheduled?

Fast track

- People would have access to a range of services to seek initial assessment and advice e.g. NHS 111.
- If treatment in an ED or an UTC is most appropriate, an appointment slot (or arrival time) and location would be booked.
- **On arrival, patients who have been referred will be fast tracked – they will be prioritised over people with similar needs who have walked in to the ED without being assessed first.**

All urgent care is scheduled

- **Patients would no longer be allowed to walk in to an ED and wait as they can today**.
- People would have access to a range of services to seek initial assessment and advice.
- If treatment in an ED or an UTC is most appropriate, an appointment slot (or arrival time) and location would be booked.

Public participants clearly understood the potential benefits of adopting a fast-track service including reduced waiting times and discouraging people from accessing ED who didn’t need to be there. However, acceptability was underpinned by several assumptions, namely that the digital triage service would offer patients a choice of locations should they require a face-to-face appointment, and this would draw on real time information to communicate waiting times.

In general, both public and staff participants felt that with this proposed change the system could still be overwhelmed, with arrival time slots being quickly used up. Both mentioned that this system was not too dissimilar to current demand management in primary care which is currently overwhelmed. Staff participants were concerned that demand would shift from primary care to urgent care settings if there was a perception that patients would be given arrival slots. There were also concerns from both public and staff that people would manipulate the system to move higher up the priority list.

Both public and staff participants flagged concerns about certain patient groups, namely homeless people, people experiencing abuse, non-native English speakers and vulnerable people, should this model be implemented. The fast-track model was also seen to give an unfair advantage to those digitally literate and those able to communicate effectively via NHS 111 service. The proposal was described as a ‘two-tier’ service.

Consequently, public participants felt that a ‘safety net’ or alternative pathways must be in place should a patient’s symptoms deteriorate, someone is unable to access the digital front door to arrange a booked arrival slot, or for those who are more vulnerable. Staff also raised concerns about not being able to monitor patients who are deteriorating if they were waiting at home instead of an ED waiting room.

Overall, public and staff participants expressed a preference to the fast-tracked model over full scheduled care, which was felt to be too radical. Public participants felt that certain conditions would need to be in place for scheduled urgent care to work effectively, namely, exemptions for those unable to access virtual services, access to transport, assistance in ED to help people complete online assessments, transparency about arrival times and public education.

Public expectations on scheduled urgent care

The public participant expectations on scheduled urgent care are presented in the Figure below.

Figure ES.7. Public participant final expectations scheduling urgent care

If the fast-track (don't call it that!) option be taken forward across London, we feel this could…

- Encourage greater use of scheduled urgent care (for those that choose to use it)
- Support a gradual transition towards the scheduling of all urgent care allowing time for trialling and testing of the approach to ensure that it works/ is acceptable with the public
- **However…** steps must be taken to ensure vulnerable patients are not disadvantaged/ de-prioritised if they cannot or choose not to schedule their care (e.g. homeless, elderly, young children, people suffering from mental illness etc.)

If the scheduling of all urgent care be taken forward across London, we feel this could…

- Minimise the inappropriate use of A&E, though dependent on awareness and behaviour change
- However… there may be patients who continue to walk-in (and there would need to be some appointments set aside for these), driven by the high level of reassurance of being present in a waiting room provides. A dedicated person should be on-hand to support these patients in scheduling urgent care and space provided for them to wait

Implementation of either option would need the following conditions to be in place:

- Exemptions should be made for vulnerable patients who can walk-in at any time (elderly people, non English speakers, those with young children, homeless people, people with mental health conditions, people with disabilities, etc.)
- Reassurance and clear instructions for patients waiting at home on how to manage their problem and what to do if anything changes
- A dedicated person on-hand to explain the system to walk-in patients, to reduce burden on clinical staff
- An ongoing and comprehensive publicity campaign promoting access to urgent (not Emergency) care, alternative services, expectations of services and clarity on arrival time/ appointments, consistently across all care settings. This is going to take time (years) so investment is key.
- Communications should also focus on the benefits of scheduling urgent care and which groups will be the exemptions so the most vulnerable can be reassured that they can still walk in
- Realistic expectations managed around timeframes for scheduled care, including update of any changes and reasons why
- A comprehensive publicity campaign promoting access, alternative services, expectations of services and clarity on arrival time/ appointments
- Expectations managed around timeframes for scheduled care, including update of any changes and reasons why

Staff expectations on scheduled urgent care

The staff participant expectations on scheduled urgent care are presented in the Figure below.

Figure ES.8. Staff participant final expectations on scheduling urgent care

Scheduling not possible when there's no appointments available

- Consideration needs to be given around what happens when the arrival time slots have all been taken. We need to consider how we will manage higher demand / additional pressure at different times and seasonality – children in school holidays, etc.
- There is also a risk that patients will wait for many hours, their symptoms will become more severe and they will need to be re-triaged (i.e. by 111). Staff would need to be supported if this does happen
- Fully scheduled care could work well for same day emergency care (SDEC) departments but they need to be operating around the clock. Same day OOH clinical assessment services already have this system, and arrival times don't work and you end up with huge queues. This is because they don't operate for long enough

Fast-track

- The fast-track option feels more feasible than fully scheduled care but there are some potential benefits to fully scheduled care. The test will be whether the approach can be as efficient / more efficient than just having people turn up – currently NHS 111 appointments not seen to 'work'
- A fast-track system needs to be simple enough to allow staff to manage it, yet deal with the complexity in treatment order that this would create
- How do we balance visibility of fast-track getting seen sooner with realities of waiting room and tensions this causes
- Need to avoid penalising the people who need it most, exacerbating inequality – do they need a higher acuity score?
- Is fast-track the right term to use to sell the advantages of using the digital front door to access treatment?

Concerns about managing scheduling

- Concern about how to monitor those who are waiting
- How to manage the four-hour A&E target alongside the scheduling of care?
- When patients arrive they are frustrated having been through triage. When they get the help they need they are angry; they need a time and update about how long they have waited. Have someone come round to let them know where they are in the system. Staff will also need to be supported around how to handle angry patients/ unpleasant behaviour
- Have more tools to manage people at the front-end rather than stopping people attending ED

Educating and communicating about changes to urgent care services

Public participants were asked to consider: what kind of information the public needed to know about the changes; how should education be delivered; what language should be used to help clarify what urgent care is; and what the public needed to know about the reasons behind changes to urgent care. Findings from these discussions suggest the following:

- It is important to educate and inform Londoners of the current circumstances relating to urgent and emergency care in order to convey why services are changing

- The public should be made aware of key changes and processes, such as the proposed changes discussed during the workshops

- There is a need to raise the profile of urgent care and clearly distinguish this from emergency care to support more appropriate use of health services

- Education and communication to the public requires a broad and multifaceted approach (such as the utilisation of community organisations, infrastructure and connections, the development of innovative advertising campaigns, raising awareness about changes through word of mouth and positive experiences)

Additional reflections

Throughout the dialogue and deliberation overarching themes emerged which are important to draw out:

- **Primary care transformation:** primary care plays a crucial role in the delivery of urgent care services. The expectations voiced by the public and staff sit within a wider system and rely on the transformation of primary care in London. It would be wise to undertake a detailed programme of engagement with both the public and staff to inform this.

- **Ongoing engagement with the public and staff:** As this work has shown, staff have their own set of nuanced concerns and anxieties that are relevant to them and these must be captured and addressed. For the roll out of these to be successful, further and ongoing engagement will be needed with the public and also with staff across the system. Both the public and staff need to understand why change is necessary, the intended benefits and outcomes, and be given the necessary information and reassurances required.

- **The importance of avoiding the exacerbation of health inequalities:** This work has powerfully demonstrated the importance of deep consideration around health inequalities. As with the need to do ongoing engagement, communication and education with the public and with staff, the system would also need to work with groups and individuals who represent the voices of the most vulnerable and marginalised communities in London.

Introduction

Background

There is a national ambition to transform urgent and emergency care (UEC). London wants to improve people's experiences of receiving care and ensure policy and proposals are more transformative and innovative, working with Integrated Care Systems (ICSs), healthcare professionals, as well as citizens to shape services. There is a need to focus on urgent care in particular as:

- Access is currently confusing for both patients and the system
- We often look at need through the clinical lens and underplay other important drivers of demand that is perceived as urgent by service users and may reflect wider inequalities
- There is an ambition to ensure all urgent care needs are met in a safe, appropriate, and person-centred way

This is a complex agenda, with multiple interests and issues that need to be considered as part of any pathway redesign. There was therefore a strong desire to involve both Londoners and staff in a deliberative process to understand expectations around urgent care services to inform future policy design.

Imperial College Health Partners and Ipsos were commissioned by NHS England and Improvement (London region) to design and deliver a dialogue and deliberation engagement process to understand public, patient and staff expectations around urgent care services, in particular the trade-offs these may create, to inform future decision making.

Building on previous public deliberation exercises in London, this work aimed to continue to build a different type of relationship with Londoners, understanding people's hopes, fears, and expectations in relation to how care is provided across the Capital.

Overview of approach

The programme of engagement was designed and delivered in two phases over the course of ten months.

Phase 1 (engage) focused on gathering and synthesising key insights and issues in relation to urgent care to inform Phase 2 (Dialogue and Deliberation), the design and delivery of a dialogue and deliberation with staff and citizens, supplemented with parallel engagement with diverse communities that may be most impacted by future change – see figure 1.1.

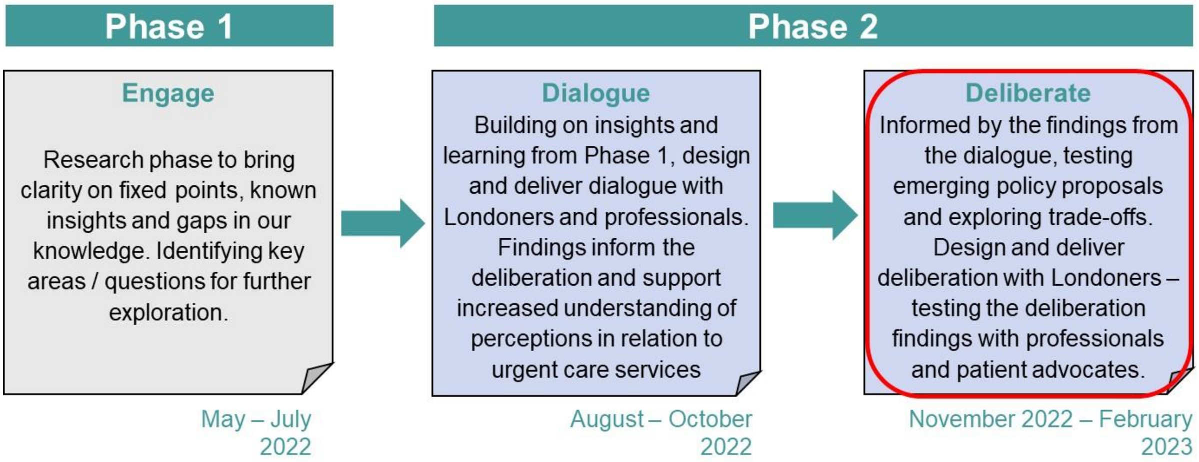
This report presents the findings from the Deliberation element of Phase 2. Reports summarising Phase 1 (insights gathering) and the Dialogue element of Phase 2 are linked below.

A brief overview of the different phase methodologies are as follows:

- **Phase 1 (May – July 2022):** focused on gathering and synthesising key insights and issues in relation to urgent care services. This was undertaken through a desk review of key literature, data and publications, as well as interviews with key stakeholders representing both the system and certain patient groups. The themes which were identified fed into the content for the Phase 2 Dialogue.

- **Phase 2 Dialogue (August – October 2022):** built on the insights and learnings from Phase 1, in the form of separate dialogues with Londoners and healthcare professionals working across the urgent care system. The dialogue process involved facilitating conversations with members of the public and staff from across the urgent and emergency care workforce with the aim of building an understanding of perceptions and experiences. Topics included: what factors define urgent care, what influences people's decision making when they are met with an urgent need, what factors drive urgency, and what builds trust and confidence in and between different types of care. Findings from the Dialogue phase shaped the principles underpinning how Londoners and staff define urgent care and how we can build trust and confidence. Key themes identified in Phase 2 Dialogue fed into the design of the Phase 2 Deliberation workshop content.

Figure 1.1: Overview of programme of work, split over two phases



Phase 1

Engage

Research phase to bring clarity on fixed points, known insights and gaps in our knowledge. Identifying key areas / questions for further exploration.

May – July 2022

Phase 2

Dialogue

Building on insights and learning from Phase 1, design and deliver dialogue with Londoners and professionals. Findings inform the deliberation and support increased understanding of perceptions in relation to urgent care services

August – October 2022

Deliberate

Informed by the findings from the dialogue, testing emerging policy proposals and exploring trade-offs. Design and deliver deliberation with Londoners – testing the deliberation findings with professionals and patient advocates.

November 2022 – February 2023

Phase 2 Deliberation: Aims and Objectives

Phase 2 Deliberation aimed to build on the findings of previous phases, working in greater depth with citizens and staff to explore different policy options for the delivery of urgent care services in the future. This phase enabled citizens and staff to deepen their understanding of not only some of the proposed changes, but also the constraints within which the system is operating that may impact future decision making. Participants were invited to grapple with trade-offs related to the proposed changes, to explore what mattered most to them and to voice any red lines.

The deliberation with citizens concluded with a recommendation forming exercise whereby Londoners were asked to form suggestions around key topics and proposals discussed, along with a list of principles/ conditions to which these proposals (if implemented) should adhere to. These findings then fed into the staff deliberation, where participants were asked to not only reflect on public perceptions and expectations but to also explore staff expectations and related trade-offs in relation to the proposed changes. Further details can be found in the methodology.

In addition to the staff and public deliberative workshops, a patient advocacy workshop with marginalised and vulnerable communities was convened to ensure proposed changes were informed by a breadth of perspectives. The focus here was on groups that may be differentially impacted by some/ all of the proposed changes. See the methodology.

Methodology

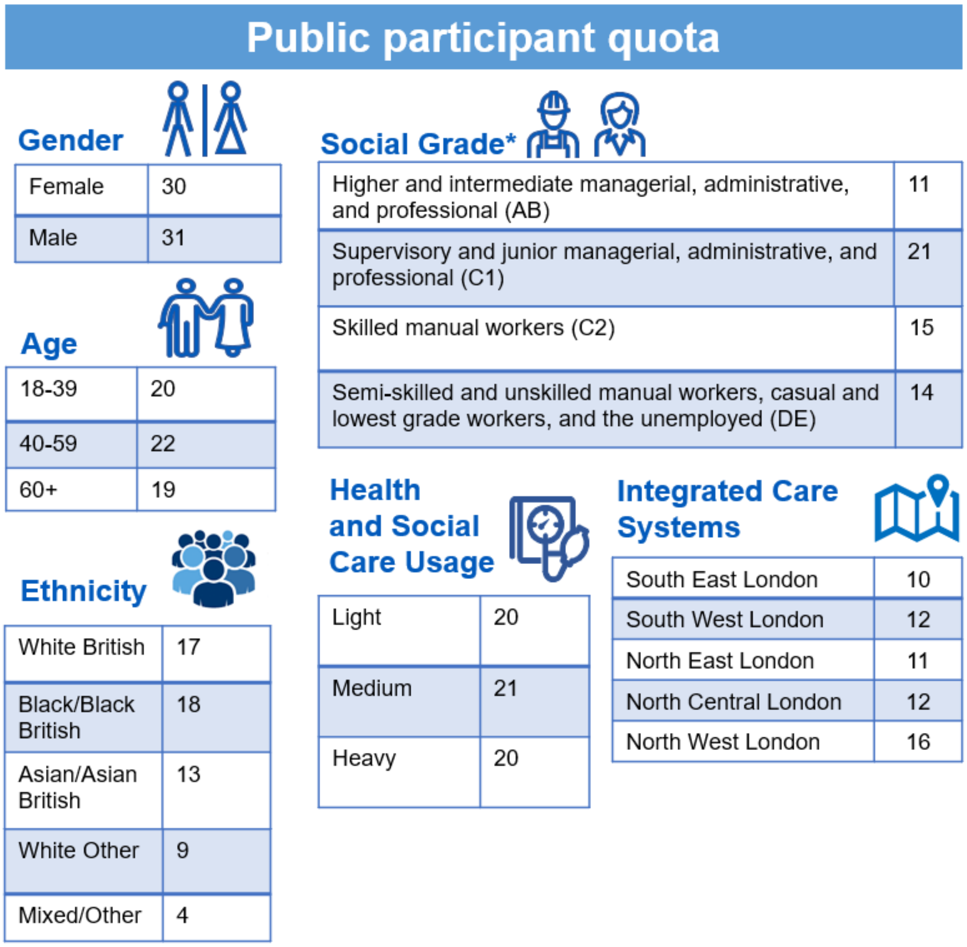
Deliberation is a progressive form of engagement to address complex problems that have related trade-offs. It convenes 'mini publics,' reflective of a larger population, over an extended period to grapple with trade-offs and dilemmas in the context of real-life constraints. This method creates an opportunity for decision-makers to understand public views that are carefully considered and rooted in real-life context and as such can help to build trust and relationships between official bodies and citizens, and inform more trusted and supported policy in the longer term. This deliberative method was deemed to be appropriate due to the complexities of the topics covered and provided a space to debate and discuss relevant issues and for key expectations to emerge.

Phase 2 Deliberation was split into three strands: public workshops, NHS staff workshops, and parallel engagement with marginalised communities through advocacy groups. The methodology for each of the groups is detailed below.

Public Workshops

The 56 participants who took part in the Phase 2 Dialogue, in October 2022, were invited back to participate in the Phase 2 Deliberation given that they had been informed about the context and case for change and had discussed their perceptions and experiences of receiving urgent care in London. Of these, 48 participants took part in the deliberation. To ensure the study participant quota was met,13 additional participants were recruited to account for attrition. A total of 61 participants took part, recruited from across all five ICS geographies in London and representing a spread across multiple demographic variables – see Figure 1.2 below.

Figure 1.2. Public participant quota



Public participant quota

Gender

Female	30
Male	31

Age

18-39	20
40-59	22
60+	19

Ethnicity

White British	17
Black/Black British	18
Asian/Asian British	13
White Other	9
Mixed/Other	4

Social Grade*

Higher and intermediate managerial, administrative, and professional (AB)	11
Supervisory and junior managerial, administrative, and professional (C1)	21
Skilled manual workers (C2)	15
Semi-skilled and unskilled manual workers, casual and lowest grade workers, and the unemployed (DE)	14

Health and Social Care Usage

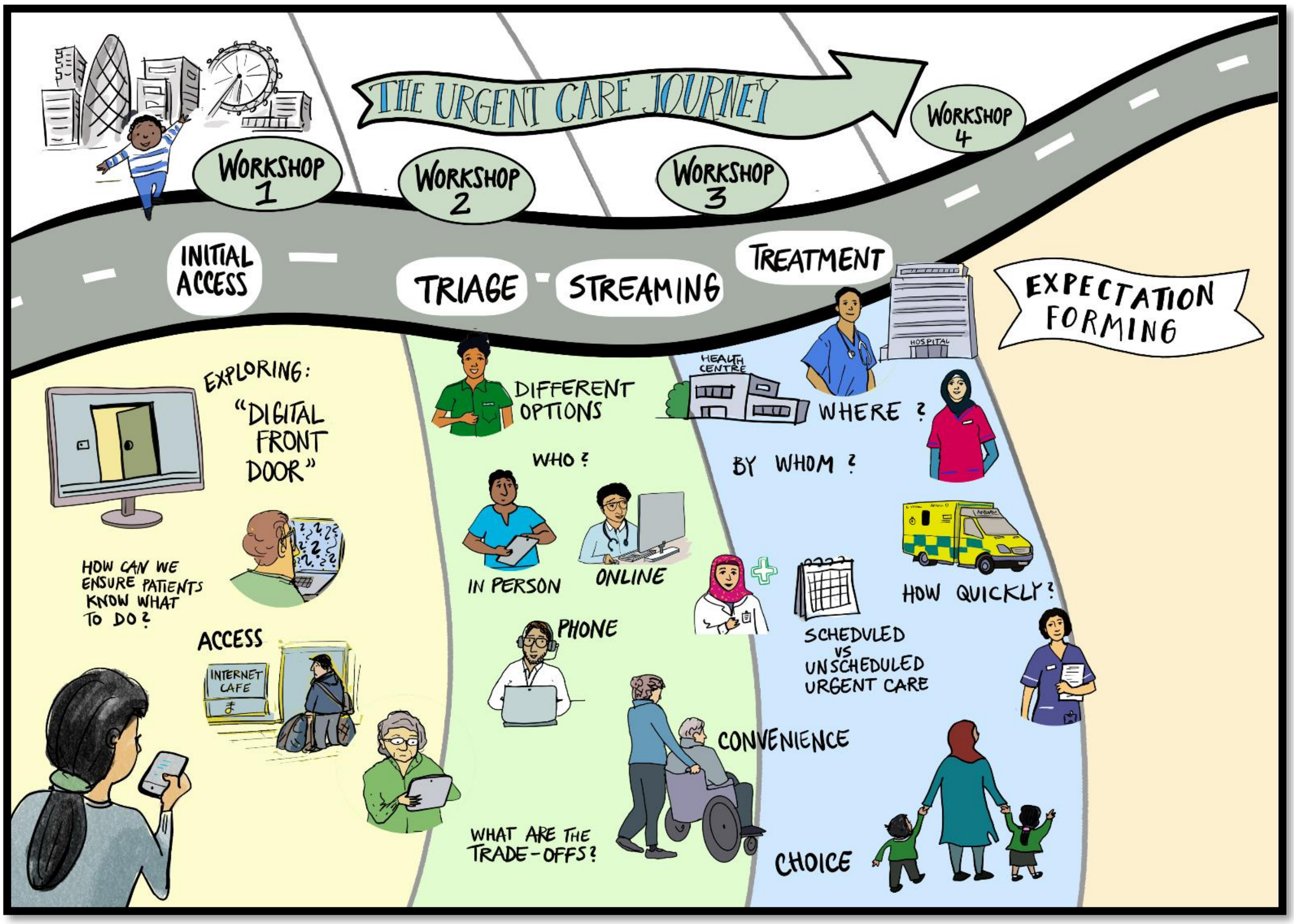
Light	20
Medium	21
Heavy	20

Integrated Care Systems

South East London	10
South West London	12
North East London	11
North Central London	12
North West London	16

Four three-hour virtual workshops were held with 61 members of the public from across London on 17, 19, 24, 26 January 2023. The workshops explored potential changes to the urgent care journey and sought to understand what mattered most to the public through the exploration of proposed potential changes and their related trade-offs – see Figure 1.3 below. The workshops consisted of presentations from experts, question and answer sessions, and smaller group discussions. Participants were mixed between sessions so that they were with different people for each workshop and small group discussions. This was done to allow them to hear a wider range of perspectives, and to avoid 'group think'.

Figure 1.3. Overview of public deliberation workshops



Workshop 1: The case for change and initial access

Workshop 1 (WS1) focused on introducing participants to the deliberative process, with a more detailed deep dive into the case for change to contextualise the deliberative process. Both public and staff feedback from the Phase 2 Dialogue workshops was provided to participants. Feedback included the main drivers for urgency from a public and staff perspective, as well as what characterises trust and confidence in urgent care services. Constraints within which any future change will happen were also outlined as these needed to be considered throughout the engagement to ensure the outputs were rooted in a real-life context, for example workforce, estate, funding, etc. Public participants were given the opportunity to ask questions about the case for change and associated constraints. After this, participants were then provided with a presentation on the first policy proposal - initial access to urgent care via a 'digital front door'. In breakout groups of six to seven people, they then reflected on the presentation before working through a series of patient personas to test examples of the digital front door.

Workshop 2: Triage, streaming and redirection

Workshop 2 (WS2) began with feeding back a summary of discussions from WS1 on initial access. The workshop then introduced the concept of triage, including three options a) digital triage, b) senior clinicians involved more in the triage process, and c) a standardised triaging tool through expert lightning talks. Public participants were invited to reflect on the options and the associated trade-offs before engaging in an exercise where they were asked about the most important characteristics and attributes for NHS staff conducting triage. In the second half of WS2, participants were introduced to the third area of proposed changes - streaming and redirection - through a presentation before reflecting and discussing their views on the acceptability of these approaches in breakout groups.

Workshop 3: Streaming, redirection and scheduled urgent care

Workshop 3 (WS3) began with feeding back a summary of discussions from WS2 on triage and streaming and redirection. Streaming and redirection continued to be explored through a series of patient journeys to test public perceptions and how they weighed up the associated trade-offs using a range of use cases. Breakout groups sought to draw out expectations in relation to travel, continuity of care and convenience. During the final part of WS3, participants were introduced to the fourth and final policy proposal on two different models of how urgent care could be scheduled. Public participants were then split into breakout groups and asked to reflect on the models, including the benefits and disbenefits of each, before working through a series of patient personas reflecting different scenarios of each model.

Workshop 4: Refining and finalising expectations, education and communication

Workshop 4 (WS4) brought deliberation to a close. Public participants were presented with a draft set of expectations for each stage of the urgent care journey, drawing on analysis of the previous three workshops. They were then split into breakout groups and provided the opportunity to ratify these expectations via live editing to better reflect participants views, adding conditions and removing content that they felt was no longer needed. This editing stage was initially conducted in small groups, before participants returned to plenary (as a whole group) to identify if there was any convergence or differences. After this, participants returned to their smaller groups to make any final changes to the expectations.

Final discussions focused on education, communication, and further engagement. Members of the ICHP and Ipsos team summarised all the groups' expectations and created a final set which was presented to participants and representatives from the system in the final plenary.

Staff Workshops

Two two-hour long virtual workshops were also held with 37[1] professionals from London's NHS workforce on 21 and 23 February 2023. Staff participants were recruited from across all five ICS's and represented a variety of occupations across the urgent care system – see Figure 1.4 below. Like the public workshops, many of the staff participants had previously been involved in the earlier dialogue phase.

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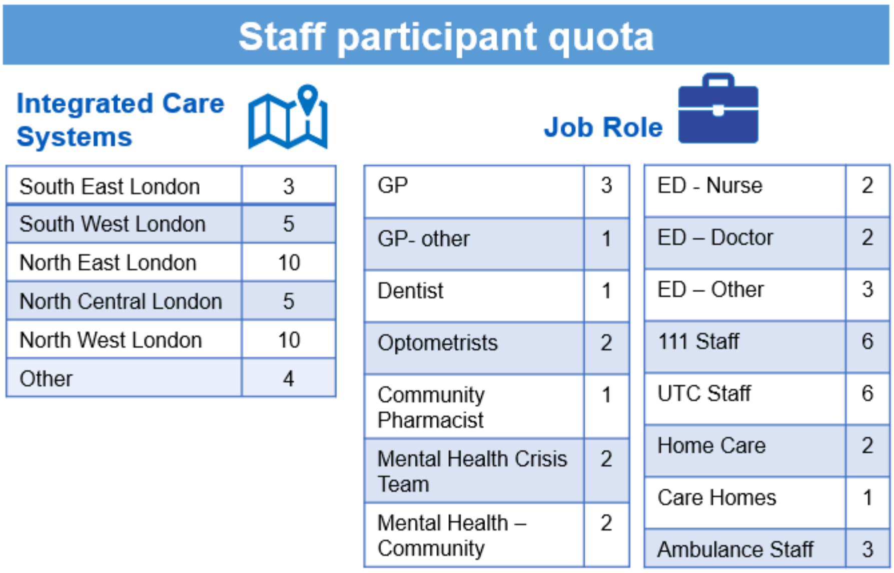
[1] A total of 37 staff participants attended across both workshops; however, one or two did not attend both workshops.

Figure 1.4 Staff participant quota



Staff participant quota

Integrated Care Systems

South East London	3
South West London	5
North East London	10
North Central London	5
North West London	10
Other	4

Job Role

GP	3
GP- other	1
Dentist	1
Optometrists	2
Community Pharmacist	1
Mental Health Crisis Team	2
Mental Health – Community	2

ED - Nurse	2
ED – Doctor	2
ED – Other	3
111 Staff	6
UTC Staff	6
Home Care	2
Care Homes	1
Ambulance Staff	3

Staff deliberative workshops drew on the content and stimulus materials used in the public deliberative workshops. However, staff were provided with summarised versions of the content given their knowledge about the system. Staff were also presented with the public's expectations and were asked to reflect on these in the context of future transformation.

The following areas were explored: initial access via a 'digital front door' combined with scheduled urgent care, triage approaches, streaming and redirection. Over the two workshops staff were split into three groups (referred to as topic cohorts) with roughly 14 people discussing each topic. Initial access via a digital front door and scheduled urgent care were merged and covered as one topic.

Given the need to retain small group discussions, there were two small sub-groups of seven within each topic cohort of 14. This allowed more time for each participant to discuss the related trade-offs from a workforce perspective, with the views of the public used to inform discussions. Below outlines the structure of the workshops.

Workshop 1: Presentation of the three broad topics and topic cohorts begin work on their areas

Workshop 1 (WS1) started in plenary with a presentation of the three broad areas and an overview of how the workshops would run. Staff participants were then split into breakout rooms within their topic cohorts and presented with more in-depth information on the topic from an expert with opportunity for Q&A. They were then presented with the relevant public expectations before being split into the sub-groups (i.e. groups of seven). They were then asked to respond to specific key questions in relation to their topic, discuss the topic and associated trade-offs, considering the public expectations, and what this means for them from a staff perspective. The topic cohorts then reconvened to feedback their thoughts and compare and contrast their views.

Workshop 2: Topic cohorts continue to work on their areas

Workshop 2 (WS2) started with a presentation from the lead moderator from each of the three cohorts who presented back an early draft of the groups' response to topic specific questions to the whole workshop. Each of the other cohorts were invited to feedback their views on the responses in the Zoom chat, with some participants being invited to share these views verbally. The feedback was collated by the moderators and, once participants had been split back into cohorts, they discussed as a group how best to accommodate the feedback into their response. These recommendations were then presented back at the end of the workshop to the whole group.

Parallel strand of engagement

A parallel strand of engagement activities ran alongside the public and staff workshops with patient advocates (Figure 1.5). This focused on engaging representatives with a deeper understanding of the issues faced by patients with complex needs, marginalised communities, and groups that may have additional needs when accessing services or be higher intensity users of services. A virtual workshop was held on 20 February 2023 which lasted four hours.

Figure 1.5 Representatives from the following organisations and groups supported:

Organisation
Peer Power
London Parents and Carers forum
Shewise
Alzheimer's UK
Southwark Travellers Action Group
Refugees in Effective and Active Partnership
Greater London Forum for older People
Wandsworth Older People’s Forum

Attendees included representation from and advocates for following:

- Gypsy, Roma and travellers
- Refugee and Asylum seekers, people who do not speak English as a first language
- Frail and elderly
- Dementia
- People with Learning Disabilities
- People who’ve experienced mental health crisis

The four areas of proposed changes - initial access via a ‘digital front door’, triage approaches, streaming and redirection, and scheduled urgent care - were presented to the participants who were then split into two breakout groups. In the breakout groups, participants reviewed these areas and their associated trade-offs, considered the public expectations, and discussed each option from the perspective of the specific needs of the communities / groups they represented. The whole group then reconvened to compare and contrast their views. The attendees shed light on some additional shared considerations for policy makers in relation to the communities they represented or advocated for.

Oversight Group

An independent Oversight Group (OG), made up of 13 people, was established to advise on the design and delivery of the engagement programme (all phases). Members represented a variety of occupations across health and care system - see Table 1.1 below. The group played an integral role in ensuring the engagement process provided an authentic and meaningful opportunity for public, patient and staff to deliberate and contribute to future policy relating to urgent care transformation in London. The OG were invited to critique and challenge the study design and deliberation content to ensure that the information provided to participants was balanced, fair and transparent.

Table 1.1. Oversight Group members

Name	Role
Zina Etheridge [Chair]	CEO, North East London Health and Care Partnership
Cathy Turland	CEO, Redbridge Healthwatch
Brin Hodgkiss	Head of Transformation Strategy (Digital UEC)
Helene Brown	PC Medical Director, NHSE/I London
Kate Adams	GP Clinical Lead, Tower Hamlets
Emma Rowland	ED Clinical Director, Homerton and London RCEM Chair
John Baker	Medical Director, Northwick Park and ED consultant
Angela McNab	Director, Mental Health and Community Services, NHSE/I London
Michael Holland	Medical Director, South London and Maudsley NHS Foundation Trust
Tony Carson	Senior Pharmacy Integration Lead, NHSE/I London
Robert Davidson	GP Clinical Lead, Southwark
Eileen Sutton	111 Lead, NHS England - London
Mark Bamlett	Head of IUC and Digital (London Region)

Alongside the OG, the deliberative workshops were supported by a small number of experts in urgent and emergency care services in London. The experts helped support the development and delivery of workshop stimulus and acted as subject-matter experts across the events.

Table 1.2. Supporting experts

Name	Role
Diana Lacey	Director of Urgent and Emergency Care, NHS England London Region
James Ray	Consultant in Emergency Medicine and Regional Clinical Advisor for London
Sue Robinson	Consultant in Emergency Medicine, Regional Clinical Advisor for London
Agatha Nortley-Meshe	Regional Medical Director for Primary Care
Sarah Davies	Head of Nursing, Acute & Emergency Medicine - Lewisham Medicine and Community Services
Matthew May	Consultant in Emergency Medicine, Clinical Lead Urgent & Emergency Care South East London ICS

Strengths and limitations

As with any methodology, there are strengths and limitations specific to deliberation.

Deliberation is a robust qualitative approach where participants are given the information, time, and space to explore and weigh-up real-world benefits, concerns, risks and constraints associated with an issue. It is well-suited to inviting the public and/or professionals to consider complex and unfamiliar issues in depth so that their views can meaningfully inform policy-making. It is used increasingly to build acceptable policy responses to questions where the issues at stake are more nuanced than a simple ‘agree’ / ‘disagree’ dichotomy.

The deliberative format of this research facilitated a genuine conversation that empowered participants to learn about the way that the NHS and urgent care in London operates, and how this impacts practical aspects of care. It enabled participants to explore the levels of acceptability in relation to potential changes to key aspects of the urgent care pathway. A mix of plenary sessions with experts and breakout discussions supported participants to weigh-up benefits and concerns, and to consider the trade-offs that were agreeable to ensure their expectations could be met in a real-world context. These activities and in-depth discussions support the emergence of an informed ‘mini-public’, which is unlike the form of discussion generally encountered through focus group methods, or other quantitative approaches. The group is therefore reliant on receiving balanced information and hearing a range of views. This deliberation used an expert Oversight Group to develop the materials and ensure balanced content. During the deliberation, experts were asked to present facts rather than advocate a position; with mechanisms for participants to ask questions and receive answers on any aspect of the materials.

Public workshops

Although we are confident that the group was appropriately diverse and thus reflective of the wider London population, the deliberation being held online over four evenings may have discouraged some people from taking part.

Whilst the work is robust, and the size of this deliberation is relatively large, the findings are not statistically representative and thus cannot be generalised to be reflective of all Londoners' views.

Staff workshops

The staff workshops allowed for a deep dive into the potential changes under exploration and allowed time in the workshops for staff to reflect on the public's expectations and co-create their own set of expectations. However, this approach meant that staff were not able to discuss all areas and instead focus on one. Workshop 2 did provide time for others to feed in their views which were taken forward for staff to consider.

Patient advocates

Whilst workshop participants provided their views as people with lived experiences or who advocate on the behalf of others, we must recognise that their views do not necessarily reflect the range and diversity of those from the various communities. It should also be noted that these participants regularly attend workshops of this nature, particularly within the health and care space, so they are arguably more informed by virtue of this.

How to read this report and stylistic conventions

A deliberative methodology is a qualitative approach, used to gain in-depth insights into the topic area. As it has a relatively small sample it is not intended to be generalisable to the views of the wider public. Findings are not intended to be statistically representative of the wider public. These findings are used to illustrate why people hold particular views rather than how many people hold those views. Due to the small sample size, and the nature of deliberative engagement, findings are presented at a whole-sample level, rather than segmenting according to demographics. Where relevant, the language indicates whether views were shared by a majority or minority of participants, for example using words such as 'some', 'many' or 'few'.

Within the public and patient advocate workshops the term 'Emergency Department (ED)' was used instead of Accident and Emergency (A&E). Throughout this report, we use the term ED.

Initial access via the digital ‘front door’

Summary

What if the only way for patients to access urgent care services is by starting the journey with a digital device or a phone? The care offered might end up being face to face, but the starting point ("front door") is virtual.

NHS 111 first

- Initial access to urgent care will be though NHS 111, with phone and online services available.
- NHS 111 will provide remote advice or direction to the most appropriate service for the patient’s need (talk before you walk)

Digital assessment for walk-ins to ED

- Walk-in patients will be required to check in at the front door of urgent care services.
- This will likely be via a digital device, where patients will be asked a series of questions about their symptoms/situation

Whilst open to the digital approach, both public and staff participants and patient advocates highlighted key risks and groups for whom this approach might not work for. This includes individuals who may not be able to report symptoms through a digital device (including patients with communication needs), older people, people with dementia, people with frailty, homeless people or those without NHS numbers, and those in mental health crisis.

Other risks and downfalls considered included, but were not limited to, lack of human contact which could impact patient safety, the system being easily manipulated, risk that people may fall through the cracks, data privacy issues and too much reliance on overly cautious algorithms which could lead to more patients being directed to ED.

Public, staff and patient advocates’ discussions concluded that a ‘one size fits all’ approach will not work and there will need to be alternative options available for people who cannot access the system digitally and/or have communication needs, as well as someone always physically present to help those who need it with completing a digital assessment.

Public and staff participants discussed that the success of the digital ‘front door’ would rest upon several factors including technology, efficiencies and capacity within NHS 111, flexibility within the system, patient expectations successfully managed and public education.

Public participants were introduced to the idea of a digital ‘front door’ in the first workshop, through an expert presentation. The presentation outlined that the digital front door was trialled during the Covid-19 pandemic, to control the spread of infection in waiting rooms, with patients calling/ going online to explain their problem before being given an appointment. The presentation recognised that patients were generally supportive of this change during the pandemic. It also posed a question about whether this would be the case moving forwards if the only way to access urgent care services was to do so by starting with a digital device or a phone.

Two access routes were introduced: 1) initial access through NHS 111 (phone and online services available); 2) a requirement to 'check in' using a digital device at the front door of urgent care services such as an Emergency Department or Urgent Treatment Centre. The digital-first approach currently in use at the Homerton hospital was used as an example of the latter. The presentation finished with an outline of some of the potential benefits of the digital front door (i.e. better demand management, convenience, and comfort for patients) as well as some of the potential risks, including less reassurance for patients, digital exclusion, and communication barriers. Public participants were encouraged to think about whether the potential benefits outweigh the potential risks, how we can avoid increasing health inequalities through this approach, how the system can replace the reassurance that turning up at ED and being seen provides, and what public education would be needed if this approach was adopted.

Staff participants were instead introduced to a high-level overview of the digital front door based on information provided to the public (i.e. in terms of what it is and how the two access routes would work). The digital front door cohort was given a more detailed presentation on the topic as well as the related public expectations, and then given the opportunity to ask questions.

Reflecting on the presentations, staff participants were asked to consider and respond to key questions during the discussions. These were: what additional considerations would staff add to the public expectations for policymakers to take forward, what are the considerations from a staff/ service perspective and what would need to be in place to help them, and colleagues, feel confident about implementing the digital front door and scheduled urgent care.

Patient advocates were provided with a presentation that mirrored the information the public received, along with the public expectations. They were asked to consider the benefits and risks associated with the digital front door proposals and then to think about and voice any additional considerations that would need to be in place to help them, and the community/ group they represented to feel confident about the public's expectations being taken forward.

The digital front door could be key to a more efficient service, thus convenient for patients and saving time, and will work well for those who are digitally enabled

Public participants were able to immediately recognise, and spoke to, the many benefits of a digital front door. In theory this method for accessing services seemed like a good idea (e.g. accessible from home, at work or on the move). Assuming the system would work as intended, with some questions about the feasibility of this approach (see below), participants recognised that it could be efficient, and more comfortable and convenient for patients - people can stay at home, rather than wait in ED. They also noted that this could save time for patients, and result in patients being quickly directed to the right place for them while also reducing the risk of being exposed to viruses and infections.

"It brings a lot of benefits, not having to have a physical place to go to, you can do it all remotely." (Public participant, Group 5, WS1)

Staff participants additionally noted that this access route would work particularly well for the younger generation who they perceived as being keen to do everything online.

Public participants also noted that the digital front door has the potential to relieve pressure on the workforce, filtering out those who do not need to be treated in ED, and enabling the system to better manage demand.

The reliance on digital access, however, comes with many downsides and risks

While open to the digital approach, public and staff participants quickly highlighted what they saw to be the main risks associated with it. Patient advocates immediately identified these risks from the perspective of the communities they represented.

Public and staff participants cautioned groups for whom this approach would not work for, given the reliance on the individuals to report symptoms through a digital device or phone, and in the absence of a face-to-face interaction.

- **Patients with communication needs**: people who do not speak English as a first language; people with Learning Disabilities; people with visual impairments or who are deaf.

- **Older people, people with Dementia or people with frailty:** in particular, those who live alone.

“This goes back to digital exclusion of people who are elderly or can't use these services. This is a potential pitfall of trying to make things more accessible and digital.” (Public participant, Group 5, WS1)

*“I'm a case manager for frail patients in the community, used to be called rapid response, now it's urgent care community services. This discussion gives me a bit of anxiety as 100% of my caseload would not be able to access digitally and it really makes me think what are the risks and opportunities for this.” (*Staff participant, Group 3, WS1)

- **Homeless people and people who do not have an NHS number**

- **Very anxious patients and those in mental health crisis**

Patient advocates also emphasised the importance of face-to-face interaction for people with communication needs, such as those who are deaf, non-native English speakers, ethnic minority communities, older people and people who have Dementia.

"With this concept of delivery, we've already excluded a large percentage of people. People who are not digitally savvy and people for whom English is a second language and those who can't speak English at all." (Patient Advocate, Group 2)

“The BME community, the problem is communication. Older people want to be assured of how they're being treated and that's not always done in a digital way because they don't have laptops or mobile phones.” (Patient Advocate, Group 2)

As the digital front door was discussed further, additional concerns were raised

While public participants suggested that for the majority of people this approach was probably acceptable, they also highlighted a number of flaws in an approach which is designed to be entirely virtual. These were mirrored during discussions among staff.

Firstly, **the lack of human contact was linked to patient safety**. Public participants voiced the concern that many symptoms are associated both with very mild conditions as well as extremely serious ones, and they questioned how a digital device would be able to decipher between these. As well, staff cautioned how patients may underestimate or misreport their symptoms, which is a risk to patient safety.

“Some people may underestimate their symptoms and may end up in lower care when they need something more. Someone may be experiencing a heart attack symptom but they don't recognise it and

underestimate. Would there be a clinical presence to monitor the rooms and pick up those things." (Public participant, Group 2, WS1)

Secondly, **the system was seen to be open to manipulation**. Patients could exaggerate their symptoms with the view to being seen quicker. When discussing one of the patient personas (Tao, a child with a fever, whose mother overemphasises the child's symptoms in a digital assessment in the hope that they will be seen more quickly), public participants felt that this was likely to be a common scenario.

"I think people are going to sway towards making symptoms worse, thinking they are going to be seen quicker. I think that's common across the board." (Public participant, Group 6, WS1)

Thirdly, **there was a perceived risk that people will fall through the cracks,** and not receive the care that they need which was linked to health inequalities and to safeguarding.

"One thing that came to the forefront was women and children that might suffer abuse, these are things that need to be assessed visually and surreptitiously." (Public participant, Group 7, WS1)

"Digital can exclude the most vulnerable at times, which would risk them not being able to access the services they needed." (Staff participant, Group 5, WS1)

Related to this, public and staff participants raised **concern about people in mental health crises** and how the absence of a face-to-face interaction could be damaging for patients in these situations.

"It's practically impossible to assess mental health without a face-to-face consultation. This has to be looked into more closely before this is actually used for assessing a person's mental health state." (Public participant, Group 3, WS1)

As the public participants discussed one of the patient personas (Jonny, a teenager in mental health crisis), some breakout groups voiced a stipulation that people in urgent mental health crisis should always have the option to bypass the digital access route and be seen as soon as possible in person, at a place most appropriate for their needs (i.e. a specialist mental health unit).

Patient advocates also expressed the importance of a human element to support people who are stressed or struggling with health issues and anxiety.

A number of other issues with the digital front door were also aired.

- Staff participants felt there would be too much reliance on overly cautious algorithms, which are notoriously risk adverse and could result in *more* patients being directed to ED.
- Public participants cautioned the number of people who might end up queuing at Emergency Departments to use the digital devices. Similarly, staff questioned how they would manage the volume of patients needing to use iPads in ED entrances.
- Linked to this, public participants also raised privacy as an issue, considering people would be expected to use digital devices or phones in public places to complete the initial assessment.

The success of the digital front door will rest upon technology, efficiencies and capacity within NHS 111, and public education

In almost all public and staff discussions, questions were raised around the feasibility of this approach, technology and the availability of patient information.

When discussing one of the patient personas (Janike, a patient with limited English who is seen in the Urgent Treatment Centre and the clinician already has notes on her symptoms since the NHS 111 call handler had sent these through), public participants recognised the importance of the transfer of information in terms of continuity of care and to avoid the patient having to repeat their story, thus also saving time.

“The next healthcare professional can take her on her journey to the next point and not have to go backwards in order to go forward. It's reassuring to the patient that she's been heard and she's not having to repeat everything over and over again, and she can go on to the next stage of the scenario." (Public participant, Group 3, WS1)

Similarly, staff raised the importance of integrating services and sharing information across the system.

Patients talked about how NHS 111 would need to work efficiently and there would need to be enough capacity within 111 in terms of managing clinical call-backs.

“My concern is if you don't fix NHS 111 you can't build upon it. They lack specialised information.” (Public participant, Group 5, WS1)

Staff too flagged current capacity within the system as a risk, as well as the potential for patients to enter back into the 111 service if they don’t initially receive the outcome that they want or are comfortable with.

“It's not too different from what we have, it's still reliant on everything else being in place, and this is where we have lots of issues. The system's going to become overwhelmed just as the current system is.” (Staff participant, Group 3, WS1)

Public participants talked about the importance of educating the public. From a very early age (i.e. in schools), coupled with a large wide-reaching communications campaign to land the messages about initial access to urgent care services via many mediums including adverts in public spaces and public transport, on TV, and via text message reminders. Public participants were keen to see the role of pharmacists amplified in any public education and communications, to raise awareness about what they can offer.

“As far as the pharmacies go, we need to make people aware, people think you go there to buy things, but make people aware that they are qualified and can give advice.” (Public participant, Group 8, WS1).

A ‘one size fits all approach’ won’t work

While it was felt that the digital front door would probably work for the majority of people, after much deliberation a clear steer from both public and staff discussions, as well as those with patient advocates, is that a ‘one size fits all’ approach will not work.

“The digital pathway I think will work for the majority of people, but I'm a bit worried about health access and the inequalities for those people that for whatever reason can't access it.” (Public participant, Group 5, WS3)

"There has to be a non-digital access route, that is not an option." (Patient Advocate, Group 1)

The perception among the public, staff and patient advocates was that there will need to be accommodations for those who require them. Choice was important for some public participants.

- There would need to be **alternative options available** for people who cannot access the system digitally and/or have communication needs. Public participants suggested access points in public places like libraries and supermarkets. Patient advocates emphasised that telephone access should be given equal importance to digital options and communications should highlight that access is for everyone, not just those who cannot use digital methods. They also highlighted how important it was that this change in access didn't deter people from trying to access services.

- There would **always need to be someone physically present** (i.e. by the iPads in an Emergency Department) to help people complete the digital assessment. These individuals could also act as a safety net for patients who present with complex social problems, as raised by staff who felt there should still be links to social services.

"You have a screaming child in your arms. You don't want to use the iPad systems." (Public participant, Group 3, WS1)

"If we're going for a fully digital front, it's still important to have a physical presence there, just if someone struggles to access the systems or needs some assistance. Instead of having solely just digital, it's important to have a mixture, especially for the elderly or vulnerable ones." (Staff participant, Group 3, WS2)

Staff participants discussing the digital front door as part of the cohort made the point that this system will work well for those who can access digital services, but it should not further exacerbate existing health inequalities.

"The same way that in GP services you now have e-consult, it exacerbates inequalities and the digital divide. Elderly, people who don't have access to the internet, people who don't speak English. Those who can and know how to use the system, can bypass everything else." (Staff participant, Group 1, WS2)

This led staff in the same cohort to conclude that there should always be an option for people to walk into ED and wait to be assessed in person. They raised the risk of backlash from the public and expressed concerns around the risk of people's needs not being addressed when they need to be. As well, accountability was questioned in relation to the algorithms.

"There should be that right for people to see a doctor and wait 12 hours if they want. Removing that would cause backlash. If I make a mistake as a GP, I am accountable. A mistake made by an algorithm, who is accountable?" (Staff participant, Group 1, WS2)

Patients will need reassurance and their expectations managed, while staff will need to know how to deal with resistant or unpleasant behaviour from unhappy patients

In terms of building patient and staff trust in the system, some staff participants suggested information and feedback should be available on how well the system is working.

Staff spoke too about the importance of managing patient expectations, suggesting a means for updating patients as to where they are in the digital queue. Related to this, public participants spoke of how the absence of information - coupled with a potentially lengthy wait at home and the fear of a condition deteriorating - could increase anxiety and mean people give up and make the decision to go to ED after all. Being given a sense of how long you might have to wait for a call back, and what to do should your symptoms get worse, could alleviate this concern, and provide the reassurance people might need.

"*Just knowing the time can be a reassurance."* (Public participant, Group 9, WS1)

In the final workshop, the digital front door staff cohort group expressed the importance of framing the digital front door as a helpful tool to get people to the right place, and empowering them to make decisions about their care, rather than a blocker to accessing urgent care.

"A concern I have about the front door is it being seen as a barrier to entering into the urgent care system when perhaps what we could do is sell it as a tool to help people choose their location. So rather than it being something they have to go through, it can be a tool we can offer them if they want to use it from the comfort of their own home and they can choose where to go." (Staff participant, Group 1, WS2)

Staff participants also raised the need to protect staff from unpleasant behaviour towards staff and resistance from members of the public.

"I don't think we got a lot of training in conflict management. It's about managing expectations of patients. If people are asked why they're being sent away or why someone has fast-track. If it's a digital one, something on the internet. Making sure staff do not end up taking all the brunt for an initiative for something we have carefully designed. The front-line staff are going to get most of it." (Staff participant, Group 2, WS1)

Public expectations

In WS4, public participants were presented with a summary of the key findings from the previous workshop discussions on the digital front door in the form of a set of draft expectations. They were asked for their reflections on the summary and whether they felt this broadly captured the views participants had expressed and heard during the workshops.

Figure 2.1. Summary shared at the start of WS4

If the digital front door is taken forward across London, we feel it could…

- Lead to better management of patient demand for NHS services whilst benefitting patients (e.g. you may be seen more quickly)
- Provide greater access to care at home (e.g. convenience) and require people to attend a health service in-person only when they need to
- Be improved over time, as technology advances (e.g. use voice commands when accessing online/ be accessible in different languages)

To ensure this approach is acceptable and trustworthy the following must be in place:

- There should always be an option for the most vulnerable (e.g. elderly, hard of hearing) or anyone who is distressed to walk-in / access face-to-face triage

- There should be a designated assistant to help those who need support navigating the digital front door (e.g. assistant present in a health service settings, interpreter services)
- There needs to be well-publicised access points for those with limited access to digital communications (e.g. in public libraries, telephone boxes)
- Clear guidance on what to do if a health problem changes/ gets worse supported by ongoing reassurance
- Education campaign for the public to communicate how to access the digital front door, confirm the approach is safe (e.g. risk averse, data is secure) and trusted (e.g. run by highly skilled/ trained staff), and what to do if you have difficulty accessing digitally

There was broad agreement across public participants that the summary accurately reflected the discussions. Rather than changing the expectations, public participants further strengthened these to include the following.

- Participants were keen to reflect the need for the digital interface to be user friendly and capable of capturing multiple conditions/ co-morbidities.
- Participants added to the list of exemptions of potential groups this would not work for, while recognising that the list was becoming potentially unmanageable. At this point in the discussions there were some breakout rooms who agreed that there should always be the option to walk in and access face to face triage (across some groups this was the consensus).
- Participants felt that digital front door access points in the community (e.g. libraries, supermarkets etc) should be 24-hour, which would be fundamental to the functioning of the digital front door.
- Participants emphasised the importance of a backup system should the technology fail.
- The draft recommendation around a communications campaign was strengthened emphasising the need for this to be hard-hitting and regular.
- Finally, it was felt that the digital front door should be regularly tested and evaluated to ensure that is working most effectively.

Figure 2.2. Public participant final expectations on the digital front door

If the digital front door is taken forward across London, we feel it could…

- Lead to better management of patient demand for NHS services whilst benefitting patients (e.g. you may be seen more quickly)
- Provide greater access to care at home (e.g. convenience) and require people to attend a health service in-person only when they need to
- Be improved over time, as technology advances (e.g. use voice commands when accessing online/ be accessible in different languages)

To ensure this approach is acceptable and trustworthy the following must be in place:

- The interface should be user friendly. The interface should be able to handle multiple conditions at one time to take account of co-morbidities
- There should always be an option for the most vulnerable (e.g. elderly, hard of hearing, young children, homeless people, people with mental health issues etc) or anyone who is distressed to walk-in/ access face-to-face triage
- There should be an alternative option / back up if the system crashes / internet goes down
- There should be a designated assistant to help those who need support navigating the digital front door (e.g. assistant present in health service settings, e.g. A&E, interpreter services) as well as a help button/ virtual assistant for those accessing at home
- There needs to be well-publicised 24-hour access points for those with limited access to digital communications (e.g. in public libraries, supermarkets, railway stations etc.)
- Clear guidance on what to do if a health problem changes/ gets worse supported by ongoing reassurance
- Ongoing and hard-hitting education campaign for the public to communicate how to access the digital front door, confirm the approach is safe (e.g. risk averse, data is secure) and trusted (e.g. run by highly skilled/ trained staff), and what to do if you have difficulty accessing digitally. This campaign should be regularly tested to ensure it is working
- Digital front door platforms should be regularly evaluated and updated to improve effectiveness

Staff expectations

Workshop 2 (WS2) started with a presentation from the lead moderator who presented back an early draft of the groups' response to topic specific questions.

Figure 2.3. Summary responses shared at the start of WS2

Making the right decision for all patients

- The **algorithm has to be on the cautious side** because the people creating the programme carry the risk in the first instance. If the digital first approach is **too risk-averse, too many people could still end up in the ED**. We need to be clear about whether the digital front door will be the full 111 algorithm triage or if there will be a tailored option
- **Not all patients will find this straightforward**. There is a risk that patients who **underestimate their symptoms** (men in 40s) or those not able to provide the necessary information (**frail people**) may 'fall through the cracks'. and those who **need a carer** with them for any follow-up triage call (e.g. through NHS111)
- We also need to think about the impact of a digital front door on vulnerable people who **come into ED as a safe place** to be - do we need to consider how social care services are linked into the digital front door? Also **anxious patients**/ those in **MH crisis** may still walk into ED

Ensuring hand offs are successful

- Services downstream need to be fully linked in and have capacity - ideally digitally - including OOH, pharmacies, Primary Care

- We need to consider hand-off for locums, e.g. pharmacists
- There is a risk that patients will go back into 111 if they didn't get outcome they wanted and these people may still go to A&E if unhappy
- NHS111 coding for urgency currently doesn't fit in with how GPs work (i.e. it gives option for two-hour or six-hour urgency whereas GP can be same day/ next day)

Evaluation and assurance – make sure it works and communicate this

- Patients and staff will need to be reassured about the effectiveness and accuracy of the digital front door
- We need to understand how we can manage patient and public expectations too – many people will still present and want treatment for minor issues. More advice about self-care too to help reduce demand on services. Important to manage expectations before they come for treatment

During the feedback session at the beginning of workshop 2, the rest of the group fed back on the responses to the questions posed to staff that the digital front door staff cohort had developed.

The following themes emerged in this feedback:

- The need to position this positively, by avoiding the word 'digital' and replacing this with 'virtual' and to emphasise the importance of saving time and getting patients to the right place.
- The risk of further exacerbating the digital divide and existing health inequalities.
- Concern about how the digital system could disincentivise people who do not have an NHS number (people with irregular immigration status), and also people who can't speak English or are unable to communicate their health issue or concerns.
- The importance of considering safeguarding when moving services to be entirely digital.
- How we must avoid passing people around the system.
- How we will be able to accommodate lots of people who need to use iPads in ED entrances.
- The importance of being able to 'get it right first time' when working with carers, on behalf of the patients that they care for (as they may not be able to wait with the patient until they are eventually seen).

The cohort worked through some of this feedback and incorporated this into the final output. These are presented in the Figure below.

Figure 2.4. Staff participant final expectations on the digital front door

The ~~**digital**~~ **virtual front door**

Making the right decision for all patients

- The **algorithm has to be on the cautious side** because the people creating the programme carry the risk in the first instance. If the digital first approach is **too risk-averse, too many people could still end up in the ED**. We need to be clear about whether the digital front door will be the full 111 algorithm triage or if there will be a tailored option
- **Not all patients will find this straightforward**. There is a risk that patients who **underestimate their symptoms** (men in 40s) or those not able to provide the necessary information (**frail people**) may 'fall through the cracks', and those who **need a carer** with them for any follow-up triage call (e.g. through NHS111)
- We also need to think about the impact of a digital front door on vulnerable people who **come into ED as a safe place** to be - do we need to consider how social care services are linked into the digital front door? Also **anxious patients**/ those in **MH crisis** may still walk into ED
- How do we ensure we don't leave behind groups because of the force of getting caught up in the service change?
- Need to reduce steps and times forms are filled

Ensuring hand offs are successful

- Services downstream need to be fully linked in and have capacity - ideally digitally - including OOH, pharmacies, Primary Care
- We need to consider hand-off for locums, e.g. pharmacists
- There is a risk that patients will go back into 111 if they didn't get outcome they wanted and these people may still go to A&E if unhappy Important to be right first time to ensure carers can assist people to the right place
- NHS111 coding for urgency currently doesn't fit in with how GPs work (i.e. it gives option for two-hour or six-hour urgency whereas GP can be same day/ next day)
- Will services have to accept or will the algorithm have the power to transfer to a service?
- Need to overcome a lack of coordination and IT systems not talking to each other

Evaluation and assurance – make sure it works and communicate this

- Patients and staff will need to be reassured about the effectiveness and accuracy of the digital front door
- We need to understand how we can manage patient and public expectations too – many people will still present and want treatment for minor issues. More advice about self-care too, to help reduce demand on services. Important to manage expectations before they come for treatment.
- An opportunity for support in choosing the right options and join the UTC virtually, an adjunct to walk into A&E
- Who is accountable for mistakes made by an algorithm?
- Is it reasonable to be transparent about the number of appointments/ capacity available?

Comms and education will be paramount

- Need to empower people to understand where they should go

Triage

Summary

Effective triage has an important role to play in supporting the NHS to manage demand, but we know it's complex! Could adopting any of the approaches below help?

1. Increasing use of digital triage, where patients input their symptoms online / over the phone and an algorithm determines the urgency and most appropriate service

2. Involving more senior clinicians in the triaging process e.g. experienced doctors, GPs and consultants

3. Introducing a standardised triaging tool which enables staff to assign a clinical priority to patients, based on presenting signs and symptoms

Public participants and staff recognised that digital triage has the potential to lead to better demand management, though they flagged risks associated with the perceived removal of the human element through the use of algorithms. They also flagged the potential for patients to manipulate the digital system.

Digital triage was perceived to present new opportunities for digitally literature patients much like other services used in everyday life, which could save patients time and be more convenient.

In some breakout rooms there was a general lack of trust in automated approaches to triaging including concerns about the ability to identify nuances in patient needs (e.g. level of pain or discomfort), risk of being sent to the wrong department and concerns about what would happen if the system crashed. Some participants felt that digital triage placed too much onus on a patient's ability to communicate their needs or symptoms, which could be challenging for certain groups.

Public participants and patient advocates also questioned the feasibility of digital triage for certain patient groups. Driven by a preference to speak to a healthcare professional, some public participants - and patient advocates - felt that there should be an option to speak to a healthcare professional within digital triage as well as alternative options (e.g. walk-in) for vulnerable people.

Interpersonal skills and experience within triaging were the key characteristics mentioned by public participants when discussing important characteristics required for triaging staff. Public participants also noted an expectation that senior clinicians would input to support those in triaging roles.

Staff participants acknowledged in an ideal world senior clinicians would be heavily involved in the triage process. However, similarly to the public, staff participants reflected on the feasibility and challenges associated with having more senior clinicians in triage functions and the need for further training to refresh their skills and knowledge.

Staff found the standardised triaging tool more appealing than public participants and thought it could more effectively streamline patient journeys, better manage demand, and help reassure patients.

Public participants were introduced to the concept of triage in the second workshop, through an expert presentation. The presentation explained what triage is and why it is important, in order to identify patients with the most time critical conditions so they can be treated in order of clinical urgency and need. It also described how triage currently works in practice, including the range of settings in which it happens and the variety of healthcare professionals involved, as well as the challenges facing urgent care services when triaging patients. For example, a large patient population bypassing primary care as they are unable to get timely appointments resulting in a growing number of patients arriving at emergency departments. The presentation also acknowledged that triage is a topic of legitimate debate and it is important for the NHS to understand what the public thinks is most important when triaging patients and why. Three triaging options were presented to the public via expert lightning talks:

1. increasing the use of digital triage (where an algorithm determines the urgency and most appropriate service to meet patient need);
2. involving more senior clinicians in the triaging process;
3. introducing a standardised triaging tool (to support staff assign a clinical priority to patients).

Public participants were encouraged to think about several considerations relating to triage, including how best to manage demand, the importance of consistency in a triaging approach, the trade-offs relating to who conducts triaging and the implications this could have on other parts of the care pathway and ensuring trust and confidence in decision making.

Staff participants were instead presented with a high-level overview of the triage options based on information provided to the public (i.e. in terms of the challenges relating to triaging in urgent care and the options being presented). The triage cohort was then given a more detailed presentation and related public expectations on triaging, and then given the opportunity to ask questions.

Reflecting on the presentations, staff participants were asked to consider and respond to key questions during the discussions. These were: how feasible it would be for the system across London to meet the public expectations about triage from a staff/ service perspective, what would need to be in place to help staff feel confident about implementing or working alongside the triage approaches discussed.

Patient advocates were provided with a presentation that mirrored the information the public received, along with the public expectations. They were asked to consider the benefits and risks associated with the triage proposals and then to think about and voice any additional considerations that would need to be in place to help them, and the community/ group they represented to feel confident about the public's expectations being taken forward.

Digital triage has the potential to lead to better management of demand, though risks were flagged early on due to the perceived removal of the human element through the use of algorithms

During initial discussions about digital triage, public participants expressed that they felt the digital triage approach has the potential to help improve the management of increasing demand for urgent care services.

"…one of the key points is it's really difficult to triage and it's causing a large strain on resources. I'm just thinking of ways to improve that or how people who are coming to those services could improve that as well. Looking at both ends of it, and the digitisation part could help with that." (Public participant, Group 2, WS2)

While at the same time, there were several risks raised early associated with the perceived removal of the 'human element' of triage, and reliance on algorithms. For example, perceived failure to take on a full account of a patient's symptoms in the same way a human could if they were asking questions, and patients being directed to the wrong place. Linked to this, public participants also expressed the potential for patients to manipulate the digital triage system by exaggerating symptoms to be seen quicker or directed to their desired service (as opposed to the most appropriate).

"…people will overexpress their conditions to ensure a quicker treatment. People will learn how to handle and 'manage' the system." (Public participant, Group 1, WS2).

Public participants were quick to point out accessibility issues for those less familiar with digital technology (i.e. the elderly).

Staff participants were broadly supportive of the introduction of the digital triage. They noted that this could help to streamline patient journeys and reduce the need for patients to be re-triaged by a healthcare professional once they arrive at a service, leading to better management of demand.

"…going digital, having information transferred across the whole board to improve the patient journey, and help us as clinicians, and get one story, one triage system standardised throughout so we will not have to triage them again, just follow up the processes." (Staff participant, Group 6, WS1)

Patient advocates were quick to emphasise the need for flexibility to accommodate the needs of more vulnerable patients, even if these processes worked for the majority. The option for face-to-face triage was felt to be essential for these groups because they have specific needs and face challenges that the average patient does not when accessing and using urgent care services.

"All staff have to be aware this is a process where 80% can be triaged virtually but the other 20%, this is the pathway for you." (Patient advocate, Group 1)

There were concerns that digitising the system would mean removing the human element. This would present additional barriers to those patients who already struggle to access and use urgent care services. In particular, people with communication difficulties (e.g. deaf people, people with no English).

However, some patient advocates noted that this approach presented an opportunity to provide better care to those who really need it, if the system was able to direct less vulnerable patients through digital routes.

"The people who need the communication face-to-face and digital and triaging... they want to talk to a nurse or doctor. A great advantage of digital is that you take people out and then the people that are left can use face-to-face." (Patient advocate, Group 1)

Digital triage was perceived to present new opportunities for digitally literate patients, much like other services used in everyday life

Public participants noted some opportunities through the digital triage process. For example, some participants were already familiar with inputting information about their health needs or symptoms online or through an App to access their GP services. They described this process as useful and felt it had the potential to save patients, and the system, time, if it meant that they could be triaged to the most appropriate place without having to go to ED and wait for several hours for a health problem that could have been better managed elsewhere.

“I suspect it would make people think twice to drive to A&E, if there was marketing done to say, 'For these conditions, please use the triage.' I've just done with my daughter this online triage. The suggestion was to visit the GP. My GP has Patient Access or something. I suppose my daughter's condition is not an emergency.” (Public participant, Group 4, WS2)

Others felt that the digital triage process could improve convenience for patients and enable patients to be triaged at home. In particular, this was thought to benefit a range of patients, including parents and children, those with disabilities and those with busy lifestyles – who might find being triaged away from the front door of an UTC or ED more beneficial.

A small number of public participants also noted that the high level of training required for staff working in digital triage provided some reassurance that the system was rigorous and would minimise risks of something going wrong. It was also noted that digital triage could potentially save time and money for the NHS which was felt to improve the acceptability of the approach.

However, the more digital triage was discussed, the more the public and patient advocates returned to and elaborated on their concerns

Despite discussing the perceived opportunities associated with digital triage, some public participants were heavily focused on the perceived downsides associated with this option that built on their concerns expressed in their initial reflections to the options.

A general lack of trust in automated approaches was raised by public participants which created an expressed concern about the automated approach to digital triage. Participants returned to the concern about the ability of the system to identify nuances in patient need (e.g. level of pain or discomfort) or override the assessment if the issues was very urgent. Some fundamentally felt uncomfortable with a computer making decisions about what to do if you have a health issue. One or two were also worried about what might happen should the digital triage system crash or go down.

Others noted concerns that the digital triage option would mean patients would be made to go through similar steps as they would trying to call or access online support for a bank. This format of triaging was felt by some to be cold and could risk patients going round in loops (particularly if they do not feel like the triage outcome met their expectations). It could also make patients feel like they may not be sent to the right person.

It was noted that the option placed too much onus on the patient to communicate their needs or symptoms. This could mean that those who are not very good at understanding and articulating their symptoms might end up in the wrong place, and those who are better able to do this might be able to ‘play the system’ to be triaged with a higher level of urgency.

“It's a bit reliant on the patient. You get questions, like how much is the pain or how much discomfort you are in, and it's all relative. What is agony for one person is like a little paper-cut thing. It comes down to having to understand yourself and your own body and how you react to things and being able to make sure you are conveying it properly.” (Public participant, Group 1, WS2)

Some participants expressed that they would still prefer to see a healthcare professional in person as they did not feel the digital triage option would provide them with the level of assurance they needed. Similarly, there were questions raised about the feasibility of this option for those patients who might find it challenging to complete a digital triage, lacked access to a digital device or were considered a high-risk patient group. These included:

- Older people
- People with physical and learning disabilities
- People with mental health conditions
- Parents with small children
- People with little or no English
- Homeless people
- People with no access to a computer smartphone or digital device
- People with underlying health conditions

Patient advocates noted by public participants aligned with those mentioned in the patient advocates workshop.

Conditions within which digital triage could work began to emerge from the discussions including an option to speak to someone and the availability of joined up care records

Public participants began to articulate some conditions that would need to be in place to make the digital triage option more acceptable.

Driven by a preference to speak to a healthcare professional, participants felt that there should be an option to call (including video call) and speak to a healthcare professional if they encountered any problems during the process or were unsatisfied with the outcome of the digital triage. For vulnerable patients, participants emphasised the importance of having a walk-in option for these patients to be triaged in person by a healthcare professional. The potential risk of missing a vital sign or symptom appeared to drive this view.

“You've got someone who's rung because they're panicking or they're ill and they just want someone to listen to them. I think the least important, for me, is for them to rush through all the questions to just get you off the phone. Some people need more time to explain themselves, especially the elderly who might be scared and need reassurance.” (Public participant, Group 8, WS2)

Both the public and staff participants also stressed the importance of having joined up healthcare records to support digital triage. This was perceived to ensure patients did not have to repeat their story and assumed that the digital triage process was sophisticated enough to take into account any flags on a healthcare record.

“We do presume that if we speak to a doctor, and speak to 111, they all know my details. And I think some of the urgent care centres are outsourced, and we presume they can access everything my GP can. And that information needs to be outside wider [available across the system]*. But we just assume they do.”* (Staff participant, Group 6, WS1)

Having more senior clinicians involved in triage was met initially with enthusiasm among the public

On hearing about the proposal, public participants welcomed the idea of having more senior clinicians involved in the triaging process. They felt this provided them with more confidence in the triaging process through having someone with a high level of clinical experience and knowledge involved. However, there were participants who noted early on that having more senior clinicians triaging patients could mean there may be fewer senior clinicians to treat patients. Participants who noted this expressed a preference for other people who specialised in triage to work within this role to allow more time for senior clinicians to treat patients.

Staff were keen to understand what involving more senior clinicians in triage would look like and in what settings would this happen. Initial reflections on the proposal mirrored some concerns expressed by the public and highlighted awareness of patient preferences. For example, staff noted a lack of public trust in healthcare professionals other than doctors which can lead to patients expecting to be seen by a doctor and not being satisfied if seen by other senior clinicians, such as nurses. However, whilst they acknowledged that having senior clinical input helped in the triage process, because it leads to less risk-averse decision making and better direction of the patient to the right professional setting, staff participants also reflected on the challenges caused by having senior clinicians working on the front desk, as opposed to further down the care pathway.

"It is good to have senior clinicians at the front door, but with staffing, it's hard to maintain that as a 24-hour thing. Whenever they call a reg or consultant, it takes away from the shop floor. It sometimes slows us down because we can't make any final decisions as well." (Staff participant, Group 5, WS1)

Others noted that some senior clinicians would be very capable of triaging patients but would require training to refresh their skills and update their knowledge about which services they can stream patients to.

However as discussions progressed, the view of what was 'ideal', in terms of having more senior clinicians involved in triage, was challenged as this felt unfeasible in practice

Both public and staff participants acknowledged that in an ideal world senior clinicians would be heavily involved in the triage process. There were perceived benefits associated with this option shared by both public and staff participants:

- **Patients prefer to be seen and assessed by a doctor**. There was broad acknowledgement that patients would prefer to be seen by a doctor in the triage process. Public participants noted that they felt senior clinicians, predominantly doctors, would be the most ideal healthcare professionals to triage patients because of the perceived level of competency associated with the role and the level of trust placed in doctors (e.g. in disclosing information about a sensitive issue). This perception of the public was as noted by staff participants who also mentioned the high level of trust patients place on doctors.

"I think there are more benefits when it comes to a senior doctor doing the triaging… it's important to have experienced people when it comes to health." (Public participant, Group 1, WS2)

- **Senior clinicians are better able to ensure patients end up in the right place.** Both participant groups noted situations where senior clinicians had been involved in the triage process and were able to quickly identify the problem and either triage the patient to an appropriate place or provide reassurance to the patient that they would be OK. This level of trust and assurance was felt to be difficult to replicate in less senior roles.

"It is reasonable to have a senior clinician performing triage, for example going to a pharmacy, if you have more experience there's a lot more you can say to justify the reason as to why it's more appropriate." (Staff participant, Group 6, WS1)

Patient advocates participants preferred this option because they felt it gave patients the most confidence. The option also involved a human element which they repeated very important for vulnerable patient groups.

"The best position is the senior clinician triaging because that gives a lot of confidence to the patient, that they're being assessed by someone who understands their position." (Patient advocate, Group 2)

However, some public and staff participants noted downsides to greater senior clinician involvement, identifying that more senior clinical involvement in the triage process could mean less clinical input for treating patients. For example, some public participants felt that a senior clinician should not be answering telephones to triage patients but that their resource should be better utilised elsewhere treating patients.

"If I ring 111 and a senior doctor answers the phone, I am thinking, 'Why are you not in the hospital?'. I don't want a senior clinician triaging at that level." (Public participant, Group 1, WS2)

Some public and staff participants felt that this option was unrealistic given the pressures placed on the existing workforces and that it could be too reliant on a limited section of the workforce.

"I think it's too highly skilled labour reliant. It does take them out of the workforce, so it's not really a solution." (Public participant, Group 5, WS2)

Staff participants also noted that this approach might be unfeasible given the pressures on the existing workforce and could have a negative impact on staff job satisfaction.

"There are so few senior staff in our department, we only have one person at a shift at a time, so if one is stuck at the front door, who will be treating the seriously ill patients? I know it would be lovely for patients to be picked up at the front door, but as a member of staff in the system, I just don't think it is the right thing to do at the moment, and if someone told me to do that I might just retire now." (Staff participant, Group 6, WS1)

Interpersonal skills and experience in triaging are what matter most

Public participants were asked to consider what characteristics of staff members carrying out triage are most important. Participants were quick to mention medical knowledge and expertise as the most important characteristic. Participants also considered qualifications and training related to the triage role as important characteristics.

As the discussions progressed, public participants began to think more about the specific personal characteristics of those undertaking triage that are most important to them. Participants described and prioritised the importance of interpersonal skills as the essential characteristic for staff conducting triage. Public participants noted that interpersonal skills were important in triaging because the person doing the triaging needs to know how to engage with a range of people; demonstrate compassion and the ability to listen; and, be confident in what they are doing so they can provide reassurance to patients.

"I think for me, competence and interpersonal skills are going to be the main things, that's the thing that makes people reassured." (Public participant, Group 9, WS2)

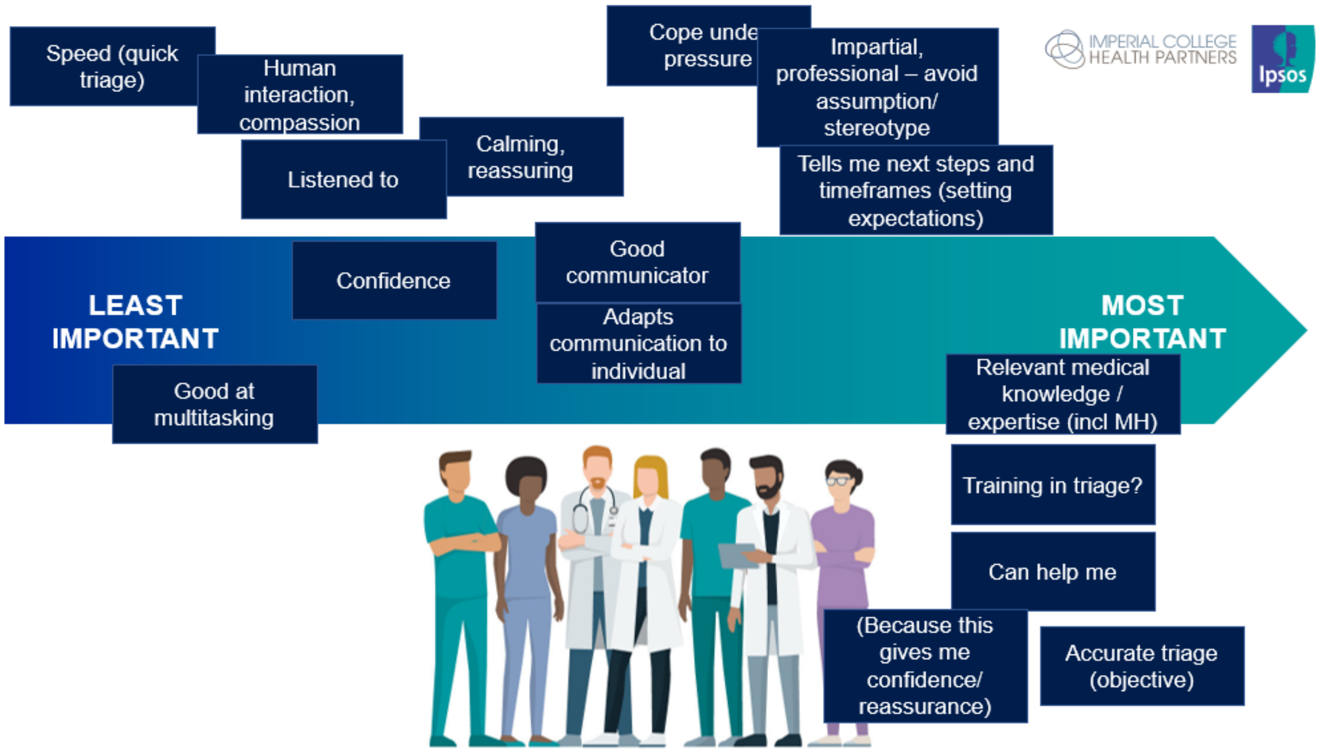
Experience in triaging was also noted by public participants as a key characteristic for staff carrying out triage. It was assumed that this experience would involve staff having undergone training and spent time in the role to develop experience. They also felt that experience would help instil confidence in the patient that their problem was being dealt with seriously and by a competent person.

"Experience is very important, if you've seen something time and again you know what you're looking for." (Public participant, Group 3, WS2)

Public participants also noted an expectation that there should be senior clinical input to support those working in triage roles, to provide clinical or medical knowledge if there was a specific issue that needed escalating. Staff participants also noted that senior clinical input into the triage process was common in the services they worked in and worked to great effect, for example, when a senior clinician occupied or worked alongside staff in a triaging role.

Awareness of local services was also considered important by public participants, but it was felt that information about local services could be built into the system to support staff and patients find the most appropriate service.

Figure 3.1. Example of triage characteristics and attributes exercise: Public WS2



Source: Public participants, Group 2, WS2

A standardised triaging tool was more appealing to staff than the public

Staff participants were optimistic about the potential of the standardised tool. They noted that it had potential to improve efficiency within the triage process by supporting staff make decisions about how best to prioritise patients. The standardised nature of the tool was also felt to ensure greater consistency across services in London, as staff would be working from the same criteria.

"Probably starting with a standardised triaging tool would be most efficient, not relying so much on human resources. Having a standardised tool that a trained streamer can do would be more efficient in this place." (Staff participant, Group 5, WS1)

Some staff felt that a standardised tool could boost confidence in their abilities and provide reassurance that they were making the right triaging decision.

"I think using the digital triage is also good, they can input rudimental information that an algorithm spurts out what is likely or not likely to be, as a senior clinician it would support my decision as well, it's the start of artificial intelligence, what we are talking about. These algorithms, AI in health care. I would feel more confident that its not just me." (Staff participant, Group 6, WS1)

Staff participants also noted that the standardised nature of the tool could help reassure patients that they will receive the same outcome wherever they access care.

"The standardised thing across the board sounds good to me, and hopefully would be reassuring to the public, wherever people access it they will get the same result, so standardising will be good." (Staff participant, Group 6, WS1)

In contrast, most public participants appeared hesitant about the introduction of a standardised tool to triage patients. This was driven by an assumption that the tool would be delivered digitally and a general hesitancy towards computerised decision making about patient needs. Particular concern was focused on the perceived lack of nuance or ability for the tool to acknowledge or adapt to unique and specific patient needs which could risk a vital symptom or sign being missed. This was often discussed in comparison to staff conducting the triage whom participants felt were better equipped to identify and understand individual needs or where something might be wrong and need to be escalated quickly.

"If your symptoms are not those that one would expect one to have with a certain type of illness, or something like that, then, in my opinion, would those questions be able to still recognise that it's urgent or would you be seen as less urgent? I don't think it fits the needs of every patient." (Public participant, Group 8, WS2)

Patient advocates perceived a standardised tool as being unlikely to deal with and address multiple clinical problems.

"I think most patients would accept standardised triaging. The only problem is that when they're triaging, people go there for one particular clinical problem, but they may have multiple clinical problems and the triaging will only concentrate on one particular issue." (Patient advocate, Group 2)

Public participants were also unclear about how the triaging tool would work and the level of testing and trailing that had been put into systems where the triaging tools were already being used. In response to this, public participants expressed they would like more information about how the standardised tool had been developed and what measures were put in place to ensure it was working appropriately.

Some participants, however, did see benefits in this approach, similar to those identified by staff participants (e.g. supporting the triage process, providing greater consistency in triaging across services).

"If I'm understanding it right, everybody would have the same software, I guess, so you don't get differing outcomes depending on where you live. From that point of view, I think it's a must, personally." (Public participant, Group 4, WS2)

The need for joined up access to healthcare records was, again, noted by both public and staff participants as being key to supporting this option.

Public expectations

In WS4, public participants were presented with a summary of the key findings from the previous workshop discussions on triage in the form of a draft expectation. They were asked for their reflections on the summary and whether they felt this broadly captured the views participants had expressed and heard during the workshops.

Figure 3.2. Summary shared at the start of WS4

We expect the urgent care triage process to…

- Have input from senior clinicians where possible (recognising workforce limitations)
- Utilise technology to support the triage process, such as digital triage and/or use of a standardised triaging tool (either process must be rigorously tested ensure it is safe, can be trusted and minimises risk to patient safety)
- Continue to offer an option for human/ face-to-face contact for vulnerable patients (e.g. small children, older people, people with learning disabilities) and those where further explanation or reassurance is needed after a triage decision (e.g. if the decision does not meet the patient's expectations)

These expectations should be underpinned by the following:

- Communicating to the public about how senior clinicians and other staff are involved in safe triaging to ensure confidence and trust in the system
- Ensuring, where possible, those who work in triaging are qualified and experienced healthcare professionals. However, recognising workforce constraints limit the availability of these roles, triage staff need to have the following skills:
    - Experience in triaging
    - Excellent interpersonal (e.g. calm, confident), customer service (e.g. compassionate) and communication (e.g. reassuring) skills
- Sharing of patient records across the system to ensure the triage process has information about a patient’s history (e.g. to help minimise the risk of missing underlying issues)

There was broad agreement across public participants that the summary accurately reflected the discussions. However, public participants wanted greater emphasis placed on the following:

- The importance of training for staff conducting triaging
- Communication about the triage process, including explaining that the face-to-face and digital triage processes follow the same approach
- Assurance that the algorithm used to support triaging processes is routinely updated and working effectively (and safely)
- The need for healthcare records to be shared across the system to reduce patients having to repeat their story and support triaging staff

“I would say sharing of patient records across the system is really important. That really needs to be in place, so you cut out having to repeat yourself over and over again.” (Public participant, Group 5 WS4)

Across a small number of breakout groups, one or two public participants noted that they would like to include expectations that the wider group did not think should be included because they were deemed less important by the group as a whole. This included consequences for patients found to exaggerate symptoms to be triaged quicker or to a service their preferred service (that might not be appropriate for their needs) and desire to be triaged in person by a senior clinician (typically a consultant).

The public participant expectations on triage are presented in the Figure below.

Figure 3.4. Public participant final expectations on triage

We expect the urgent care triage process to…

- Have input from senior clinicians/qualified healthcare professionals when required e.g. for complex conditions (recognising workforce limitations)
- Utilise technology to support the triage process, such as digital triage and/or use of a standardised triaging tool (either process must be rigorously tested ensure it is safe, can be trusted and minimises risk to patient safety) and where appropriate an option for video call triaging to see physical symptoms/injuries
- Continue to offer an option for human/face-to-face contact for vulnerable patients (e.g. small children, older people, people with learning disabilities, those with pre-existing conditions), those who may not be able to access digital services and those where further explanation or reassurance is needed after a triage decision (e.g. if the decision does not meet the patient's expectations)

These expectations should be underpinned by the following:

- Communicating to the public about how senior clinicians and other trained staff are involved in safe triaging to ensure confidence and trust in the system. E.g. senior clinicians working alongside triaging staff to provide support as needed
- Communicating to the public that digital and face-to-face triaging follow the same approach/tool
- Ensuring, where possible, those who work in triaging are qualified and experienced healthcare professionals with access to a senior clinician if needed. However, recognising workforce constraints limit the availability of these roles, triage staff need to have the following essential skills:
    - ➢ Extensive experience in triaging
    - ➢ Some form of clinical expertise/training
    - ➢ Excellent interpersonal (e.g. calm, confident), customer service (e.g. compassionate) and communication (e.g. reassuring) skills as well as the ability to effectively manage a patient’s expectations
- Sharing of patient records across the system to ensure the triage process has information about a patient’s history (e.g. to help minimise the risk of missing underlying issues or the patient having to repeat their story)
- Regular, standardised and accredited training
- Regular testing and updates to digital triaging platforms

Staff expectations

Workshop 2 (WS2) started with a presentation from the lead moderator who presented back an early draft of the groups' response to topic specific questions.

Figure 3.5 Summary responses shared at the start of WS2

What do you think about the proposed approaches to triage?

1) Digital triage:

- A long time coming
- Streamlines patient journey at initial point of contact; efficient
- Convenient for patients to have remote access

However…

- Can exclude the most vulnerable
- May require more education to the public to instill confidence in the triager – especially when patient is not given the outcome they expect (e.g. instruction to go to A&E, which we know for many pts gives them a sense of safety)

2) More senior clinicians triaging:

- Can be efficient (e.g. helps with flow at ED when done by consultants/registrars)
- Can reduce patient journey/number steps overall as more are taken care of in one swoop; senior staff can help direct to right places
- Senior staff can also have more robust conversations with patients – leading to better decisions
- Instils patient trust and confidence – otherwise patient may request to see doctor when not seen by one

However…

- May not be best use of resources / feels less feasible especially given workforce challenges. In some settings there is often only one senior person on shift
- Some senior staff may not *want* to add triage to their role – especially considering that training and periodic refreshes would be required

3) Standardised triaging tool:

- Effective and speedy; relies on less human time
- Staff can be trained well to do this, similar to "streamer" role in hospital setting
- Helps capture one story, which reduces need to re-triage
- Standardised - same result wherever you are is a good thing
- Standard initial triage would be helpful for senior clinician decision making/assessment next (avoid re-triage)

Triage in general:

- Triagers need to have **very good knowledge of pathways and onwards services/options** to send patients to – this is not always the case at present
- Good if patients can **access triage from home**
- In some instances it may be useful and efficient to **separate triage from assessment** – e.g. initial triage process could determine whether you need an assessment and how quickly
- Despite efforts, **some patients will just turn up –** concerned if we then send them away. Risk of frustration and harm to staff; need to mitigate

How feasible is it for the system, across London, to meet the public expectations about triage from the perspective of your role/service?

- Digital/online may be more **feasible for certain groups of patients**, e.g. younger patients may be more comfortable
- For other patients, some people do need to have **two-way interaction** (reassurance and compassion achieved through talking to a person). This feels **achievable** to offer to some patients
- There are examples where video consultations do work for triage, and we've seen it's possible through the pandemic
- Suggest we have a pre-screening of some kind to identify who really needs the face-to-face option – eg certain mental health issues, vulnerable groups, elderly

However…

- Video may not be feasible to introduce everywhere from the system side – e.g. some GP appointments are only available via telephone.
- Not every patient will have access to video technology at their end either – e.g. especially the elderly who are less likely to have access to a smartphone

What would need to be in place to help you, and your colleagues, feel confident about implementing or working alongside…

Digital triage:

- We need to have a route to give the patient **reassurance** where required, via two-way interaction
- A **video option** for triagers would add to a clinician's ability to triage better. Some patients cannot explain their symptoms but they are able to show you. Also, a staff member is able to observe behaviour and tone – which is especially important in mental health
- **Escalation routes** must be available to triagers to enable them to involve more senior/experienced staff where needed (and info sharing in these hand-offs is crucial)

More senior clinicians triaging:

- If involve more senior staff, should be permanent staff rather than reliance on agency staff – as **training** is important and would be a challenge if trying to train transient staff

Triage in general:

- **Data sharing and access to patient records** is critical – all staff involved in the process of a patient's care should have access to the same level of patient records, including care plans, history, previous interactions, etc, in one place – e.g. summary care record
- **Access to that data** may need to be via handheld devices e.g. iPads for staff triaging in-person, e.g. paramedic doing a home visit
- **Training** is very important for triage role – including not only clinical skills but interpersonal skills as managing patient expectations is important
- **Staff also need feedback** in order to learn/develop and gain confidence on their triaging
- There is an opportunity to **develop more staff** e.g. pharmacists and optometrists, to do first stage triaging

During the feedback at the beginning of WS2, staff participants from the other two cohorts were given the opportunity to feedback on the triage cohort's response to the key questions on triage. The following themes emerged in this feedback:

- **Digital triage:** having the option to triage via video call would be beneficial for staff. This option could work particularly well for patients presenting with less urgent symptoms. However, clearer guidelines on when to triage via video call is needed to support staff and services should still offer in-person triaging for vulnerable patients.

- **Involving more senior clinicians in the triage process:** senior clinicians were perceived to be more effective at triaging, compared with junior staff who were perceived to be more risk averse. However, staff participants acknowledged that this might not be practical to support other aspects of the care pathway and raised key conditions that could support better triaging overall. For example, ensuring that triaging staff are permanent staff, create a new triaging role (e.g. like an Advance Nurse Practitioner), rotating staff in the triaging role, and ensuring access to senior clinical support for staff doing the triage.

- **Standardised triaging tool:** the tool needs to be clear for clinicians to use and provide an outcome (similar to e-consult); ensure it does not exclude patients or provide alternative option for human triaging for vulnerable patients; and, provide sufficient training for staff to learn how to use the tool.

The cohort worked through some of this feedback and incorporated this into the final output and these are presented in the Figure below.

Figure 3.6. Staff participant final expectations on triage

How feasible is it for the system, across London, to meet the public expectations about triage from the perspective of your role/service?

What would need to be in place to help you, and your colleagues, feel confident about implementing or working alongside…

<u>Digital triage:</u>

- Unsure if digital triage can be equal to face-to-face triage. A **video option** for triagers would add to a clinician's ability to triage better. Some patients cannot explain their symptoms but they are able to show you. Also, a staff member is able to observe behaviour and tone – which is especially important in mental health.
    - ➢ In an ideal world we'd have visual triage for all, but we recognise the constraints
    - ➢ We can limit use of this to where it's really needed (e.g. ambulance example – use for assessing open fractures)
    - ➢ We can also have patients send images, as another option – which may be more feasible than video
- Digital/online may be more **feasible for certain groups of patients**, e.g. younger patients may be more comfortable.
- Staff can also triage remotely from a wider range of places

However…

- We need to offer alternative options for those that <u>cannot</u> access digital – and that do not <u>want</u> to access digital
- Some people also need to have **two-way interaction** (**reassurance** and compassion achieved through talking to a person). This feels **achievable** to offer to some patients where it is needed
    - ➢ There are examples where video consultations do work for triage, and we've seen it's possible through the pandemic
    - ➢ Suggest we have a pre-screening of some kind to identify who really needs the face-to-face option – eg certain mental health issues, vulnerable groups, elderly.
    - ➢ Sometimes the patient just needs to speak to a person for that reassurance. If this reassurance is given remotely – it <u>needs to be fast</u> to give faith (long call backs – can mean people aren't reassured and just go to A&E).
    - ➢ Reassurance in the triage outcome can also be supported by giving patient <u>clear expectation of timeframe</u> and next step (e.g. "I will call you within three hours", example from optometry)
- Video may not be feasible to introduce everywhere from the system side – e.g. some GP appointments are only available via telephone
- Not every patient will have access to video technology at their end either – e.g. especially the elderly who are less likely to have access to a smartphone

<u>More senior clinicians triaging:</u>

- Senior staff can do triage more quickly and efficiently
- When we should rely on more senior staff triaging: more complex cases, as back-up/escalation (if person triaging needs second opinion)

- If involve more senior staff, should be permanent staff rather than reliance on agency staff – as **training** is important and would be a challenge if trying to train transient staff

However…

- May not be best use of resources/feels less feasible especially given workforce challenges. In some settings there is often only one senior person on shift
- Some senior staff may not *want* to add triage to their role – especially considering that training and periodic refreshes would be required
- Training and experience triaging is key to getting comfort making good, quick decisions (which is what a triager needs to do)
- Generally, more important than seniority, is that the triager has the right skillset and training for the role. This is feasible to do – we can train staff to confidently triage, e.g. train to use a standardised tool, to use a pro-forma, to make sure nothing is missed
- **Escalation routes** must be available to triagers to enable them to involve more senior/experienced staff where needed (and info sharing in these hand-offs is crucial)

Triage in general:

- **Data sharing and access to patient records** is critical **–** all staff involved in the process of a patient's care should have access to the same level of patient records, including care plans, history, previous interactions, etc, in one place – e.g. summary care record
- **Access to that data** may need to be via handheld devices e.g. iPads for staff triaging in-person, e.g. paramedic doing a home visit
- **Training** is very important for triage role – including not only clinical skills but interpersonal skills as managing patient expectations is important
- **Staff also need feedback** in order to learn/develop and gain confidence on their triaging
- There is an opportunity to **develop more staff** e.g. pharmacists and optometrists, to do first stage triaging

Streaming and redirection

Summary

How can we ensure processes around streaming and redirection work effectively for both staff and patients?

Streaming

The patient is streamed within the department or to another service on the same site with the right clinical skills and diagnostic and treatment capabilities to meet their care needs in a timely way.

Redirection

The patient is redirected to a service at a different location that is more suitable for their needs e.g. pharmacy, their GP *(or an alternative GP practice which can see them sooner)* or to an emergency department.

Both streaming and redirection were broadly accepted by the public, and streaming was particularly uncontentious.

However, staff participants raised doubts about redirection including concerns about feeling the brunt of patient frustrations when they are redirected, and shared concerns about their own level of comfort redirecting patients. Staff expressed a lack of confidence that patients would agree to being redirected and also had uncertainty around who held accountability and risk as patients transit to a new service.

Public participants did discuss the potential challenges redirection poses for patients and staff including inconvenience to patients, uncertainty about what might happen during the redirection process and concerns that not everyone would be able to travel. Reassurance was key for patients to feel confident and comfortable with being redirected.

Both public and staff participants reflected on uncertainties faced by the patient when redirected given how the system currently operates. With this in mind, public and staff participants felt streaming and redirection was acceptable as long as conditions were in place. These included building in exemptions for patients at higher risk and providing support with travel, providing patients with proof or evidence to take with them to the service they have been redirected to. Public participants also discussed setting limits for how far a patient has to travel when they are redirected, providing patient choice and receiving clear instructions.

Staff participants also felt streaming and redirection needed to be consistent, have specific criteria, have input from senior clinicians and have the ability to share information to ensure these changes worked effectively.

After they had finished deliberating triage and the associated trade-offs in the first half of the second workshop, public participants received a presentation from an expert about streaming and redirection. The presentation introduced the concept of streaming and redirection, based on the triage assessment, and described two options around this:

- **Streaming:** the patient is streamed within the department or to another service on the same site with the right clinical skills and diagnostic and treatment capabilities to meet their care needs in a timely way

- **Redirection:** The patient is redirected to a service at a different location that is more suitable for their needs e.g., pharmacy, their GP (*or an alternative GP practice which can see them sooner*) or to an emergency department

The presentation also described what a patient journey might look like if they were streamed or redirected. It went on to explain why these processes are important (e.g. to utilise NHS services, encourage patients to consider alternative services, relieve pressure on busy services and potentially see patients more quickly) and the challenge of implementing these changes (e.g. redirection is challenging once a patient has arrived at a service, scope for unwarranted variation, requiring patients to go through stages before a decision is made and having to travel further).

Public participants were also asked to consider how to ensure trust and confidence in the process, how acceptable it is to ask patients to travel somewhere else, what their red lines are (if any) and what education is needed to raise awareness of the changes.

Staff participants were introduced with a high-level overview of streaming and redirection, based on information provided to the public. The streaming and redirection cohort was presented with the more detailed presentation along with the related public expectations and given the opportunity to ask questions.

Reflecting on the presentations, staff participants were asked to consider and respond to key questions during the discussions. These were: how feasible it would be for the system across London to meet the public expectations and what would need to be in place to help staff feel confident about implementing the approaches to streaming and redirection.

Patient advocates were provided with a presentation that mirrored the information the public received, along with the public expectations. They were asked to consider the benefits and risks associated with the streaming and redirection proposals and then to think about and voice any additional considerations that would need to be in place to help them, and the community/group they represented to feel confident about the public’s expectations being taken forward.

Both options were broadly acceptable to the public with streaming particularly uncontentious

In their initial reflections, public participants were quick to accept and support streaming. Most assumed this happened already and felt that being streamed to another service or department on the same site where they presented would be expected in order to ensure they received the best care.

“I think, for me, that's obvious isn't it? In a hospital, you have specific departments for individual issues. For me, I don't see that as a problem. I can understand that people will get frustrated if they're moving from one place to another without being seen, but I think that's something I'd expect, that I'd go to a clinic specific for my illness or symptoms.” (Public participant, Group 2, WS2)

Public participants were also broadly supportive of redirection. They felt it was acceptable to request that patients who can travel to another service for more appropriate care should be asked to do so. However, many noted that they were not aware that services were able to send patients to another service who might be able to better meet their needs or see them quicker.

"I agree [that redirection is acceptable] *too. As long as you're directed to the correct place, that's acceptable. Triage is the first port of call so I'd expect to be directed to another more suitable place."* (Public participant, Group 6, WS2)

"I didn't know you could be sent to another GP if your GP didn't have a slot. I've never had that before. I don't have a problem with my GP, it works well for me but I had never heard of that option." (Public participant, Group 10, WS2)

Staff were more forthcoming with concerns on how redirection would work

Staff participants were quick to raise concerns about how patients would react to redirection. In particular, they were concerned about feeling the brunt of patient frustration who might become very unhappy about having to be redirected to a new service.

"I can expect them to be quite unhappy with redirection, understandably. Especially if they've called 111 for example and been referred there, and then to be told they need to go to a pharmacy or something where we don't prescribe, they would be quite unhappy with that." (Staff participant, Group 4, WS1)

Others discussed that the idea of redirecting people made them feel uncomfortable and they felt unclear about who the risk would lie with when a patient is in transit to a new service.

"There was nothing I found surprising when it came to redirection. I've never been able to work in an ED which has been able to redirect properly for the exact reasons mentioned. The more information you gather and the more you get involved, the bigger your duty of care is to that patient, and the harder it is to say, You're probably better going to someone else'. EDs are able to deal with everything, even though they're not the most ideal, so if you come in with an urgent problem it is possible to do it there, and for many clinicians there is the temptation to stay and treat rather than redirect." (Staff participant, Group 1, WS1)

Concerns began to emerge about the uncertainty of redirection as discussions developed and as the public discussed different patient personas

At the end of Workshop 2, public participants were asked to discuss their views on the acceptability of streaming and redirection. The main focus of the discussions turned to redirection and as discussion developed, public participants began to note the potential challenges redirection poses for patients and staff.

For example, some noted that being asked to move from one location to another might be very inconvenient for patients. There was a risk that some patients simply would not want to go somewhere else to receive care and might find adjusting to this new way of providing care difficult. Others were quick to point out that some patients might find it more difficult to travel to another location because they are unfamiliar with the area, have mobility issues or lack the means of transport.

"It's how far and inconvenient is it? If it's where you live it's not too bad and you're familiar with the area if you're somewhere else, it's very different." (Public participant, Group 9, WS2)

Patient advocates felt strongly that redirecting vulnerable patients was unacceptable. They noted that most vulnerable patients would likely have had to overcome challenges just to present at the front door and being asked to go somewhere else would be too much of a challenge. For example, some may not have the money to afford transportation to travel between services. They may also struggle to understand why they were being redirected somewhere else due to a lower understanding of how health services are run.

Others highlighted the importance of ensuring that the initial access stage ensures that a patient turns up at the appropriate service.

“What I'd re-emphasise is if somebody is physically in the building, it's too late, particularly if it's somebody with dementia. It'll be difficult enough for them to travel around the site they're in. Also, taking into account the exhaustion that comes with being told you have to start over. If they come through the door, something has to happen there. The other element is how do we avoid that as much as possible, and that's by the infrastructure that comes in through the phone line. If someone is using online, we can make the assumption that they know what they're doing to some extent. The phone line has to be as good as possible to make sure people are going to the right place as much as possible.” (Patient advocate, Group 2, WS2)

There was also uncertainty and speculation about what might happen during the redirection process. Public participants raised questions relating to redirection, including:

- What would happen if a patient’s condition got worse during the redirection, what should they do and who should they contact
- Whether there would be instructions on how to get to the location of the new service, how far they would be expected to travel to the new service, and whether there would be transportation support for those who might need help to get there
- Whether and how long they would have to wait at the new service, if the new service would be aware they were coming, and whether they would be given options of where they could go

“If I were to wait for two to three hours, and then they say, 'Sorry, you need to go somewhere else.' If there is somewhere else, have they made an appointment for me? Will I be seen? I don't want to go to that somewhere else and be told to come back tomorrow. I can see that happening in real life.” (Public participant, Group 1, WS2)

There was also an underlying theme emerging from the discussions that there would need to be considerable reassurance provided to patients in order for them to feel confident and comfortable in being redirected. This appeared to relate to the need for whoever is conducting the triage and communicating to the patient to have excellent interpersonal skills.

“It's important to make people feel that they are not being simply sent away. Sometimes people don't want to be sent somewhere else. It's important people know that there is someone better to see them rather than just being dismissed from A&E. People need to feel like the next place is going to be a better place for them to be in.” (Public participant, Group 9, WS2)

Staff participants also reflected on uncertainties faced by patients (and aired by the public) with how the system currently works and additional challenge redirection might pose to patients trying to navigate a very complex system.

“I think they're all entirely reasonable and sensible what ifs from the public. I think the healthcare system is quite hard to navigate. It's quite hard as clinicians sometimes, so for patients to navigate that system can be a complete headache. What they don't want is to feel they're being fobbed off, what they want is for them to feel like they're being given a targeted service that they need.” (Staff participant, Group 4, WS1)

Staff participants also raised questions about what to do if something went wrong and the patient missed their appointment after redirection. This appeared to echo the public’s question calling for greater clarity around the proposed option.

“Giving people an appointment time is brilliant, but where that fails, where transport has failed and the patient is late and gets turned away, that makes for very disgruntled patients. So the transport can affect the outcome, and my experience has been that it's been transport arranged by our services. So when they don't get to that appointment there's the question, do they come back to us or do the service give them a new appointment?” (Staff participant, Group 1, WS1)

Streaming and redirection felt to be acceptable as long as there are clear exemptions, limits on travel time, choice and information as well as reassurances

During the first part of Workshop 3, public participants took part in an exercise looking at different patient streaming and redirection journeys and were asked to reflect and discuss these journeys. As they worked through the examples, themes relating to the expectations around streaming and redirection became clearer, as did the conditions which would need to be in place to make these options acceptable.

A summary of the themes is described below.

- There are specific patient groups where redirection was considered to be inappropriate and therefore exemptions should be applied to avoid placing patients at a perceived risk. For example, parents with young children, the elderly and frail, people with mental health conditions and disabled people were perceived as patient groups where it would be unacceptable to be redirected elsewhere. In these circumstances, measures should be put in place to enable patients to be seen at the first location they present to. Some public participants also felt that consideration should be given to patients who might be incapacitated by their symptoms (e.g. bad migraine) or unable to take in the information about where they were being directed to.

When discussing one of the patient journeys where the patient was redirected for a scan the next day: *“It's such a shame someone who is bleeding and worrying about losing her baby has to spend a night fretting because of a piece of equipment. It goes well until the scan. It undoes all the good work.”* (Public participant, Group 2, WS3)

- The requirement to travel to another location was perceived as a particularly important point. Some public participants were quick to state that patients should not be expected to travel more than 30 minutes to a new service, by any mode of transport. Other noted that support with transportation should be offered to patients who need it, including those with mobility issues and those with no money to pay for public transport.

- Patients should be provided with a choice of options, including information about how far each of the services is, the length of wait and the availability of affordable parking. A sense of control about where they could go appeared to appeal to public participants as it seemed to give them a sense of agency.

- Information provision and communication was also important. It was noted that there would need to be clear instructions about where to go, how to get there, what to do if something went wrong and who to contact if redirection would work effectively. There would also need to be a member of staff in place who was highly capable of explaining this to patients and ensuring that staff at the new service were aware they were coming. Public participants also spoke of wanting to take some form of proof or evidence with them that they could show to the service they had been redirected to. This would provide them with confidence that their needs would be met by the services receiving them.

When discussing one of the patient journeys: *“A waiting number, that updates on your phone. I'm worried Joe might miss the call if he went to the toilet. Or they may not call back, and you'd have to wait again. A call slot, so you know how long it's going to be. Something that keeps you up to date.”* (Public participant, Group 7, WS3)

Patient advocates also echoed the themes that emerged from the public workshops. In particular, they stressed the importance of the system having access to patient healthcare records so that the healthcare professional dealing with a vulnerable patient could access their history. Similarly, they noted that greater clarity and communication was need on waiting timelines, to help manage expectations, allow patients (and carers) to weigh up options and avoid confusion.

“Sharing of records is paramount. Clear information about timelines, with the caveat of can you reasonably meet those timelines? We know what it can be like when healthcare professionals are under pressure, timelines start to slip, and that can be frustrating…You need to ensure the onus is taken off the person. Once someone has met them, they need to get them as far as they can and hand them over to the next person, rather than the person with dementia or their carer having to work out a new set of rules.” (Patient advocate, Group 2)

Similar themes emerged from the staff participant discussions. For example, staff felt quite strongly that they should be offering patients an appointment and they should have the facilities to be able to book patients in at the front door. This would help ensure patients feel more reassured they are being managed appropriately and make it easier for staff to encourage patients to be redirected elsewhere.

“I think being able to make those appointments at the front door, because if you say, 'No, you really need to get your GP to deal with this', but if they could get their GP to deal with it, they would have gone to them in the first place.” (Staff participant, Group 4, WS1)

Some staff participants also described how providing support with transport worked well in their own service and had the potential to facilitate safe transit of a patient being redirected from one service to another. In one example, it was described that patients were also reassured by having a dedicated staff member to explain the reason for redirection and the steps involved.

“We already have that in our urgent treatment centre. We have a patient champion who explains to the patient that we are sending them to a hospital where they are going to be best served, and they are usually happy. And then we provide transport so that they can get there on time.” (Staff participant, Group 1, WS1)

Public expectations

In WS4, public participants were presented with a summary of the key findings from the previous workshop discussions on streaming and redirection in the form of a draft expectation. They were asked for their reflections on the summary and whether they felt this broadly captured the views participants had expressed and heard during the workshops.

Figure 4.1. Summary shared at the start of WS4

We expect streaming and redirection to…

- Be happening already across NHS urgent care services

To improve acceptability of these processes, the following conditions must be in place:

- **Patients need to be reassured about the steps being taken regarding streaming/ redirection, including:**
    - Being made aware of the reason for streaming/ redirection and why another service is more appropriate
    - Being given clear instructions on where to go, what to do if things don't go to plan/ their symptoms get worse
    - That the service they are redirected to is aware they are coming and able to see them
- **Patients should be given a choice about where they are redirected to, based on:**
    - Length of wait to be seen at other services
    - Ability to travel to other services taking into consideration, distance of other services, access to transport, cost of transport, mobility and ability to comprehend instructions
    - The type of health professional a patient will see other services
    - Capacity to make a decision/ choice (about the above)
    - Contingency plans should be put in place for vulnerable patients to minimise dependency on one health professional, should their preferred health professional be unavailable

There was broad agreement across public participants that the summary accurately reflected the discussions. However, public participants wanted to ensure there was greater clarification on the length of time a patient could be expected to wait at the new service or an appointment, as well as requesting that there be effort to educate the public on the changes to build awareness.

The public participant expectations on streaming and redirection are presented in the Figure below.

Figure 4.2. Public participant final expectations on streaming and redirections

We expect streaming and redirection to…

- Be happening already across NHS urgent care services and not be a surprise to patients due to effective education campaign

To improve acceptability of these processes, the following conditions must be in place:

- **Patients need to be reassured about the steps being taken regarding streaming/ redirection, including:**
  - ➢ Being made aware of the reason for streaming/redirection and why another service is more appropriate
  - ➢ Being given clear instructions on where to go, what to do if things don't go to plan/ their symptoms get worse e.g. address, telephone number etc
  - ➢ That the service they are redirected to is aware they are coming and able to see them. This could be via an appointment time/SMS confirmation/reference or referral number.
  - ➢ That their information / record is shared with the new service to avoid repetition of history.
  - ➢ They are given clear information about how long they will wait to be seen at the new service.
  - ➢ If people are being redirected, other services need to be able to cope with the demand (the whole system needs to work)
- **Patients should be given reasonable options and a choice about where they are redirected to, based on:**
  - o Length of wait to be seen at other services with a commitment to a maximum wait or a confirmed appointment time
  - o Ability to travel to other services taking into consideration, distance of other services, access to transport, cost of transport, length of transport, access to/cost of parking, mobility and ability to comprehend instructions
  - o The type of health professional a patient will see in other services
  - o Capacity to make a decision/choice (about the above)
  - o Ability for transport to be provided in extreme situations, e.g. for most vulnerable
- **Contingency plans should be put in place for vulnerable patients to minimise dependency on one health professional, should their preferred health professional be unavailable**

Staff expectations

Workshop 2 (WS2) started with a presentation from the lead moderator who presented back an early draft of the groups' response to topic specific questions.

Figure 4.3. Summary responses shared at the start of WS2

How feasible is it for the system, across London, to meet the public's expectations from a staff/ service perspective?

Services will need to:

- Ensure patients have the means to be redirected (relating to patient capacity, mobility, comprehension, language skills)

- Ability to offer options to patients

This present opportunities to:

- Educate patients about the variety of services through which they can access care
- Save the system time

What would need to be in place to help you, and your colleagues, feel confident about implementing these approaches to streaming and redirection?

Ability to offer patients:

- Clarity on how to re-access the system should they need to **AND** what to do if circumstances worsen during or after redirection
- Transportation between services for those that need it

System capacity to:

- Deliver a seamless process where other services know the patient is coming **AND** waiting times are known upfront
- Bolster pharmacy provision

Staff education/ training to:

- Develop staff skilled in streaming/ redirection AND Improve consistency of streaming/ redirection approach
- Build knowledge and confidence in other services
- Increase awareness about what services are available and when, as well as capacity to receive patient
- Improve communication between services – e.g. notify redirecting service that patient has arrived/been accepted

Questions to decision makers:

- Who has final say if a patient does not want to be redirected?
- How do we deal with serial presenters who are not registered with a GP?
- How will this work if an appointment cannot be guaranteed at the other service?
- What happens to patients who arrive late to an appoint?
- How do we make streaming/redirection seamless?
- How do we improve consistency?

During the feedback at the beginning of WS2, staff participants from the other two cohorts were given the opportunity to feedback on the cohort’s response to the key questions on streaming and redirection. The following themes emerged in this feedback:

- **Input from senior clinicians:** the value of senior clinicians was again highlighted by staff participants in supporting staff to make decisions about streaming and redirection. It was also raised that some patients might need reassurance from a healthcare professional (rather than a receptionist or healthcare assistant) before feeling confident about being redirected. Senior clinicians could support this.

- **Information sharing:** again, sharing of healthcare records was mentioned as a key facilitator to ensuring changes worked effectively. There also needed to be clear communication and sharing of information between services so that all parties were up-to-date on the patient's situation.
- **Criteria for redirection:** concerns were raised about the criteria for redirection, including how should vulnerable patients be treated, is it acceptable to redirect patients solely to reduce demand and how should transportation be prioritised to help patients travel from one site to another.
- **Consistency:** will there be a consistent offer across London.

The cohort worked through some of this feedback and incorporated this into the final output and these are presented in the Figure below.

Figure 4.4. Staff participant final expectations on streaming and redirection

How feasible is it for the system, across London, to meet the public's expectations from a staff/service perspective?

Services will need to:

- Redirecting patients early in the journey (at the beginning of their journey) – especially if resource not available at the site (ensure that they are redirected before having to wait too long)
- Provide patients with a guide/framework/road map for what they need to do if something goes wrong
- Ensure patients have the means to be redirected (relating to patient capacity, mobility, comprehension, language skills) and the ability to relay information - 'tell their story' (a workaround needed - summary report/form/letter) if the service is unable to share information – or a 'hotline' back to original service
- Develop a comprehensive criteria of is 'vulnerable' (as this is very subjective and difficult to define)
- Ability to offer options to patients – patient should have the final say as to if they are redirected and the option to wait for unscheduled care

This presents opportunities to:

- Educate patients about the variety of services through which they can access care – this helps to limit patient frustration/manage expectations - if they are making better decisions about going to the most 'appropriate' place (an information pack at pt. of registration)
- Save the system time

What would need to be in place to help you, and your colleagues, feel confident about implementing these approaches to streaming and redirection?

Ability to offer patients:

- Clarity on how to re-access the system should they need to **AND** what to do if circumstances worsen during or after redirection
- Transportation between services for those that need it or universal offer? (Not agreement on this due to cost)
- A more efficient (faster) and 'appropriate' service (when redirecting based on demand); we must be careful to frame in this way

System capacity to:

- Deliver a seamless process where other services know the patient is coming **AND** waiting times are known upfront **BUT** If we give waiting/appointment times this might raise expectations for patients! As much as possible provide live waiting times (an App)
- Bolster pharmacy provision – make it easier and more accepting for people to use (information campaign to raise awareness)

Staff education/ training to:

- Develop staff skilled in streaming/ redirection **AND** Improve consistency of streaming/ redirection approach – educate pharmacists on red flag symptoms
- Build knowledge and confidence in other services
- Increase awareness about what services are available and when, as well as capacity to receive patient
- Improve communication between services – e.g. notify redirecting service that patient has arrived/ been accepted

Questions / issues for decision makers:

- Who has final say if a patient does not want to be redirected? The patient
- Staff are concerned about staff abuse and we need to protect staff
    - ➢ How do we deal with unhappy patients if being told they are to be redirected (staff may have concerns) – this relates to the importance of explaining that redirection may offer them less of a wait
- How do we deal with serial presenters who are not registered with a GP?
- How will this work if an appointment cannot be guaranteed at the other service? **What if there is NO appointment available?**
- What happens to patients who arrive late (or not at all) to an appoint? Who follows this up and takes responsibility for the patient?
- How do we make streaming/redirection seamless?
- How do we improve consistency?
- Better not to use senior clinicians (junior and early in the journey) or else tempted to ‘stay and play’
- In the redesign and dissemination of this must stress that this is NOT about ED to GP – its about the most ‘appropriate’ place for the patient

Scheduled urgent care

Summary

Would it be feasible and beneficial to move towards a model where more urgent care is scheduled?

Fast track

- People would have access to a range of services to seek initial assessment and advice e.g. NHS 111.
- If treatment in an ED or an UTC is most appropriate, an appointment slot (or arrival time) and location would be booked.
- **On arrival, patients who have been referred will be fast tracked – they will be prioritised over people with similar needs who have walked in to the ED without being assessed first.**

All urgent care is scheduled

- **Patients would no longer be allowed to walk in to an ED and wait as they can today**.
- People would have access to a range of services to seek initial assessment and advice.
- If treatment in an ED or an UTC is most appropriate, an appointment slot (or arrival time) and location would be booked.

Public participants clearly understood the potential benefits of adopting a fast-track service including reduced waiting times and discouraging people from accessing ED who didn't need to be there. However, acceptability was underpinned by several assumptions namely that the digital triage service would offer patients a choice of locations should they require a face-to-face appointment, and this would draw on real time information to communicate waiting times.

In general, both public and staff participants felt that with this proposed change the system could still be overwhelmed, with arrival time slots being quickly used up. Both mentioned that this system was not too dissimilar to current demand management in primary care which is currently overwhelmed. Staff participants were concerned that demand would shift from primary care to urgent care settings if there was a perception that patients would be given arrival slots. There were also concerns from both public and staff that people would manipulate the system to move higher up the priority list.

Both public and staff participants flagged concerns about certain patient groups, namely homeless people, people experiencing abuse, non-native English speakers and vulnerable people. The fast-track model was also seen to give an unfair advantage to those digitally literate and those able to communicate effectively via NHS 111 service. The proposal was described as a 'two-tier' service.

Consequently, public participants felt that a 'safety net' or alternative pathways must be in place should a patient's symptoms deteriorate, someone is unable to access the digital front door to arrange a booked arrival slot or those who are more vulnerable. Staff also raised concerns about not being able to monitor patients who are deteriorating if they were waiting at home instead of an ED waiting room.

Overall, public and staff participants expressed a preference to the fast-tracked model over full scheduled care, which was felt to be too radical. Public participants felt that certain conditions would need to be in place for scheduled urgent care to work effectively namely, exemptions for those unable to access virtual services, access to transport, assistance in ED to help people complete online assessments, transparency about arrival times and public education.

In the third workshop, after they had finished deliberating streaming and redirection and the associated trade-offs, public participants received a presentation setting out potential proposal to increase the scheduling of urgent care. The presentation introduced the concept of scheduling urgent care to help reduce the pressure on services. Two models were presented:

- **A ‘fast track’ service:** whereby people who have accessed urgent care for an initial assessment and advice through NHS 111 or their GP, and are deemed to require treatment in an emergency department or an urgent treatment centre, would be given an appointment slot (or arrival time) and a location (of their choice) would be booked. On arrival, patients who have been referred in by 111 or a GP would be ‘fast tracked’ and prioritised over people with similar needs who have walked in.

- **All urgent care being scheduled:** whereby patients would no longer be allowed to walk into an ED/UTC and wait as they can now. Like the fast-track service, people who have accessed urgent care for an initial assessment and advice through NHS 111 or their GP and are deemed to require treatment in an emergency department or an urgent treatment centre, would be given an appointment slot (or arrival time) and location (of their choice) would be booked.

The presentation outlined several potential benefits of these models including supporting the NHS to manage demand, supporting patients to access services most appropriate for their needs, a clearer indication of timescales involved, increased choice (in relation to where to be given an appointment slot), and a reduction in patients waiting in ED. Further, the presentation outlined the potential risks:

- Some patients deemed to be less urgent may end up waiting longer
- More reliance on triage systems
- Patient behaviour and familiarity with the current ‘walk in and wait’ model
- Reduced patient choice and potential to increase health inequalities given that scheduling urgent care might inadvertently disadvantage those without access to a phone/online services and/or those who are not registered with a GP.

Across both models, it was explained that there would be no changes to the existing approach to accessing emergency care for life threatening conditions. Patients who call 999 and are determined to be at high risk would still be directed to an ED and an ambulance would be dispatched if required.

Staff participants were introduced with a high-level overview of the two approaches to scheduling urgent care, based on information provided to the public. Then the scheduled care staff cohort was given a more detailed presentation alongside the related public expectations and given the opportunity to ask questions.

The benefits of a fast-track service were clear to the public, yet acceptability was underpinned by several key assumptions

Public participants were able to immediately recognise the potential benefits that increased scheduling of urgent care could bring about including the reduction of the number of people waiting in ED, a sensible way to discourage patients from walking in who didn’t need to be there, and linked to this the provision of timescales for patients to better manage their expectations.

“The time frames are good so people have an idea rather than waiting for a long time.” (Public participant, Group 10, WS3)

“I think the biggest selling point for me is the priority part. I would definitely be calling 111 just so that I can get priority over others once I get there, and they do a phone assessment too so they send you to the correct department.” (Public participant, Group 3, WS3)

There was an assumption that the system would be able to offer patients with a choice of locations by using real time information about how busy each service is. For some people, this was fundamental to their acceptance of the fast-track model.

“It seems like it's a live system where they can check where is busy and where people wait and you can be allocated elsewhere, at least have a choice to speed up the process.” (Public participant, Group 4, WS3)

At the same time, there were questions over how reliable and up-to-date the system would be and what would happen if the system crashed.

While there were public participants who understood the concept of an arrival time, there was also confusion among public participants who thought the proposal was to offer appointments. Facilitators needed to remind participants that the proposal was for arrival time slots, not appointments.

“I like the idea of getting an appointment slot and the location and the flexibility to find a location that is a bit further away but might allow you to be seen quickly. Having that flexibility is really good. I like the fact that by taking the initiative to get an initial assessment allows you to be fast-tracked.” (Public participant, Group 4, WS3)

Linked to timings was the expectation that people would not be waiting a long time for an arrival slot if their condition was high priority. Although some noted that the wait times were inevitable and there would be benefits to waiting at home, rather than in a hospital setting.

When discussing one of the patient personas: “*I still think the wait is too long for a fracture as if it's not looked at fairly quickly then it's much harder to sort out. She was waiting at home rather than A&E which has to be better and she could give pain relief to the child I guess, that's preferable to sitting in a horrible waiting room with hundreds of people so I guess the outcome is better.”* (Public participant, Group 3, WS3)

Staff participants were quicker to move to their concerns about the fast-track model, on occasion there was acknowledgement that this way of prioritising patients already exists in practice in some parts to some extent. This was not always met with optimism, however (see section below).

“I think it's being done now and if we want that to be the case going forwards we just work on what we have already. At the moment you get there at your appointment time and you're put to the back of the queue behind who just walked in front of me, so we have the system but it's just not being utilised effectively across the board…. If we can argue we already have it people might be less opposed than trying something new.” (Staff participant, Group 2, WS1)

The fast-track service as a new idea that will inevitably inherit existing problems, particularly in relation to capacity within primary care

Both public and staff participants struggled to see how the system would not still be overwhelmed, even if the fast-track model was implemented, and there was a voiced assumption that arrival time slots would quickly be used up and run out, meaning that problems would still occur. Staff questioned how and if the fast-track service would work alongside the existing four-hour A&E target.

“To add to those points, one key criteria to meet for most emergency departments is the four hour wait. You want to see patients in four hours regardless. The four-hour waiting time is for urgent care. A lot of urgent care centres are tied in with A&E and it would have to be a separate distinction a separate way of funding, and people need to distinguish between the two.” (Public participant, Group 9, WS1)

Staff expressed concern that the system would continue to be swamped with demand, and people will manipulate the system by reporting that their conditions are more serious than they are to be prioritised, and therefore seen quicker. This perception was possibly because the staff discussing scheduled care were not as cognisant of the other proposed changes to the patient pathway being discussed in other groups. For example, patients being more effectively assessed, triaged, streamed, and redirected to services which will better meet their needs could reduce demand on hospital based urgent care services.

Staff and public participants highlighted that the fast-track service felt very similar to current demand management within primary care including GP out-of-hours (with the clinical assessment service). Staff noted that the demand, and queues, within these services remain very large and thus failed to see how the proposal would be radically different here.

Patient advocates also highlighted concerns about recreating the issues seen in primary care but in urgent care.

"I think you're at the risk of creating a system within a load of systems that can replicate the GP, creating a back door. Scheduling is not how this service should work." (Patient advocate, Group 2)

During the scheduled care staff cohort discussions in Workshop 2, staff reiterated these concerns and flagged the risk that demand will shift from primary care to urgent care rather than better manage it. Both staff and patients suspected that patients would increasingly use UTCs as an alternative to accessing a GP. There was a strong steer from both public and staff participants that it was essential to address the current issues within primary care.

“It is absolutely overwhelming and I think [we need] to really look into that, we need to look at what is going on in our community. What is going on with our GP services.” (Staff participant, Group 4, WS1)

Concerns over a fast-track service were dominated by safety related risks and the ethics of a two-tiered system

Throughout the deliberations, public and staff participants continuously returned to the potential risks associated with a fast-track service. Both groups flagged their concerns about patient groups that they felt would potentially receive a worse deal, such as homeless people, people experiencing abuse, non-native English speakers, and vulnerable people more generally. Staff were concerned about how patients might be deprioritised if they can’t access the fast-track service through no fault of their own.

Public participants cautioned the need for a ‘safety net’, to ensure that there were protocols in place should a patient’s symptoms deteriorate or if a patient couldn’t access a booked arrival slot soon enough. The worry was that people might be waiting at home where they would otherwise be waiting in a hospital setting and thus doctors and nurses would be available should someone’s condition require more urgent attention.

Public participants spoke of the ‘grey area’ before an urgent situation turning into an emergency. When discussing one of the patient personas (Albie, a seven-year-old boy who had fallen off his bike and hurt his arm and was given an arrival time at an UTC later that evening), the fact that the child and his mum were waiting at home and not in a hospital setting was seen by many as *more* dangerous. Staff also raised the concern about not being able to monitor patients who are deteriorating – which they would be able to do currently in a hospital setting.

The fast-track model was seen to give an unfair advantage to people who are digitally able and those able to communicate effectively via the NHS 111 service. This was linked to the idea of exacerbating existing health inequalities.

“*The biggest risk is health inequality; they exist across the NHS already.”* (Public participation, Group 8, WS3)

Further, the feasibility of this model was questioned by public participants in relation to how it would work for certain patient groups including the elderly, parents of young children, people with mobility issues, individuals with mental health conditions or learning disabilities. Some suggested an alternative system for children.

“I think if you're elderly or you've got young kids, how easy is it going to be to be able to travel to all these places?” (Public participant, Group 4, WS3)

There were both public and staff participants who described the fast-track service as a ‘two-tiered’ system. For some staff, this felt completely unethical. In the final workshop, staff returned to the ethics of the proposal and further voiced their disapproval.

The concerns about the creation of a two-tiered service, that rewards those who are able and penalises those who are not, were echoed in discussions with patient advocates.

“It seems all self-evident for a chunk of older people who are digitally enabled. Middle class are all online, familiar with broadband and have no problem with online triaging. On the other hand, during the pandemic and thereafter there are a lot who can't afford broadband, don't have tablets, and are not able to deal with that sort of thing either through infirmity, Alzheimer's or some other disabling factor. Consider most older citizens to be able but a large number it's not suitable or practical.” (Patient advocate, Group 1)

Additionally, public participants were concerned about the optics of the fast-track service and how patients would likely notice the two queues and take out their anger and frustration on staff working in the service. These concerns were echoed by staff, who questioned how they would manage patients in waiting rooms.

Fully scheduled care felt too radical a shift, though the fast-track service could act as a steppingstone to fully scheduled urgent care in the future

Overall, across the public and staff groups, there was an expressed preference for the fast-track model over fully scheduled urgent care (the no walk in model). There were staff who preferred neither but when pushed, chose the fast-track model. While on occasion, and in particular when discussing some of the patient personas, it felt justified to public participants to remove the walk-in option. Though fundamentally, the fully scheduled urgent care model – across the board - was felt to be too radical a shift. It was described as ‘drastic’, ‘brutal’ and ‘risky’ by public participants, many who could not imagine patients no longer being able to walk into a ED.

“I just feel like the no walk in model will create so much upset and anxiety on a daily basis, whether it's next week or five years' time, people are still going to walk in. Just the thought of not being able to walk into an emergency department just sounds so ridiculous.” (Public participant, Group 3, WS3)

“What was quite shocking was that the patients might not be allowed to just walk in and wait their turn. That's quite radical.” (Public participant, Group 4, WS3)

Some patient advocates were very clear that fully scheduling urgent care is unacceptable and will never work for people who are vulnerable and unable to access digital channels. There was a feeling that both options (fast-track service and scheduling all urgent care) discriminate against the most vulnerable.

“Neither of those options are acceptable, we have to accept we can't change the system, we can tweak and make it better, fast tracking is completely unacceptable. They both cross red lines, people who are vulnerable and who cannot use digital systems, no option. NHS can do a huge amount more with scheduling. It will discriminate, it's absolutely illegal moves, it's not going to work.” (Patient advocate, Group 1)

Public participants raised the need for exemptions, for those unable to access virtual services to undertake an initial assessment, and to ensure that the service didn’t inadvertently penalise certain groups. In Workshop 4, public participants added to the list of exemptions. However, they had also previously identified the challenge in choosing which groups to make exceptions for and how difficult it would be to adhere to/monitor.

“Are we going to make an exception? If you start making exceptions, everyone will behave in the same way. That'll be one of the most difficult things to sort out. I'm not sure how that could be resolved.” (Public participant, Group 9, WS3)

Public participants also suspected that removing the walk-in option would create pressure on 999.

For any scheduling of urgent care to be acceptable, certain conditions would need to be true

When discussing the idea of scheduling urgent care, the following conditions of acceptability emerged. These were mostly voiced by public participants:

- There would need to be effective initial assessment and triage. Public participants raised the concerns over digital triage and the reliance on patients being able to accurately report their symptoms (covered in more detail in the triage chapter), and on the professionalism and knowledge of those working in the 111 service

- Patients would need to have access to transport to be redirected elsewhere (if appropriate), particularly if they were being sent to a service some distance away from where they live

- There would always need to be someone on hand in ED to help people complete the online assessment (which relates to expectations voiced around the digital front door), and to reassure patients if they are redirected, or asked to return later at a provided arrival time

- Patients would need to be educated on the difference between emergency and urgent care for the scheduling of urgent care to feel acceptable. Some public participants noted that even with good communications, the fast-track model could take years to fully embed

"You need to educate people on what's A&E and what's emergency and urgent. It's re-educating people." (Public participant, Group 8, WS4)

- The system would need to be very clear about arrival times (and not confuse these with appointment times).

"If you're going to get booked a slot, they need to make it clear it's an appointment slot. It's an arrival time, not an appointment." (Public participant, Group 9, WS3)

- There would need to be full transparency regarding expected waiting times – which would also need to be reasonable. Patient advocates echoed the need for the system to be fully transparent about timings and the expected waiting times to allow people to make informed choices and plan their time

- There would need to be adequate capacity within other services, in particular general practice, to alleviate the pressure from hospital based urgent care services

Public expectations

In Workshop 4, public participants were presented with a summary of the key findings from the previous workshop discussions on streaming and redirection in the form of draft expectations. They were asked for their reflections on the summary and whether they felt this broadly captured the views participants had expressed and heard during the workshops.

Figure 5.1. Summary shared at the start of WS4

If the fast-track option be taken forward across London, we feel this could…

- Encourage greater use of scheduled urgent care (for those that choose to use it)
- Support a gradual transition towards the scheduling of all urgent care allowing time for trialling and testing of the approach)
- However, steps must be taken to ensure vulnerable patients are not disadvantaged/ de-prioritised if they cannot or choose not to schedule their care

If the scheduling of all urgent care be taken forward across London, we feel this could…

- Minimise the inappropriate use of A&E
- However…there may be patients who continue to walk-in, driven by the high level of reassurance of being present in a waiting room provides. A dedicated person should be on-hand to support these patients in scheduling urgent care

Implementation of either option would need the following conditions to be in place:

- Exemptions should be made for vulnerable patients who can walk-in at any time
- Reassurance and clear instructions for patients waiting at home on how to manage their problem and what to do if anything changes
- A dedicated person on-hand to explain the system to walk-in patients, to reduce burden on clinical staff

- A comprehensive publicity campaign promoting access, alternative services, expectations of services and clarity on arrival time/appointments
- Expectations managed around timeframes for scheduled care, including update of any changes and reasons why

On the whole, the public felt that the set of draft expectations reflected the discussions that they had had, with the exception of some participants who were either unconvinced that scheduled urgent care could work and/or were very clear that all patients should still have the option to walk in and wait. The following additions were made to the draft expectations in the final session.

- An emphasis on scheduling of urgent care in London being subject to awareness and behaviour change. And a caveat added that there would still need to be some appointments set aside for people who walk in, as well as space provided for them to wait.
- A defined list of groups (see expectations below) who would need to be exempt from scheduling (for example if a fast-track service was adopted) and would still be able to walk in at any time and be seen or fast-tracked if it was felt to be appropriate (not deprioritised or penalised).
- The emphasis of an ongoing (as well as comprehensive) communications campaign that promotes access to urgent (not emergency) care and focusses on the benefits of scheduling urgent care for the majority and being clear on those groups who would be exempt and could still walk-in, and why. The addition of the caveat that it is going to take time (years) to change behaviour and embed, hence investment would be key.

Figure 5.2. Public participant final expectations scheduling urgent care

If the fast-track (don't call it that!) option be taken forward across London, we feel this could…

- Encourage greater use of scheduled urgent care (for those that choose to use it)
- Support a gradual transition towards the scheduling of all urgent care allowing time for trialling and testing of the approach to ensure that it works/is acceptable with the public
- **However,** steps must be taken to ensure vulnerable patients are not disadvantaged/de-prioritised if they cannot or choose not to schedule their care (e.g. homeless, elderly, young children, people suffering from mental illness etc)

If the scheduling of all urgent care be taken forward across London, we feel this could…

- Minimise the inappropriate use of A&E, though dependent on awareness and behaviour change
- However, there may be patients who continue to walk-in (and there would need to be some appointments set aside for these), driven by the high level of reassurance of being present in a waiting room provides. A dedicated person should be on-hand to support these patients in scheduling urgent care and space provided for them to wait

Implementation of either option would need the following conditions to be in place:

- Exemptions should be made for vulnerable patients who can walk-in at any time (elderly people, non-English speakers, those with young children, homeless people, people with mental health conditions, people with disabilities etc)
- Reassurance and clear instructions for patients waiting at home on how to manage their problem and what to do if anything changes
- A dedicated person on-hand to explain the system to walk-in patients, to reduce burden on clinical staff
- An ongoing and comprehensive publicity campaign promoting access to urgent (not Emergency) care, alternative services, expectations of services and clarity on arrival time/ appointments, consistently across all care settings. This is going to take time (years) so investment is key.
- Communications should also focus on the benefits of scheduling urgent care and which groups will be the exemptions so the most vulnerable can be reassured that they can still walk in
- Realistic expectations managed around timeframes for scheduled care, including update of any changes and reasons why
- A comprehensive publicity campaign promoting access, alternative services, expectations of services and clarity on arrival time/appointments
- Expectations managed around timeframes for scheduled care, including update of any changes and reasons why

Staff expectations

Workshop 2 (WS2) started with a presentation from the lead moderator who presented back an early draft of the groups' response to topic specific questions.

Figure 5.3. Summary responses shared at the start of WS2

Scheduling not possible when there's no appointments available

- Consideration needs to be given around what happens when the arrival time slots have all been taken. We need to consider how we will manage higher demand / additional pressure at different times and seasonality – children in school hols etc.
- There is also a risk that patients will wait for many hours, their symptoms will become more severe and they will need to be re-triaged (i.e., by 111). Staff would need to be supported if this does happen
- Fully scheduled care could work well for SDEC departments but they need to be operating around the clock. Same day OOH clinical assessment services already have this system, and arrival times don't work and you end up with huge queues. This is because they don't operate for long enough.

Fast-track

- The fast track option feels more feasible than fully scheduled care but there are some potential benefits to fully scheduled care. The test will be whether the approach can be as efficient / more efficient than just having people turn up – currently NHS 111 appointments not seen to 'work'
- A fast track system needs to be simple enough to allow staff to manage it, yet deal with the complexity in treatment order that this would create

Concerns about managing scheduling

- Concern about how to monitor those are waiting
- How to manage the four-hour A&E target alongside with the scheduling of care?
- When patients arrive they are frustrated having been through triage. When they get the help they need they are angry - they need a time and update about how long they have waited. Have someone come round to let them know where they are in the system. Staff will also need to be supported around how to handle angry patients/unpleasant behaviour
- Have more tools to manage people at the front-end rather than stopping people attending ED

During the feedback at the beginning of WS2, staff participants from the other two cohorts were given the opportunity to feedback on the cohort's response to the key questions on scheduling of urgent care. The following themes emerged in this feedback:

- **Ethics:** Not allowing people to walk into ED seemed unethical and against the core principles of the NHS. No-one should be able to 'jump the queue', care should always be prioritised based on clinical need and urgency. Some staff expressed that they would not want to work in such a service.
- **Equality:** Concern that we will end up penalising people who need the care most because they have not been through the right (digital) channels. Some felt that it will be practically impossible to move to all urgent care to being scheduled as there will always be (and should be) a degree of self-presentation.
- **Visibility and optics vs the likely reality:** the need to make it clear to patients that if they follow the right path, they will be seen quicker, while carefully considering how a fast-track service might be experienced, thus creating poorer experiences if expectations are not met (long waits, busy waiting rooms, what happens when the arrival times run out). Linked to this, caution over naming this a 'fast-track' service.

The cohort worked through some of this feedback and incorporated this into the final output and these are presented in the Figure below.

Figure 5.4. Staff participant final expectations on scheduling urgent care

Scheduling not possible when there’s no appointments available

- Consideration needs to be given around what happens when the arrival time slots have all been taken. We need to consider how we will manage higher demand/additional pressure at different times and seasonality – children in school hols etc.
- There is also a risk that patients will wait for many hours, their symptoms will become more severe and they will need to be re-triaged (i.e., by 111). Staff would need to be supported if this does happen
- Fully scheduled care could work well for SDEC departments but they need to be operating around the clock. Same day OOH clinical assessment services already have this system, and arrival times don’t work and you end up with huge queues. This is because they don’t operate for long enough.

Fast-track

- The fast-track option feels more feasible than fully scheduled care but there are some potential benefits to fully scheduled care. The test will be whether the approach can be as efficient / more efficient than just having people turn up – currently NHS 111 appointments not seen to ‘work’
- A fast-track system needs to be simple enough to allow staff to manage it, yet deal with the complexity in treatment order that this would create
- How do we balance visibility of fast track getting seen sooner with realities of waiting room and tensions this causes
- Need to avoid penalising the people who need it most, exacerbating inequality – do they need a higher acuity score?
- Is fast track the right term to use to sell the advantages of using the digital front door to access treatment?

Concerns about managing scheduling

- Concern about how to monitor those are waiting
- How to manage the four-hour A&E target alongside with the scheduling of care?
- When patients arrive they are frustrated having been through triage. When they get the help they need they are angry; they need a time and update about how long they have waited. Have someone come round to let them know where they are in the system. Staff will also need to be supported around how to handle angry patients/unpleasant behaviour
- Have more tools to manage people at the front-end rather than stopping people attending ED

Educating and communicating about changes to urgent care services

During the final breakout of workshop 4 public participants were asked to consider how best the NHS should go about educating, communicating and engaging with Londoners about the potential changes to urgent care.

Public participants were asked to consider: what kind of information the public needed to know about the changes; how should education be delivered; what language should be used to help clarify what urgent care is; and, what the public needed to know about the reasons behind changes to urgent care.

It's important to educate and inform Londoners of the current circumstances in order to convey why services are changing

Transparency emerged as very important for public participants. They noted that it was important to explain to the public and make them aware of the current pressures facing the system. For example, highlighting the key points from the 'case for change' presentations, including the pressure the service is facing, and the fact that patients are not getting the right services appropriate to their need and / or they are waiting a long time to be seen in some services.

Participants felt that by explaining the challenges facing urgent care currently, the case for change and the related expected benefits could be more effectively communicated.

"I think they need to know why the change is taking place, so educating people on not just the fact that we're changing for the sake of it. There is a need to change and the benefits of such. Obviously, shorter waiting times, better access to the NHS, alleviating the pressure on staff. Things like that." (Public participant, Group 1, WS4).

However, there were one or two participants who felt that exposing too much information about the challenges facing the NHS could shock some members of the public. Thus, any communications activity in this regard needs to be treated as a sensitive subject and handled accordingly.

"I'm slightly dubious about making too much mention of the horrible things like an elderly person being on a trolley for 19 hours. It could cause problems. That sort of admission, I'm not sure." (Public participant, Group 2, WS4)

The public should be made aware of key changes and processes

Reflecting on the approaches, models and options presented to them throughout the workshops, public participants noted that it was important to inform and educate the public on how these activities worked. For example, improving awareness of how NHS 111 services are run, who works in them, the level of training and qualifications staff have and how the service is monitored. It was felt that this would not only improve public trust in the service but provide a greater understanding of how NHS 111, as well as other processes such as triage, work and therefore support the public to make better use of them.

"Everything needs to be explained. It's to stop the confusion. If you are told, this is the process, then you are less likely to have people misusing the service…You need to clarify the pathway." (Public participant, Group 9, WS4)

Similarly, should changes be made around redirection and the scheduling of urgent care, efforts to raise awareness about these changes should be communicated to the public.

Raise the profile of urgent care and clearly distinguish this from emergency care

Public participants also noted the need to make the public more aware about what health needs are more appropriate for an ED setting, focussing on 'life threatening' situations (not 'accidents' as part of A&E), and what health needs are more appropriate for urgent care, as well as improving the brand of NHS 111, UTCs and other community services such as pharmacists.

"The difference between urgent care and A&E. Explain what the differences are very clearly…life threatening vs not life threatening." (Public participant, Group 10, WS4)

In relation to 111 specifically, there was much discussion within the public workshops about how the service has developed a poor reputation and received bad publicity so a whole refresh is required. This would elevate the importance of this service, and thus increase people's confidence in using it. One participant suggested a fly on the wall tv documentary all about the 111 service.

Education and communication to the public requires a broad and multifaceted approach

Reflecting on how best to educate the public, participants discussed a range of ideas to educate and communicate to the public about the changes and increase awareness. These are summarised below.

- **Utilise community organisations, infrastructure and connections:** such as educating parents through children's centres and schools, disseminating promotional materials libraries and mobilising the third sector

- **Develop innovative advertising campaigns** based on historic campaigns that are known to be successful. For example, the green cross code for learning how to cross the road or the clear messages communicated during the pandemic about '111 first'

"They had a green cross code for people learning how to cross the road. It could be something like that. You could have a red, amber and green." (Public participant, Group 2, WS4)

Social media was also raised as a key platform for capturing large audiences, particularly in engaging younger people who could form an important group in changing the mindset of generations to come

- **Word-of-mouth and raising awareness through experience:** some participants were content with the public being made aware of these changes through trying to access urgent care and being informed of the changes when they are doing so. They felt that the changes would naturally be discussed through word of mouth and that is how the public would find out. However, it was also noted that the NHS needed to ensure that patients had a good experience from the first point of contact as this would determine attitudes towards using the service and whether people embraced the change(s) or referred back to old behaviours (e.g. walking into ED)

"You've got to show that it works. If it doesn't then the word of mouth will get around, and people will go to A&E because the system doesn't work, and they've been told or that's been their experience." (Public participant, Group 6, WS4).

Additional reflections

Throughout the dialogue and deliberation, several clear overarching themes emerged which are important to bring out here as we draw the report to a close.

Primary care transformation

Urgent care touches on most parts of the health system and what has become very clear – through in-depth discussions with public, staff and patient advocates – is that primary care plays a crucial role in the delivery of urgent care services.

The expectations voiced by the public and staff in this report sit within a wider system and rely on the transformation of primary care in London. It would be wise, as has been done here, to undertake a detailed programme of engagement with both the public and staff to inform this.

Ongoing engagement with the public and staff

Often there is an assumption that when the health service needs to make changes to the delivery of services, members of the public will be the most resistant to change. The focus is usually therefore on public engagement, communications and education. It cannot, and should not, be assumed however that staff do not also need to be taken on this journey. As this work has shown, staff have their own set of nuanced concerns and anxieties that are relevant to them and these must be captured and addressed.

This work has generated some detailed principles and expectations that will need to be implemented at a local level across London if these proposals are taken forward. For the roll-out of these to be successful, further and ongoing engagement will be needed with the public and also with staff across the system. Both the public and staff need to understand why change is necessary, the intended benefits and outcomes and be given the necessary information and reassurances required.

The importance of avoiding the exacerbation of health inequalities

This work has powerfully demonstrated the importance of deep consideration around health inequalities. Throughout the public workshops, participants grappled with patient personas purposively designed to show the potential impact of the proposals on certain groups. The public worked through these and voiced specific considerations for vulnerable and marginalised communities. Additionally, the patient advocate workshop shed further light on some of these considerations and provided a helpful steer around what would need to be in place to avoid further exacerbating existing health inequalities.

As with the need to do ongoing engagement, communication and education with the public and with staff, the system would also need to work with groups and individuals who represent the voices of the most vulnerable and marginalised communities in London.

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