

Insights to  
inform a shift

From hospital  
to community

From analogue  
to digital



NHS



NHS



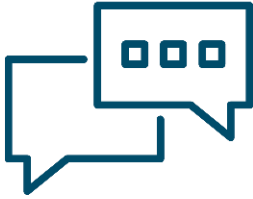
# A&E Attendance Insights East Kent

A Healthwatch Kent report  
October 2025

**healthwatch**  
Kent

INSIGHTS AT  
**EK360**  
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## About Us



Healthwatch Kent is your local independent champion for health and social care. Our aim is to improve services by ensuring local voices are heard – we want to hear about health and social care experiences so to influence positive change for communities across the Kent area. We have the power to make sure NHS leaders and other decision makers listen to your feedback and improve standards of care.

We use your feedback to better understand the challenges facing the NHS and other care providers, to make sure your experiences improve health and care services for everyone. It is really important that you share your experiences – whether good or bad, happy or sad. If you've had a negative experience, it's easy to think there's no point in complaining and that "nothing ever changes". Or, if you've had a great experience, that you 'wish you could say thank you'. Your feedback is helping to improve people's lives, so if you need advice or are ready to tell your story, we're here to listen.



Notice on Healthwatch England changes announcement.

As part of the Dash Review published in July 2025 Healthwatch England and the Local Healthwatch network was recognised for its work in listening to and raising the voice of the people who use Health and Social Care services across the country. The review highlighted the government's desire to streamline bodies contributing to patient safety and consequently Local Healthwatch responsibilities will be transferred to ICBs and Local Authorities. This transformation will take time and therefore, here in Kent and Medway, we will continue to work with the public and stakeholders to achieve change for local people. We also recognise that since the announcement, while the current body Healthwatch will cease to exist, there has been an acknowledgement of the need for high quality, independent voice to remain.

Healthwatch Kent is hosted by EK360.

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# Summary

## Introduction

Healthwatch Kent was commissioned to conduct visits to William Havey Hospital (WHH) and Queen Elizabeth Queen Mother Hospital (QEQM), speaking to people about their journey to the initial assessment area of Accident and Emergency. Across 2 visits to each site, 50 people shared their experiences which included what services they had interacted with before attending and if they felt their attendance could have been avoided.

## Key Findings

- 88% of people had contacted one or more services in the lead up to their A&E attendance
- 74% of people we spoke to had been directed to go to A&E by one or more other services.
- Only 8% of people reported attending A&E because they were unable to get a GP appointment
- There were notable differences when comparing responses by level of deprivation and rurality.
- A greater proportion of people at QEQM were unsure whether their attendance could have been avoided (28% compared to 4%)
- 22% of people spoken to were unsure what alternatives to A&E were available to meet their needs.

## Learnings and Insights

In total, almost one-third of participants (**32%**) believed their A&E visit could have been avoided, while half considered it unavoidable (**52%**) and a further **16%** were unsure.

Despite national concerns around inappropriate A&E use, only a small proportion of participants (**8%**) cited difficulty accessing a GP appointment as the reason for their attendance.

Participants from urban and higher overall deprivation areas were overrepresented in the sample, however they were more likely to report uncertainty in the avoidability of their A&E visits

Against a backdrop of rising pressures on emergency departments nationally and regional reviews into Urgent Treatment Centres (UTCs), this study contributes to the growing body of research that challenges simplified assumptions about “inappropriate” A&E use and informs discussions around a shift from Hospital to Community.

## Introduction

Healthwatch Kent were commissioned by East Kent Health and Care Partnership to gather and analyse insights from participants about their attendances to A&E departments at the William Harvey Hospital in Ashford and the Queen Elizabeth The Queen Mother (QEQM) Hospital in Margate.

These insights were intended to inform the Urgent Care Delivery Board in East Kent and to test the notion that people from the East Kent area are turning up to A&E because they have been unable to get a GP appointment, or that some people are not attempting to try alternative avenues to receive help before attending A&E. By reviewing existing research around the issues of A&E attendances and the accessing of alternative health services before emergency services, and linking engagement approaches into this existing literature, this study aimed to focus on whether distinct similarities or differences existed in the local context in comparison to the national picture.

This study therefore intends to provide insights into A&E attendance research that would further inform the Urgent Care Delivery Board in East Kent, as opposed to being a proportionally representative overview of how all patients across the East Kent area are accessing A&E.

# Background

## National Context

In February 2025, the waiting list for consultant-led elective care stood at 7.4 million cases, consisting of around 6.24 million individual patients waiting for treatment in England ([British Medical Association, 2025](#)). Approximately 3.02 million of these patients had been waiting for over 18-weeks and 194,000 had been waiting for over a year (see *Figure 1*).

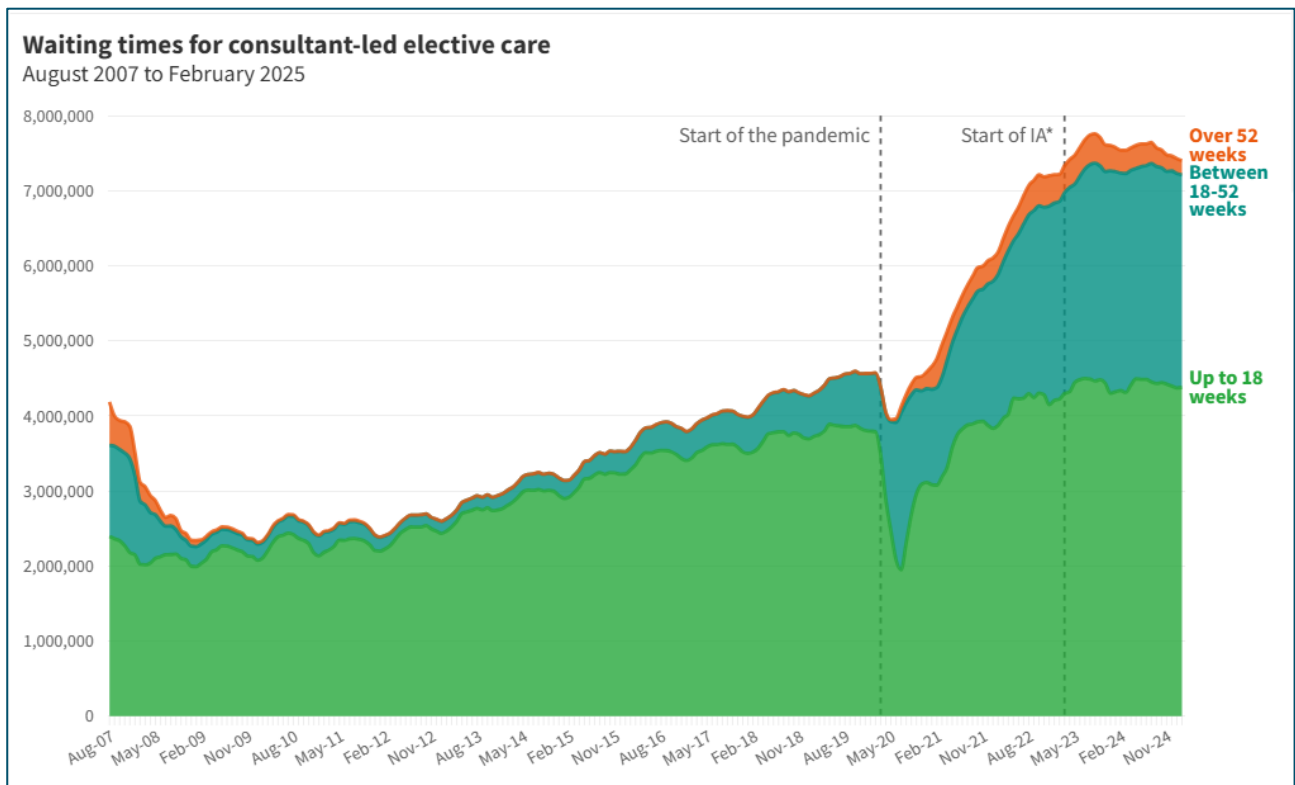


Figure 1: waiting times for consultant-led elective care in England. ([British Medical Association, 2025](#)).

The numbers of cases and individual patients have risen considerably since the start of the COVID-19 pandemic. The combination of the suspension of non-urgent services and changes to individuals’ behaviour has meant the number of people joining the waiting list is far higher than pre-COVID ([British Medical Association, 2025](#)).

The overall trend in A&E attendances shows that the number of people going to A&E has risen substantially over time and surpassed pre-pandemic levels (see *Figure 2*). In 2023/24, there were 26.2 million attendances, compared with 21.6 million in 2011/12 ([The King’s Fund, 2024](#)).

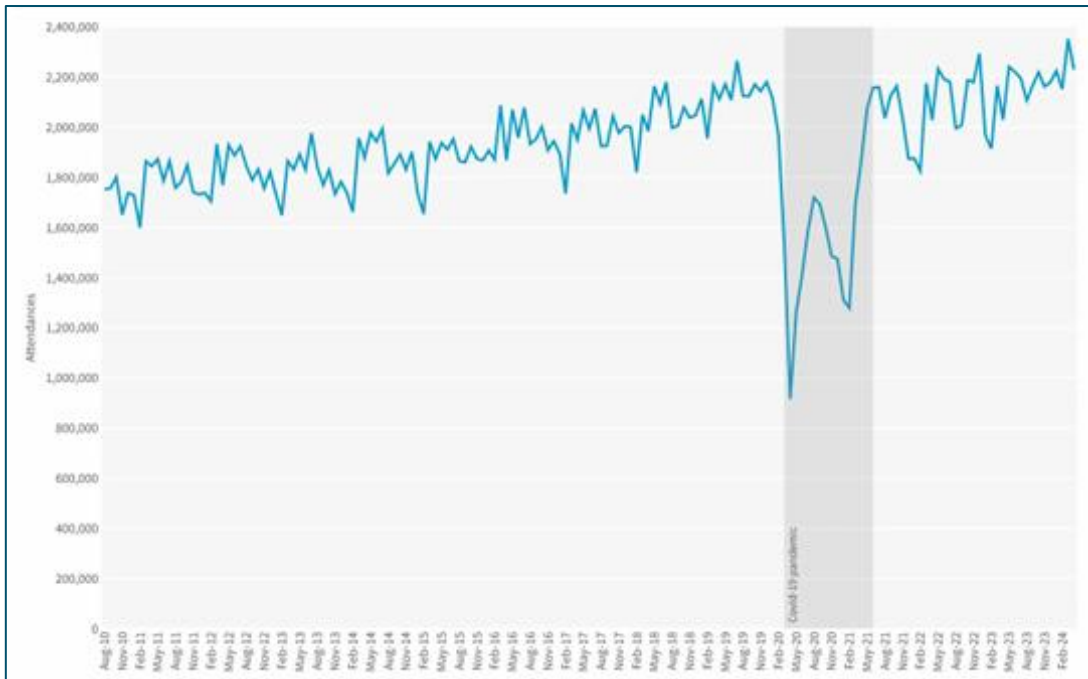


Figure 2: A&E attendances (all types) in England. (The King's Fund, 2024).

In 2024, The King’s Fund found that the increased pressure on A&E departments was more closely associated with rising numbers of emergency admissions to hospitals rather than increases in A&E attendances. The capacity to meet rising demand has come under increasing pressure due to an insufficient number of hospital beds and severe staff shortages (The King’s Fund, 2024). The number of 12 hour or more waits for admission has spiked dramatically since the COVID-19 pandemic. In 2019, less than 5,000 people experienced a 12 hour or more wait; in March of 2024 alone, over 140,000 people experienced a 12 hour or more wait time (see Figure 3 and Figure 4).

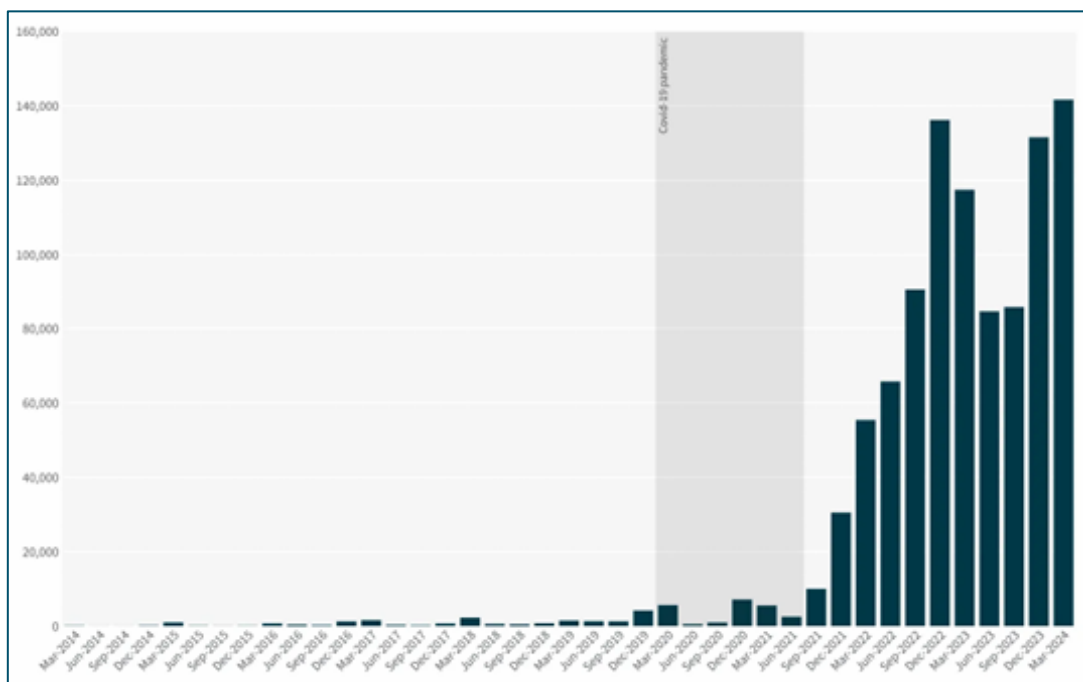


Figure 3: quarterly number of patients spending more than 12 hours from decision to admit to admission in England. (The King's Fund, 2024).

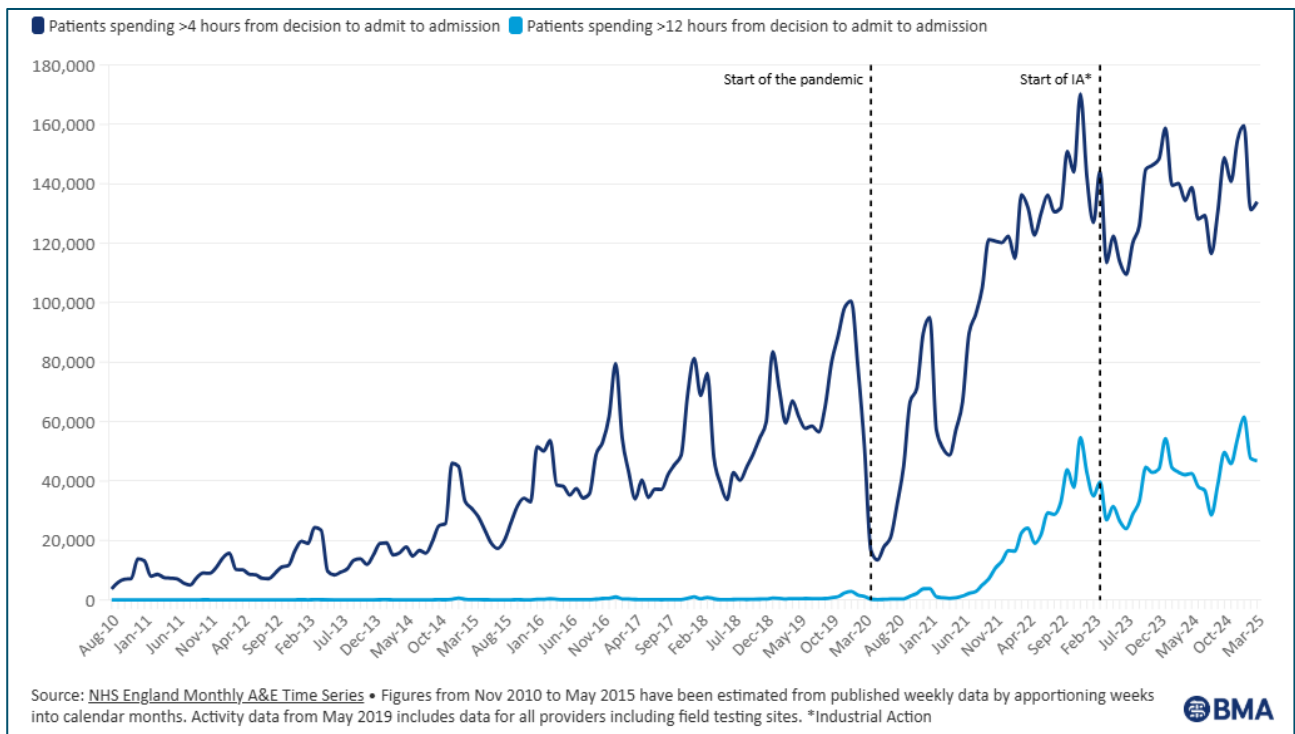


Figure 4: patient waiting times for emergency admissions (August 2010 to March 2025) in England. ([British Medical Association, 2025](#)).

The increasing number of emergency department attendances is an issue facing emergency health services worldwide ([Calastri et al., 2025](#)). Demographic characteristics were found to be the strongest predictors of A&E attendance rates across multiple studies conducted, with socioeconomic deprivation the strongest predictor (see: [Hull et al., 2018](#); [Rudge et al., 2013](#); [Scantlebury et al., 2015](#)). Population characteristics have been found to explain the majority of variations in admission rates (approx. 72%), with urban/rural status accounting for an admission variance of approx. 75% ([O’Cathain et al., 2014](#)). Further to this, health systems serving populations with high levels of deprivation and in urban areas have been found to have high rates of potentially avoidable admissions ([O’Cathain et al., 2014](#)). Deprivation explained most of the variation in avoidable admission rates across these studies, though all found further research into the complexity of the relationship between deprivation and avoidable admission was needed.

Low use of GP surgeries by individuals has been found to be associated with a lower attendance at emergency departments (see: [Hull et al., 2018](#); [Ismail et al., 2013](#)). There has been either negligible or inconclusive evidence to suggest that inability to access the GP surgery is associated with increased attendance at emergency departments (see: [Calastri et al., 2025](#); [Hunter et al., 2013](#); [Cowling et al., 2013](#)). However, one study ([Dolton et al., 2016](#)) found that increasing GP openings to 7-days per week could have an estimated reduction in A&E attendances of 9.9%. And some studies have found that continuity of care is associated with reduced emergency department attendance and emergency hospital admissions (see: [Huntley et al., 2014](#); [Deeny et al., 2017](#); [Tammes et al., 2017](#)).



This background research suggests that NHS pressures to emergency care services appear to be exacerbated by long-standing systemic issues and intensified by the COVID-19 pandemic. The significant rise in waiting times and overall attendances (as reported by the [British Medical Association, 2025](#) and [The King's Fund, 2024](#)) underscores challenges in service capacity, including bed shortages and workforce constraints. Socioeconomic and demographic factors, particularly deprivation and urban status, are seen to play a substantial role in emergency care demand and admission rates. While low GP usage correlates with a lower A&E attendance, evidence on access to GP services as a driver of A&E usage remains inconclusive. Nonetheless, some findings support the value of improved continuity and availability of primary care in potentially easing pressure on emergency services. Although this background research is not exhaustive, it provides evidence of wider research that has taken place into the issues facing emergency departments and secondary care services.

## Local Context

In [2025, NHS Kent and Medway](#) performed a review of Urgent Treatment Centres (UTCs) across East Kent to evaluate performance and explore opportunities for improvement. The review made use of a public survey that received 1,866 responses from East Kent residents; engagement sessions with voluntary organisations and community groups; stakeholder engagement with local councillors, MPs and community representatives; and social media campaigns.

The review found that UTCs provide efficient and quick care, are comprised of professional and caring staff, are easily accessible and convenient, and are structured with a well-organised and transparent system. The review also found that there were issues with waiting areas and facilities, signage and directions, on-site diagnostic services, and waiting times during peak hours.

Headline findings from the review included:

- Roughly **60%** of people spend 15 minutes or less travelling to a UTC.
- **28%** of people choose to go to UTCs because they can't get a GP appointment within two days (see *Figure 5*).
- **47%** of people are seen at a UTC within 30 minutes, however **25%** of people wait for over an hour before being seen.
- The most common reason for attending UTCs is ear and throat infections (**11%**), although **34%** of people report attending UTCs for "other" reasons.

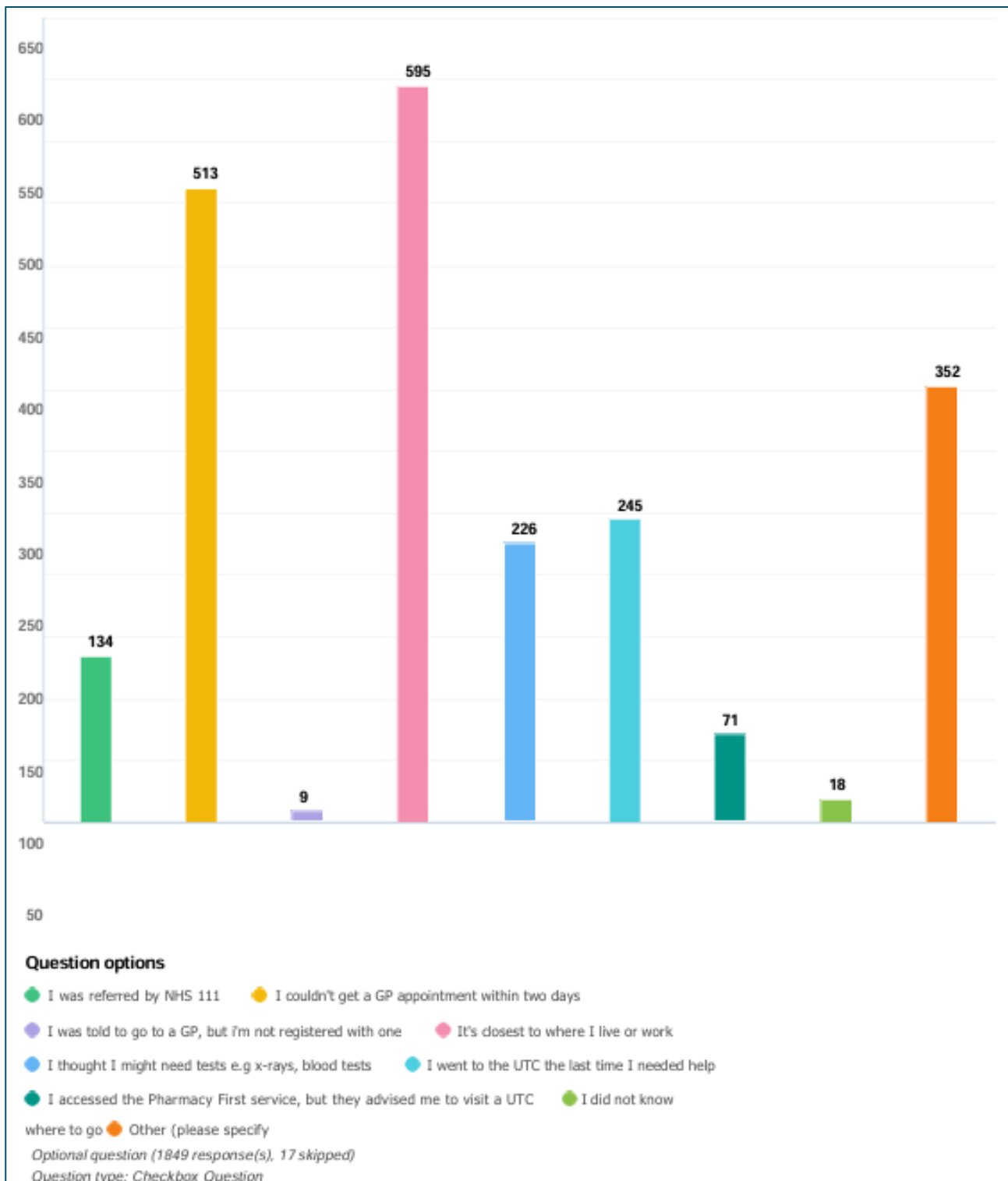


Figure 5: why people in East Kent chose to attend an Urgent Treatment Centre (NHS Kent and Medway, 2025).

Some participants of the public survey commented upon a lack of confidence in A&E departments, with NHS Kent and Medway observing that this was leading to “patients opting for UTCs to avoid long waits or perceived lower quality of care”. The variety of responses suggested that “UTCs are filling gaps in primary care access, emergency care avoidance, and timely medical treatment”. NHS Kent and Medway concluded that UTCs play an essential role in providing timely and effective care, although acknowledged there were key issues in need of addressing to improve overall patient experience.

# Methods

## Procedure

Our study made use of structured interviews with participants to gather self-reported data on their experiences leading up to attending A&E. The interview questions were developed in collaboration with the East Kent Health and Care Partnership team and shared with East Kent Hospital staff]. The conversational framework that was used with participants is provided in **Appendix A**.

Structured interviews with all participants were conducted between May – June 2025 and were completed in person. Consent was obtained from all participants prior to interviews commencing.

## Measures

Our study looked at two critical measures that were drawn from the background research conducted:

1. The services utilised by participants prior to attending A&E.
2. The perceived avoidability by participants of attending A&E.

## Sample Selection

A total of 50 participants took part in our study. This included people who had attended the William Harvey Hospital in Ashford and the Queen Elizabeth The Queen Mother (QEQM) Hospital in Margate.

Participants were recruited to the study after being triaged by the initial assessments team. The logistics of on the day engagement was supported by [East Kent Hospitals].

## Assessment of Risk of Bias

The methodological quality of this study was evaluated using Cochrane's Risk of Bias Tool (ROBINS-E) for non-randomised studies (see: [Higgins et al., 2024](#)). This tool assesses bias across several domains including: confounding variables, participant selection and missing data.

Some of the considerations for this particular study are:

- The numbers and percentages within the report are referring to people already triaged by the initial assessment team and not the whole cohort of people using A&E.
- There were no morning or weekend visits. Patterns of people presenting at these times may have differed to the people that were spoken to.
- There were a number of people who didn't want to share their experience. It could have been necessary for a greater proportion of these people to be present at A&E compared to the cohort of people we spoke to. Conversely, a greater proportion of people may not have needed to be there than those that did share their experience.
- The answers given are people's own perceptions and may not align with actual medical need.
- The demographic information provided by people taking part isn't fully aligned with the wider East Kent population. It's possible that this would have resulted in different responses.

Based on the assessment, this study was judged to have a low risk of bias, indicating that while residual confounding cannot be entirely ruled out due to the observational nature of the study, there were minimal concerns regarding bias in the results.

## Analysis

A combination of quantitative and thematic analysis was used to interpret participant responses and categorise into meaningful topics and themes. This analysis aimed to identify behavioural patterns, experiences and insights within the participant sample. To ensure clarity and accuracy throughout the report, responses were systematically grouped into topics and/or themes during data analysis.

All participant data was analysed independently of the empirical field research ensuring that observations and interpretations were objectively drawn from the collected responses. Findings are clearly defined and distinctions between self-reported behaviours, perceived experiences and statistical insights are explicitly maintained. To uphold the anonymity of participants, direct quotations have been edited wherever identifiable information is presented.

## Demographics

Participants in our study answered several demographic questions (see: **Appendix B**) providing context, depth and relevance to this study through insights into the characteristics of the participant sample. An overview of key demographic information is provided below:

- Location:** Our largest response was from people living in Thanet (**28%**). Our smallest response was from people living in Swale (**2%**). The full range of locations is provided in *Figure 6*.

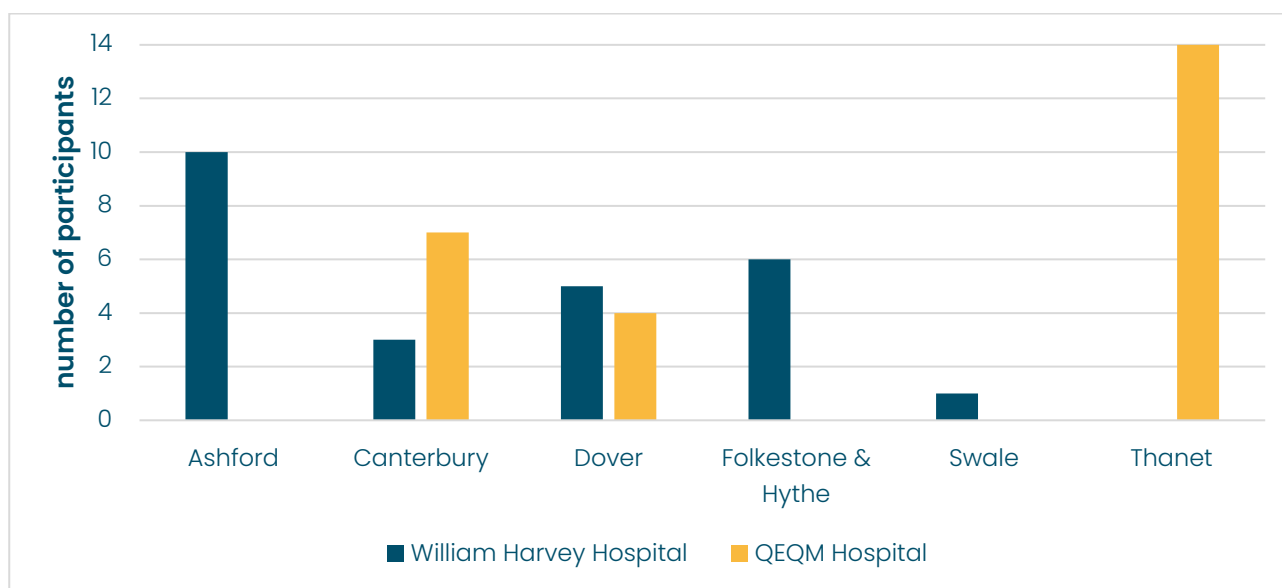


Figure 6: the number of participants by location, split by hospital.

- Age:** Our largest response was from people aged 35-44 (**20%**). Our smallest response was from people aged 85-94 (**6%**). The full range of ages is provided in *Figure 7*.

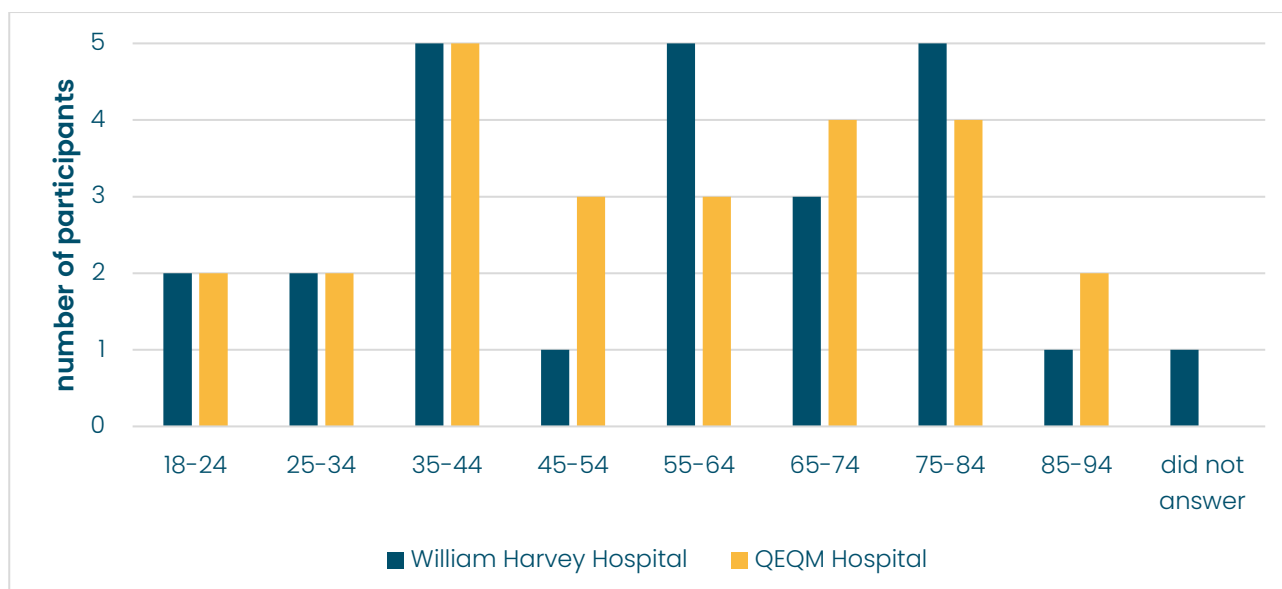


Figure 7: the number of participants by age group, split by hospital.

- **Gender:** **58%** of people were female and **42%** were male.
- **Sexual orientation:** **82%** of people were heterosexual/straight, **4%** were gay/lesbian, **4%** were bisexual, **2%** were pansexual, **4%** opted to prefer not to say and **4%** did not answer.
- **Disabilities and health conditions:** **16%** of people had a disability (**84%** did not have a disability); **24%** of people had a mental health issue (**76%** did not have a mental health issue); and **50%** of people had a long-term health condition (**50%** did not have a long-term health condition).
- **Neurodiversity:** **6%** of people were neurodiverse and **94%** were neurotypical.
- **Ethnicity:** **76%** of people were White British, **10%** were any other White/White British background, **4%** were Irish, **4%** were any other Asian/Asian British background, **2%** were Pakistani, **2%** were any other mixed/multiple ethnic background and **2%** opted to prefer not to say.
- **Carer status:** **14%** of people were carers and **80%** were not carers. **4%** of people did not answer and **2%** opted to prefer not to say.
- **English as a first language:** **86%** of people spoke English as their first language and **14%** of people did not. Other first languages included French, Hebrew, Polish, Russian and Urdu.
- **Religion:** Our largest response was from people who were Christian (**46%**). Our smallest response was from people who were Jewish and Muslim (each at **2%**). The full range of religious beliefs is provided in *Figure 8*.

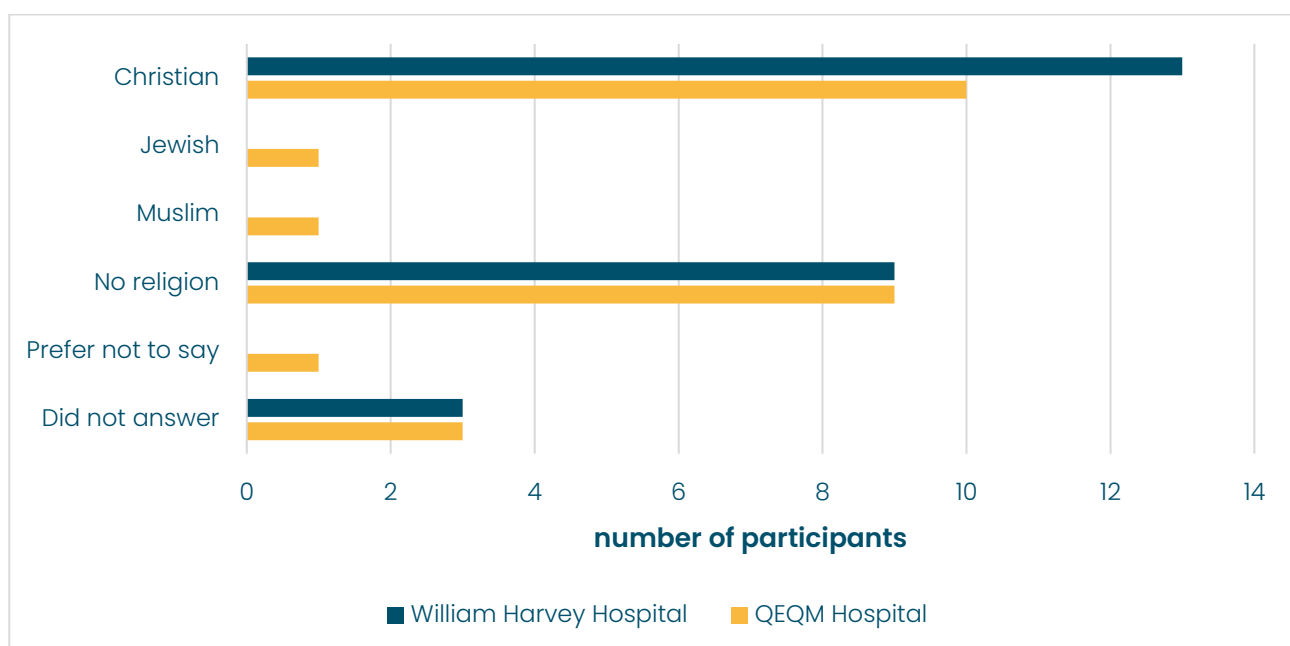


Figure 8. the number of participants by religion, split by hospital.

- Employment status:** Our largest response was from people who were retired (**42%**). Our smallest response was from people who were part-time employed and students (each at **2%**). The full range of employment statuses is provided in *Figure 9*.

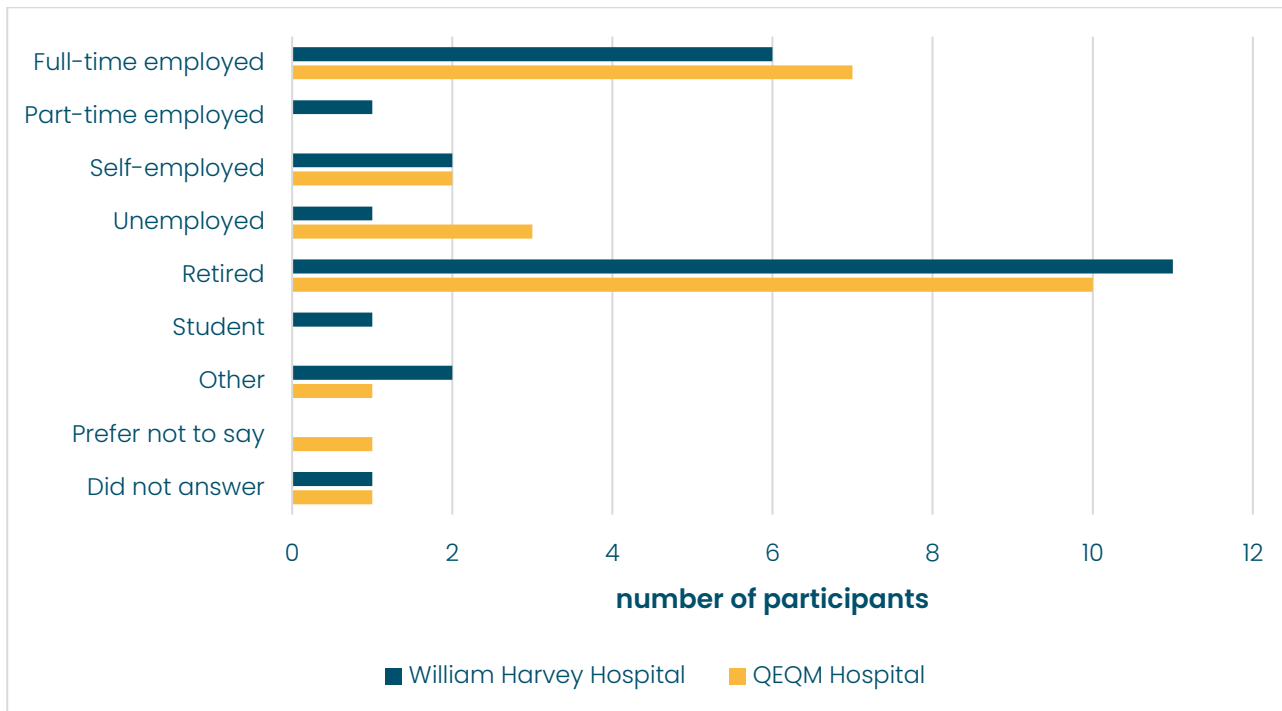


Figure 9: the number of participants by employment status, split by hospital.

- Education level:** Our largest response was from people whose highest education level was GCSE/equivalent (**34%**). Our smallest response was from people whose highest education level was Level 4 Diploma / equivalent and Level 5 Higher Diploma / equivalent (each at **2%**). The full range of education levels is provided in *Figure 10*.

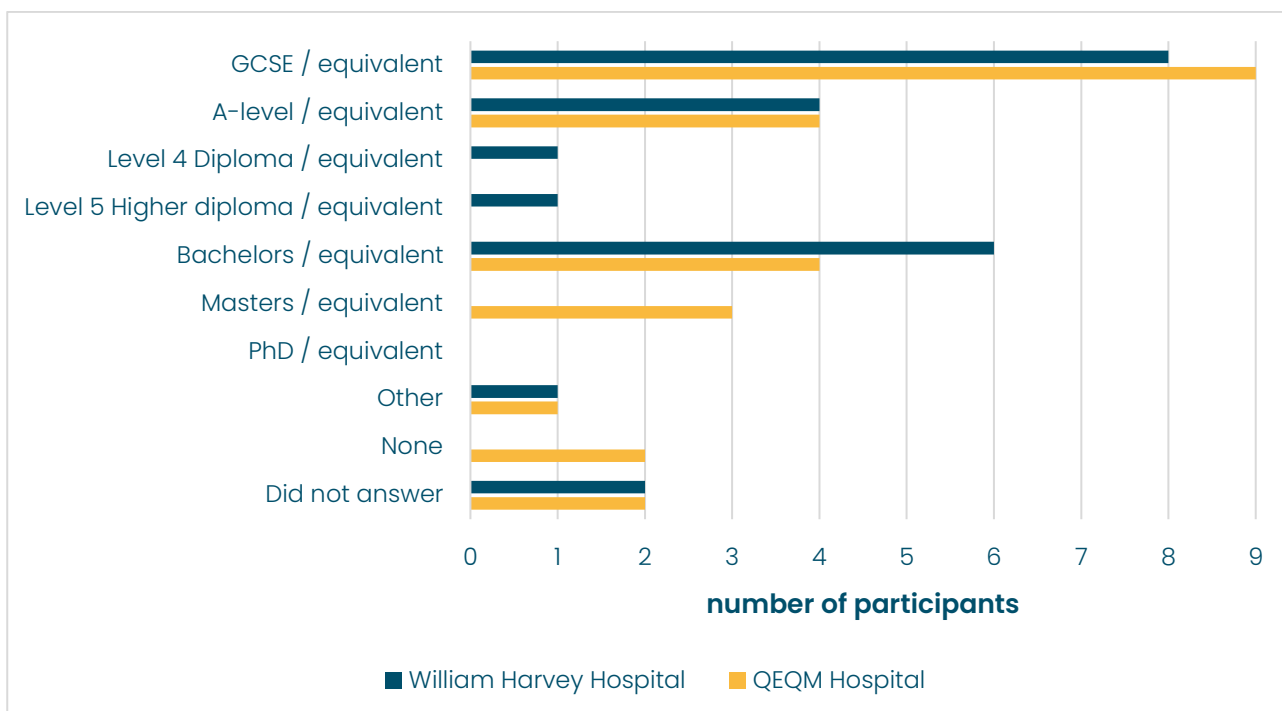


Figure 10: the number of participants by education level, split by hospital.

- **Refugee, asylum seeker and migrant status:** 86% of people told us they were not refugees, asylum seekers or migrants. 12% did not answer and 2% opted to prefer not to say.
- **Homelessness status:** 90% of people told us they were not currently homeless. 4% told us they were at risk of becoming homeless in the near future. 4% did not answer and 2% opted to prefer not to say.
- **Financial status:** Our largest response was from people who in the past six months had never struggled to pay for basic necessities (60%). Our smallest response was from people who had always or often struggled to pay for basic necessities in the past six months (each at 4%). The full range of responses to paying for basic necessities is provided in *Figure 11*.

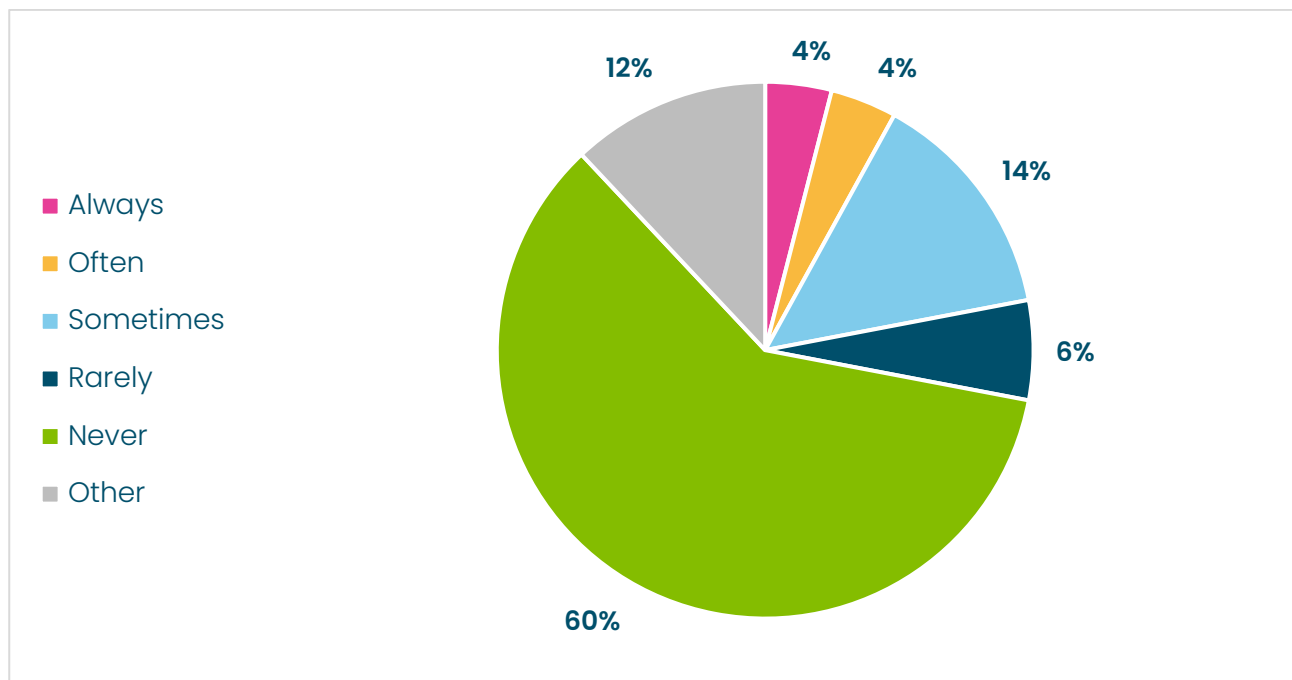


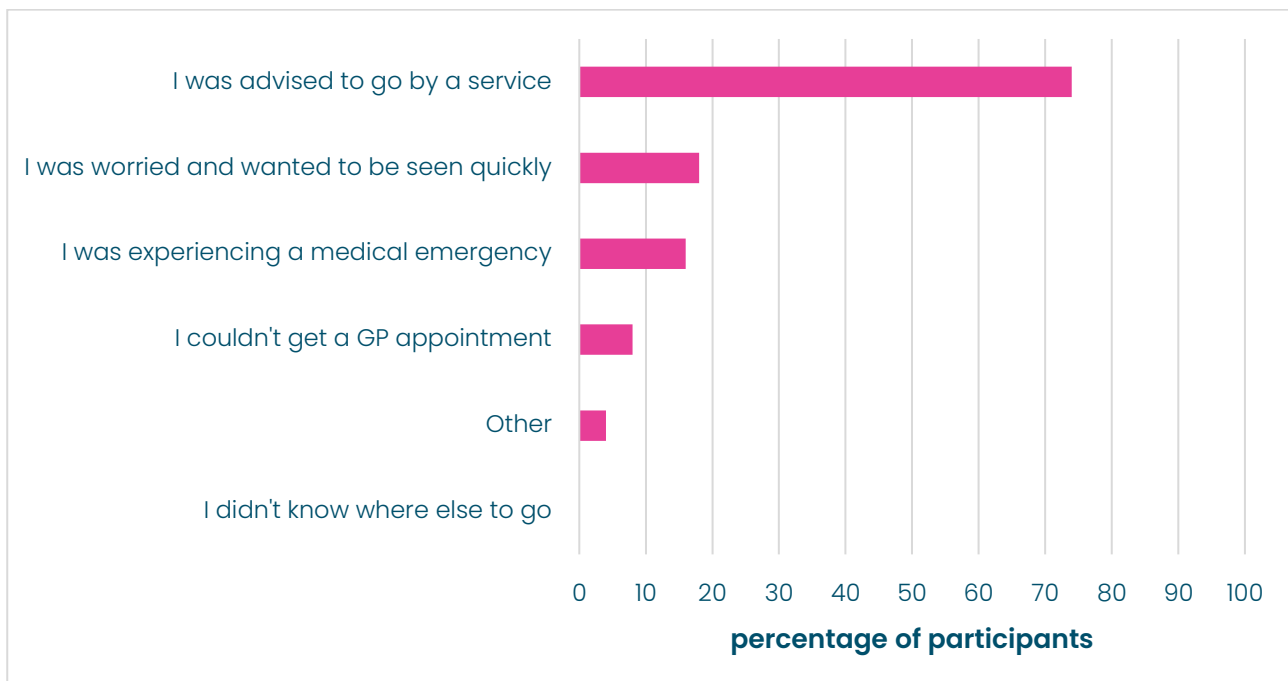
Figure 11: the percentage of participants by response to financial status.



# Findings

## A&E Attendances

We first asked participants to reflect on their visit to A&E and tell us what led them to seek care there. Participants could select multiple options from a predetermined list. The most common response by participants was that they had been advised to go to A&E (**74%**). The least common response by participants was that they attended A&E as they were unable to get a GP appointment (**8%**). In addition, participants were offered the option within the predetermined list to select “*I didn’t know where else to go*”. None of the participants we spoke with opted for this response. The full range of responses is provided in *Figure 12*.



*Figure 12: the percentage of participants by what led them to seek care at A&E.*

Over three-quarters of participants reported that they had been advised to go to A&E by a service, such as a GP, NHS 111 or Urgent Treatment Centre. When looking at the particular services that advised participants to go to A&E, the most common response was that participants had been advised to go by their GP (**66%**). The least common response was that participants had been advised to go by a pharmacy (**3%**). The full range of responses is provided in *Figure 13*.

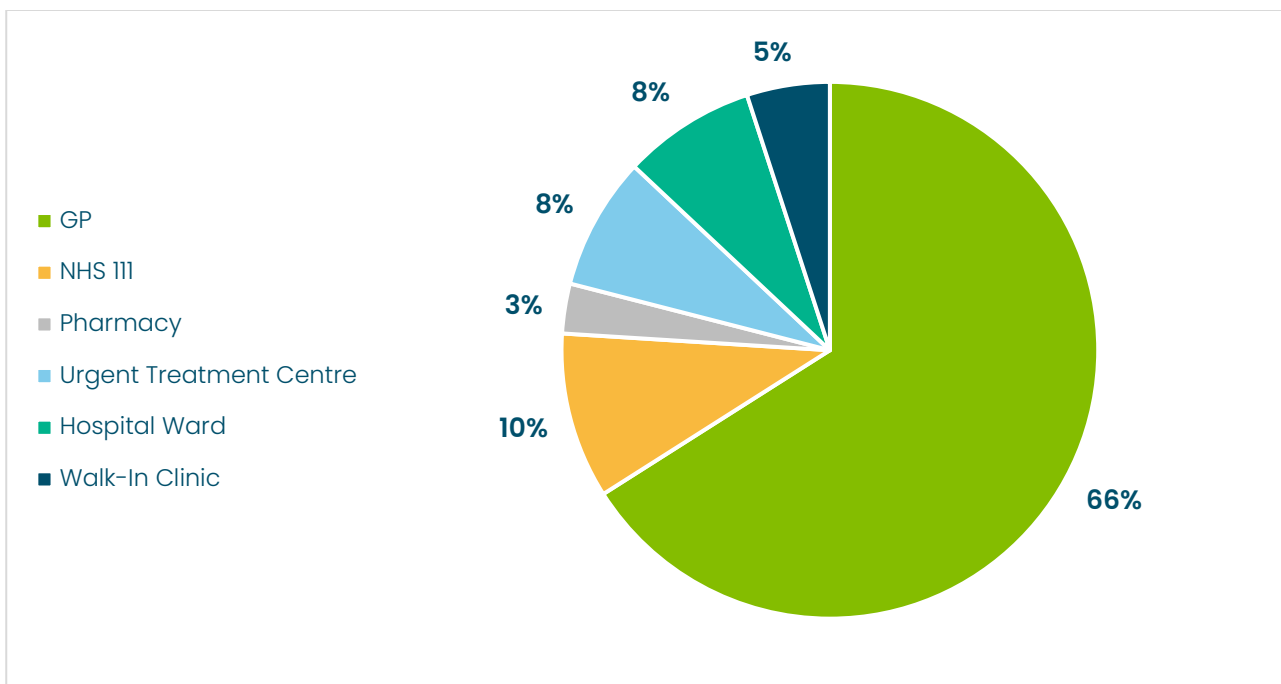


Figure 13: the percentage of responses to "I was advised to go by a service" by service type.

The responses from each hospital differed in two areas: the number of respondents advised to attend A&E by a service, and the number of respondents that went to A&E because they were worried and wanted to be seen quickly. **88%** of participants from William Harvey Hospital were advised to go to A&E by a service compared with **64%** of participants from QEQM Hospital. Conversely, **32%** of participants from QEQM Hospital responded that they were worried and wanted to be seen quickly compared with just **4%** of participants from William Harvey Hospital. Responses by participants between the two hospitals is displayed in *Figure 14*.

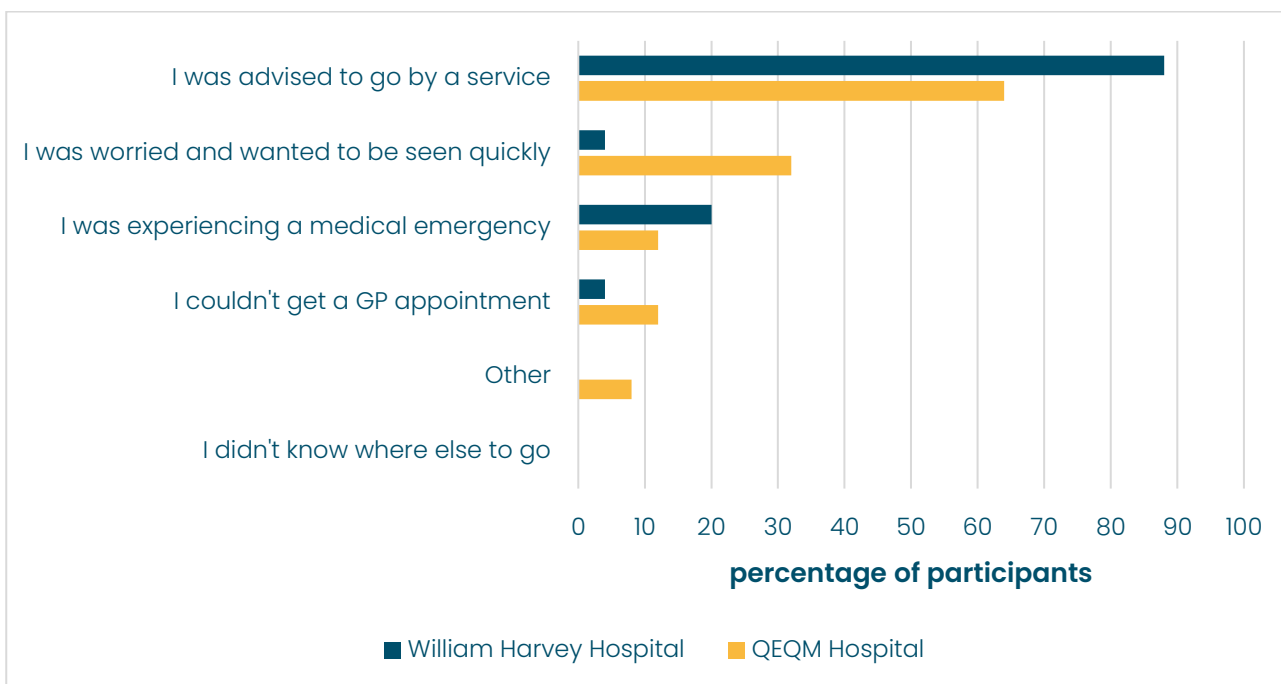


Figure 14: the percentage of participants by what led them to seek care at A&E, split by hospital.

Next, we asked participants to tell us what symptoms they were presenting before deciding to attend A&E. Participants could select multiple options from a predetermined list. The most common response was pain or infection (**62%**). The least common response was mental health issues (**2%**). The full range of responses is provided in *Figure 15*.

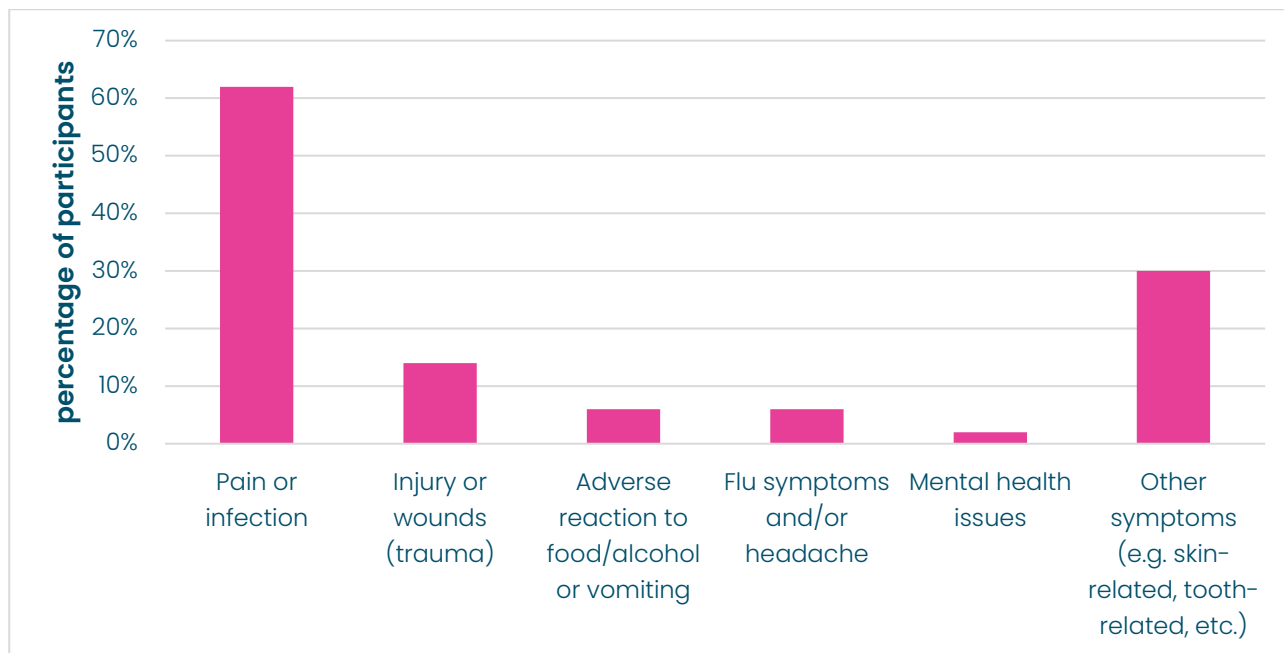


Figure 15: the percentage of participants by symptoms presented before deciding to attend A&E.

The responses from each hospital mostly presented marginal differences, however the number of participants that were experiencing pain or infection symptoms differed. **72%** of participants from William Harvey Hospital were experiencing pain or infection symptoms compared with **52%** of participants from QEQM Hospital. Responses by participants between the two hospitals is displayed in *Figure 16*.

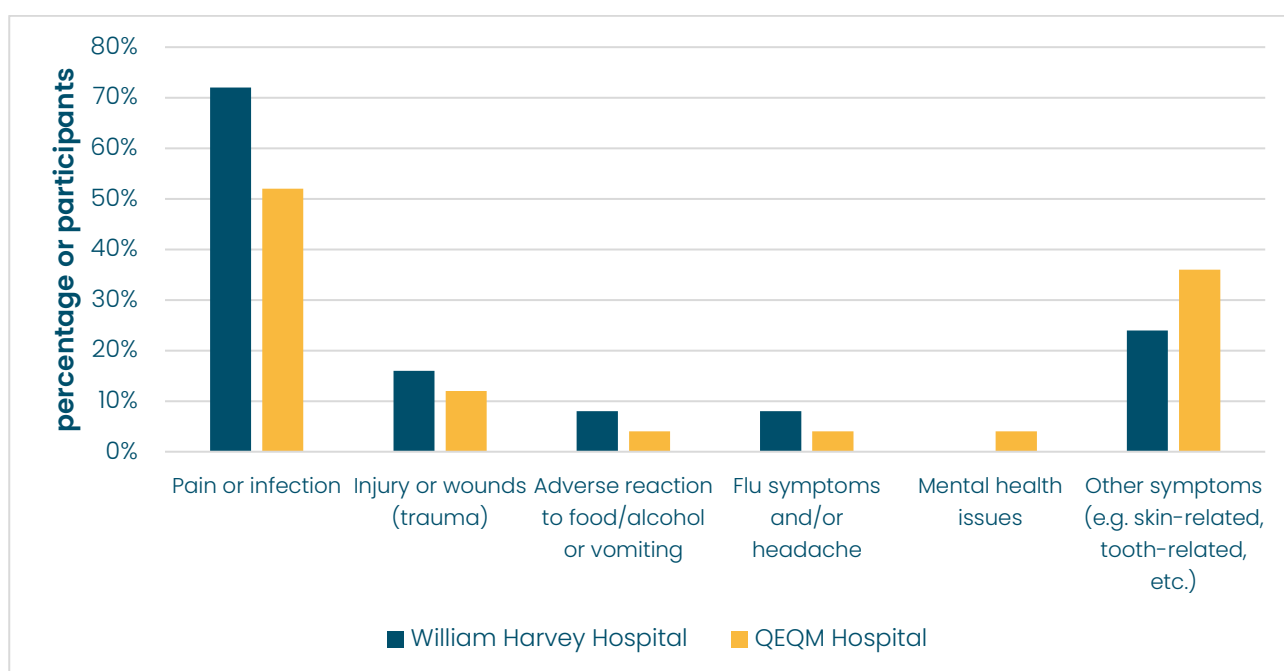


Figure 16: the percentage of participants by symptoms presented before deciding to attend A&E, split by hospital.

We then asked participants to tell us how long they had been experiencing these symptoms for. The most common response by participants was within the last 3–5 hours (**16%**). The least common response was within the last 3–4 months (**2%**). The average length of time participants had been experiencing symptoms for was 3–4 days. Additionally, **4%** of participants reported experiencing symptoms for between 1–3 years. **4%** of participants reported experiencing no symptoms before visiting A&E and **2%** of participants were unsure the length of time they had been experiencing symptoms for. The full range of responses is provided in *Figure 17*.

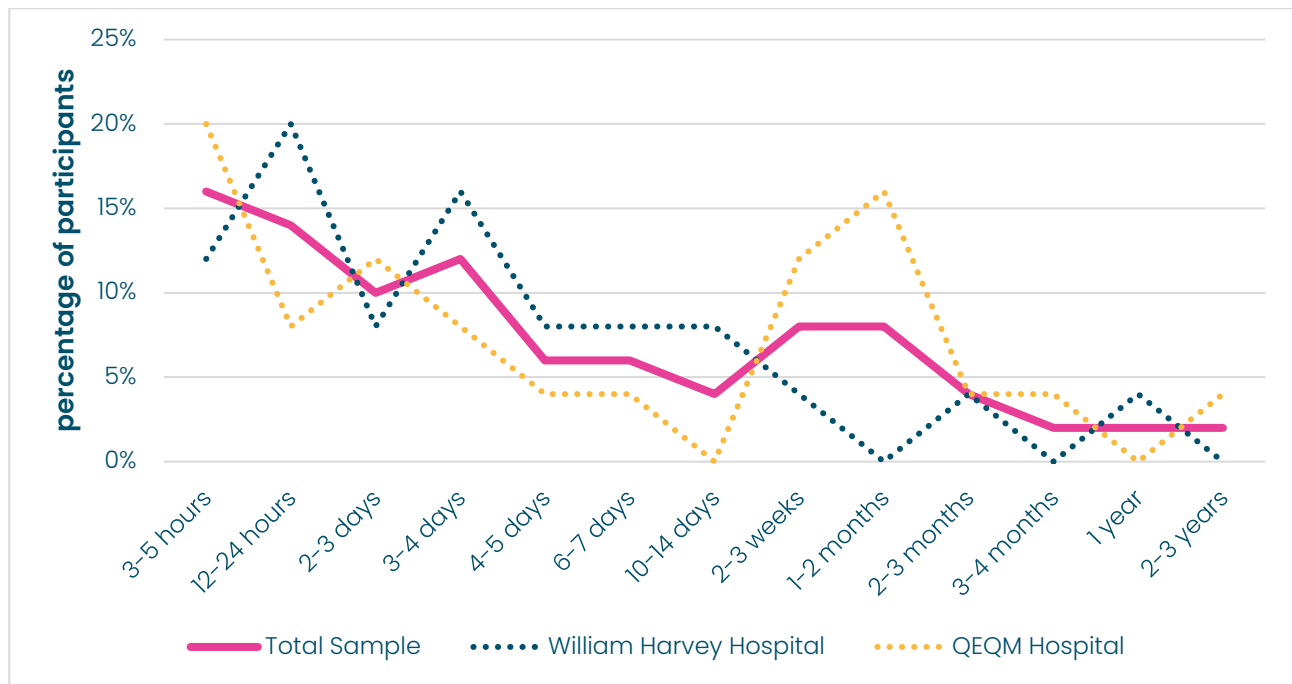


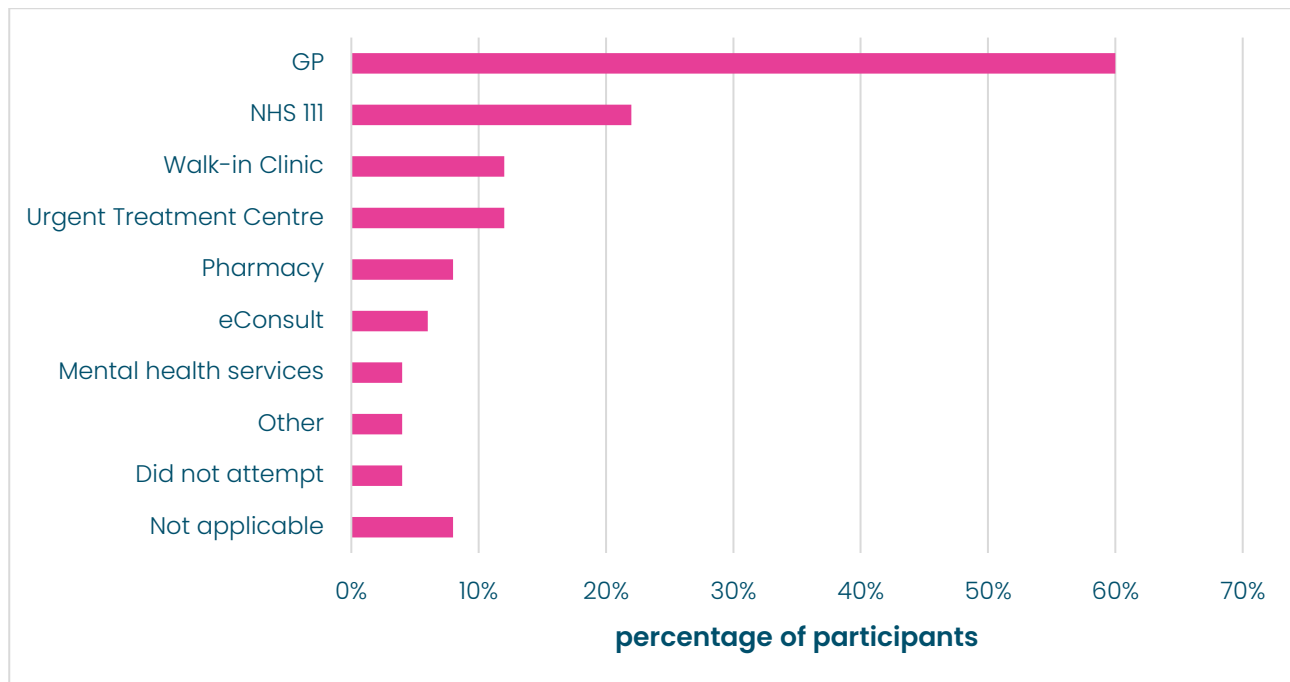
Figure 17: the percentage of participants by length of time experiencing symptoms, split by total sample and by hospital.

**30%** of all participants had been experiencing symptoms for up to 24 hours before attending A&E. **64%** of all participants had been experiencing symptoms for up to 1 week before attending A&E. And **30%** of all participants had been experiencing symptoms for 1 week or longer before attending A&E. Notably, **40%** of participants from QEQM Hospital had been experiencing symptoms for 1 week or longer before attending A&E compared with just **20%** of participants from William Harvey Hospital (see *Figure 18*).

Length of time	Total Sample	William Harvey Hospital	QEQM Hospital
0–24 hours	<b>30%</b>	<b>32%</b>	<b>28%</b>
Up to 1 week	<b>64%</b>	<b>72%</b>	<b>56%</b>
1 week or longer	<b>30%</b>	<b>20%</b>	<b>40%</b>
No symptoms	<b>4%</b>		
Unsure	<b>2%</b>		

Figure 18: the percentage of participants by length of time experiencing symptoms (grouped), split by hospital.

Next, we asked participants to tell us of any services that they attempted to get help from in the days before their A&E visit. Participants could select multiple options from a predetermined list. **88%** of participants reported attempting to access one or more services before visiting A&E. The most common response by participants was GP (**60%**). The least common response by participants was mental health services (**4%**). **4%** of participants did not attempt to visit another service before attending A&E and for **8%** of participants this was not applicable due to the nature of their visit to A&E. The full range of responses is provided in *Figure 19*.



*Figure 19: the percentage of participants by what services had been attempted to access before visiting A&E.*

Responses by participants from each hospital presented marginal differences, however the number of participants that reported attempting to access their GP before going to A&E differed. **68%** of participants from William Harvey Hospital reported attempting to access their GP before attending A&E compared with **52%** of participants from QEQM Hospital. Responses by participants between the two hospitals is displayed in *Figure 20*.

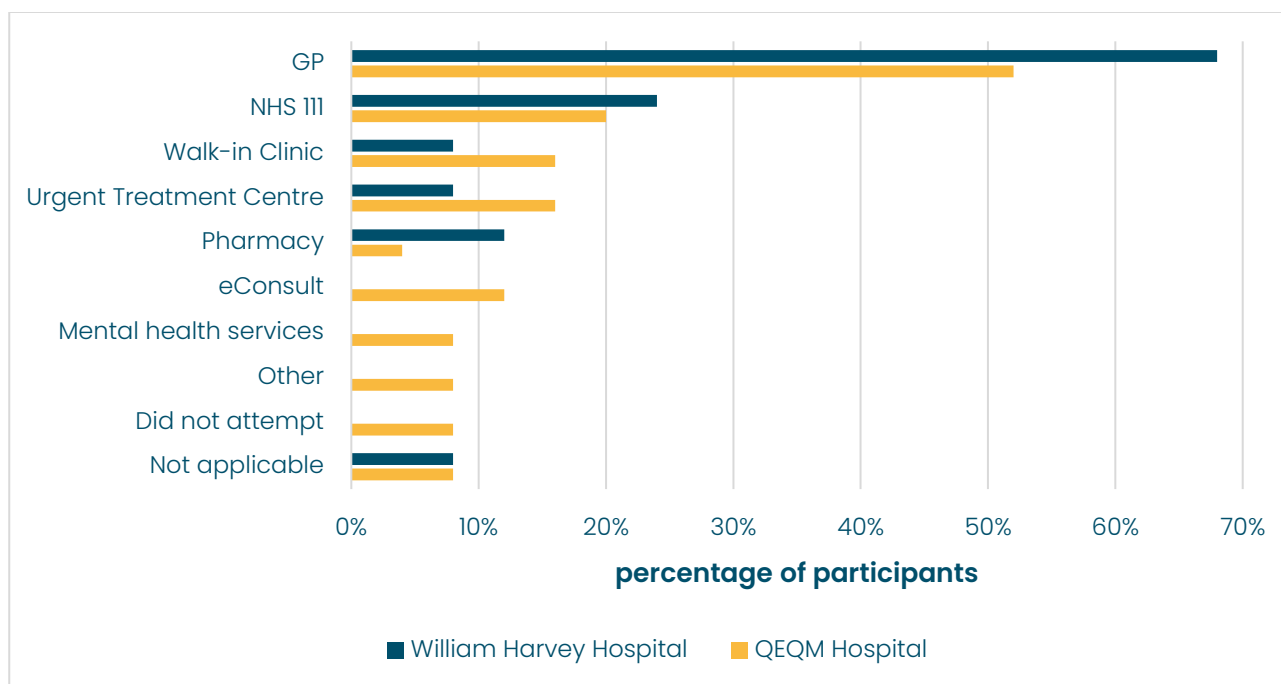


Figure 20: the percentage of participants by what services had been attempted to access before visiting A&E, split by hospital.

Finally, participants were asked to reflect on their visit to A&E and tell us whether they felt their visit could have been avoided if another service had been available or accessible. **32%** of participants responded that they felt their attendance was avoidable; **52%** of participants responded that they felt their attendance was unavoidable; **16%** of participants responded that they were unsure whether their attendance could have been avoided. Responses varied between the two hospitals (see Figure 21), with a larger proportion of participants from QEQM Hospital responding that they were unsure (**28%**) than William Harvey Hospital (**4%**).

Could the visit to A&E have been avoided?	Total Sample	William Harvey Hospital	QEQM Hospital
Yes	<b>32%</b>	<b>40%</b>	<b>24%</b>
No	<b>52%</b>	<b>56%</b>	<b>48%</b>
Unsure	<b>16%</b>	<b>4%</b>	<b>28%</b>

Figure 21: the percentage of participants by response to "do you feel that your visit to A&E could have been avoided if another service had been available or accessible", split by hospital.

Participants were asked to expand on their answers with rationale. Their responses were separated by answer ("Yes", "No" and "Unsure") and then themed into categories during the analysis of findings. Participants who answered "Yes" to the question mostly responded that their rationale was due to being advised to attend A&E by another service (**44%**). Similarly, participants who answered "No" to the question mostly responded that their rationale was due to being advised to attend A&E by another service (**46%**). And participants who answered "Unsure" to the question mostly responded that their rationale

was due to not being sure what else is available or that they had uncertainty in their medical needs (both at **38%**). Rationale for responses are provided in *Figures 22 – 27*.

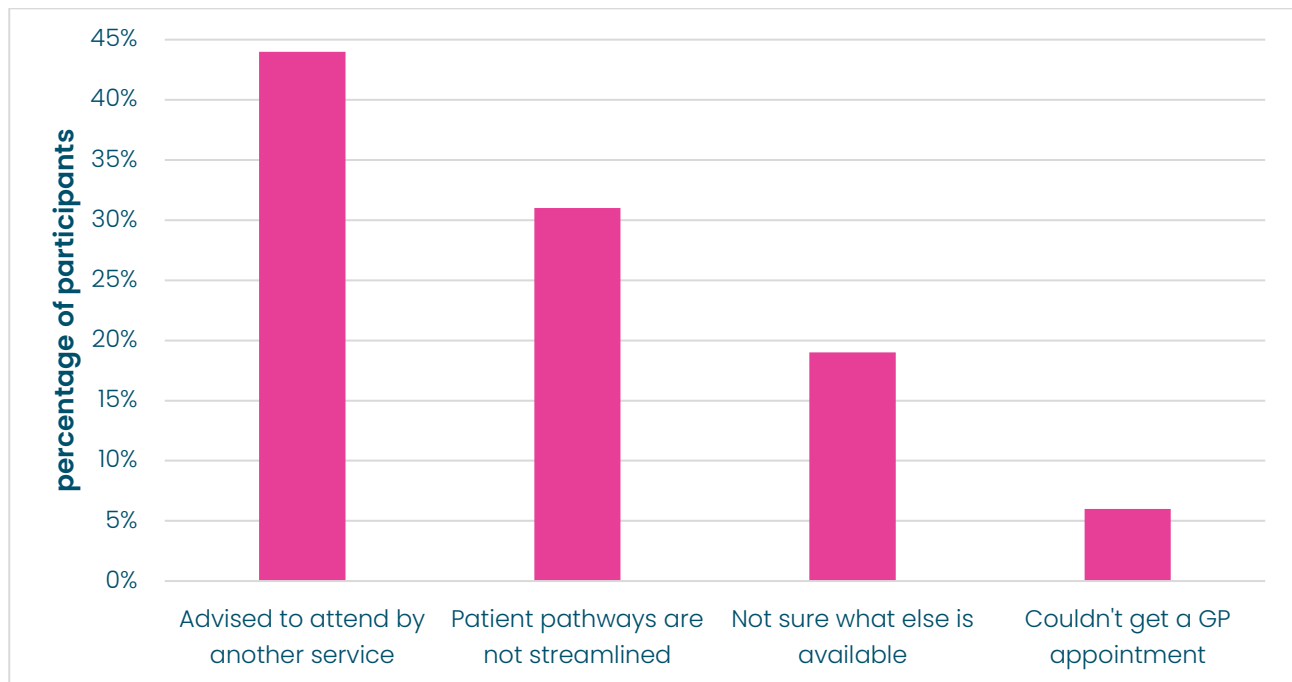


Figure 22: the percentage of participants by response "Yes" to "do you feel that your visit to A&E could have been avoided if another service had been available or accessible", split by theme.

<p><b>Advised to attend by another service (44%)</b></p> <p><i>"I'd been to another place, but it doesn't do emergencies. I went to my doctor first and then to another hospital...I would have been happy to have emergency treatments there if they had offered it. They don't, so they advised me to come here".</i></p>	<p><b>Patient pathways are not streamlined (31%)</b></p> <p><i>"If there was somewhere else I could get tests done, I'd prefer that. [The hospital] don't read notes as the doctor asked me why I'm here – that could have saved time and stressed me out going over it again. I get they're busy, but don't ask when the answers in front of you on the system. It just wastes time".</i></p>
<p><b>Not sure what else is available (19%)</b></p> <p><i>"I trust A&amp;E because I don't abuse the system...maybe if we had a walk-in service somewhere, that could be an alternative. Maybe that and knowing it's there".</i></p>	<p><b>Couldn't get a GP appointment (6%)</b></p> <p><i>"If I got through to [the GP], past the receptionists, I wouldn't be here. It would have saved everyone's time. It's terrible trying to get through. I tried this morning and it was busy all the time – they had to shut the phone lines down after twenty minutes".</i></p>

Figure 23: example quotations from participants by response "Yes" to "do you feel that your visit to A&E could have been avoided if another service had been available or accessible", split by theme.

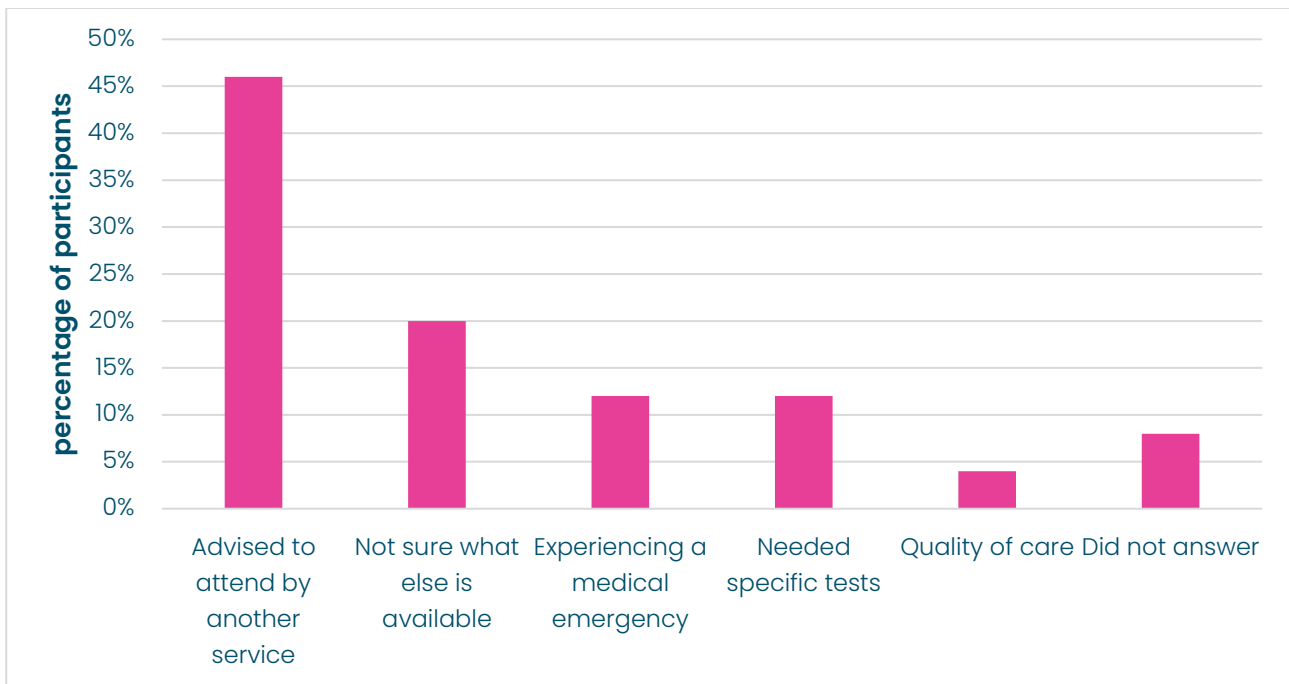


Figure 24: the percentage of participants by response "No" to "do you feel that your visit to A&E could have been avoided if another service had been available or accessible", split by theme.

<p><b>Advised to attend by another service (46%)</b></p> <p><i>"I feel better than yesterday, but [the UTC] took my bloods and said something is up...so they said to me to come to A&amp;E to get it checked".</i></p>	<p><b>Not sure what else is available (20%)</b></p> <p><i>"I can't think of what else would take its place".</i></p> <p><i>"I don't think there is anywhere else I could've gone".</i></p>
<p><b>Experiencing a medical emergency (12%)</b></p> <p><i>"The pain is so bad – I needed help".</i></p> <p><i>"I had pain since last night and have done something about it".</i></p>	<p><b>Needed specific tests (12%)</b></p> <p><i>"Ultimately, the GP doesn't have the equipment to do the scans so [I] had to come here. It's almost an hour's drive to the [walk-in clinic] and it almost crippled me just doing the short drive here".</i></p>
<p><b>Quality of care (4%)</b></p> <p><i>"They really look after me. They're a godsend. I'm going to really give them a token of my appreciation. [The staff] are brilliant".</i></p>	<p><b>Did not answer (8%)</b></p>

Figure 25: example quotations from participants by response "No" to "do you feel that your visit to A&E could have been avoided if another service had been available or accessible", split by theme.



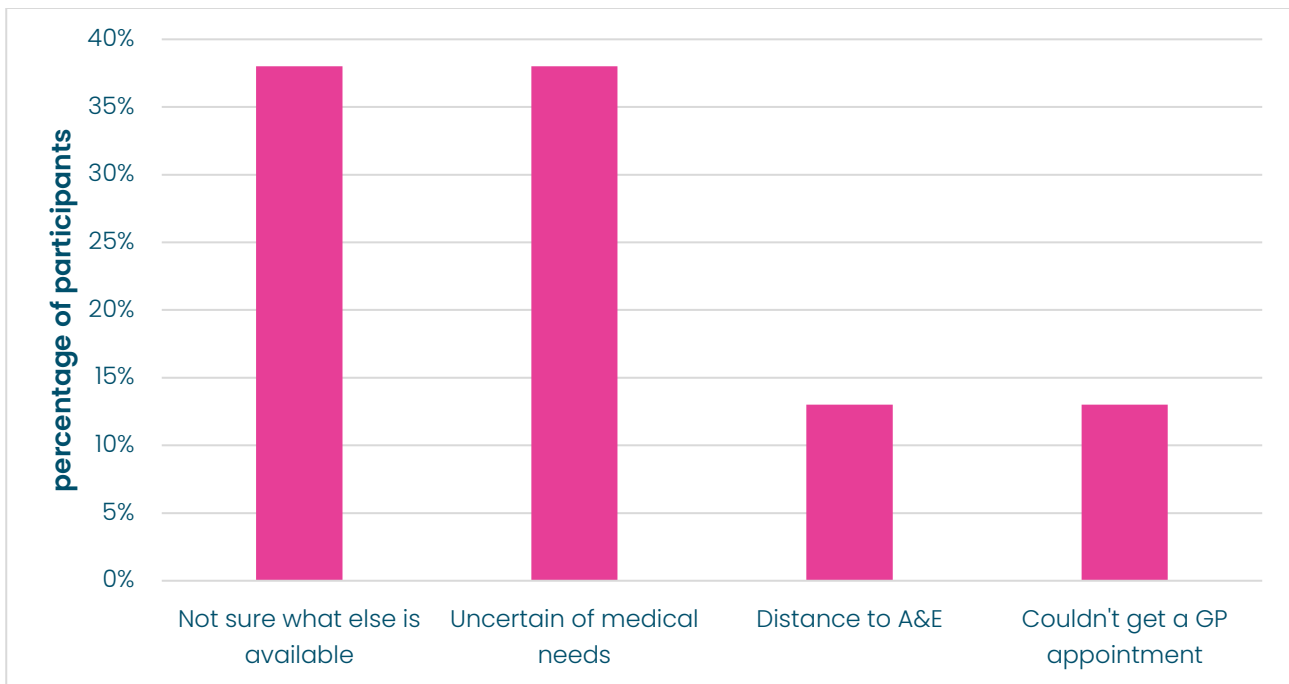


Figure 26: the percentage of participants by response "Unsure" to "do you feel that your visit to A&E could have been avoided if another service had been available or accessible", split by theme.

<p><b>Not sure what else is available (38%)</b></p> <p><i>"I don't know what's accessible or available".</i></p> <p><i>"I came for blood tests to rule out something more serious. Not sure if I could do at the doctors or not".</i></p>	<p><b>Uncertain of medical needs (38%)</b></p> <p><i>"I passed out momentarily, so UTC said I had to come here...something that A&amp;E had to check".</i></p>
<p><b>Distance to A&amp;E (13%)</b></p> <p><i>"Maybe if there was an A&amp;E nearer...I had to go on a bus. Was quite impressed with the bus as it took me right outside the door here and I just had to walk in, perfect".</i></p>	<p><b>Couldn't get a GP appointment (13%)</b></p> <p><i>"If I could have gotten a GP appointment, I would have gone as it is really close by to where I live. But the GP is limited to what it can do and the appointments it can offer".</i></p>

Figure 27: example quotations from participants by response "Unsure" to "do you feel that your visit to A&E could have been avoided if another service had been available or accessible", split by theme.

The theme of "not sure what else is available" was the only response to cut across all response types ("Yes", "No" and "Unsure") and accounted for **22%** of all responses from the total participant sample. This indicates that one in five participants felt that the avoidability of attending A&E was dependent upon their own knowledge of what other services were available or accessible.

## Deprivation and Urban/Rural Areas

**76%** of participants provided us with their postcode information which allowed us to examine deprivation levels and urban/rural status. Deprivation level was calculated using GOV.UK's indices of multiple deprivation mapping tool (see: [GOV.UK, 2019](#)). And urban/rural status was calculated using ONS Geography's rural urban classification (RUC) mapping tool (see: [ONS Geography, 2025](#)).

Participants in our study were predominantly from urban areas (**64%**) and areas of higher overall deprivation (**42%**). **16%** of all participants were from postcode areas that fall within the top 20% most deprived parts of England and Wales. Conversely, **12%** of participants were from rural areas, of whom none were from postcode areas that fall within the top 20% most deprived parts of England and Wales. Overall, **6%** of participants were from postcode areas that fall within the top 20% least deprived parts of England and Wales. The full range of participants by area of deprivation and urban/rural status is provided in *Figure 28*.

	Total Sample			Urban ( <b>64%</b> )			Rural ( <b>12%</b> )		
10% most deprived	6%	<b>16%</b>	<b>42%</b>	9%	<b>25%</b>	<b>59%</b>	0%	<b>0%</b>	<b>33%</b>
20%	10%			16%			0%		
30%	6%	<b>12%</b>		6%	<b>16%</b>		17%	<b>17%</b>	
40%	6%			9%			0%		
50%	14%	<b>16%</b>		19%	<b>19%</b>		17%	<b>33%</b>	
50%	2%		0%	17%					
40%	12%	<b>26%</b>	<b>34%</b>	19%	<b>34%</b>	0%	<b>33%</b>	<b>67%</b>	
30%	14%			16%		33%			
20%	2%			0%		17%			
10% least deprived	4%	<b>6%</b>		6%	<b>6%</b>	0%	<b>17%</b>		
N/A	<b>24%</b>								

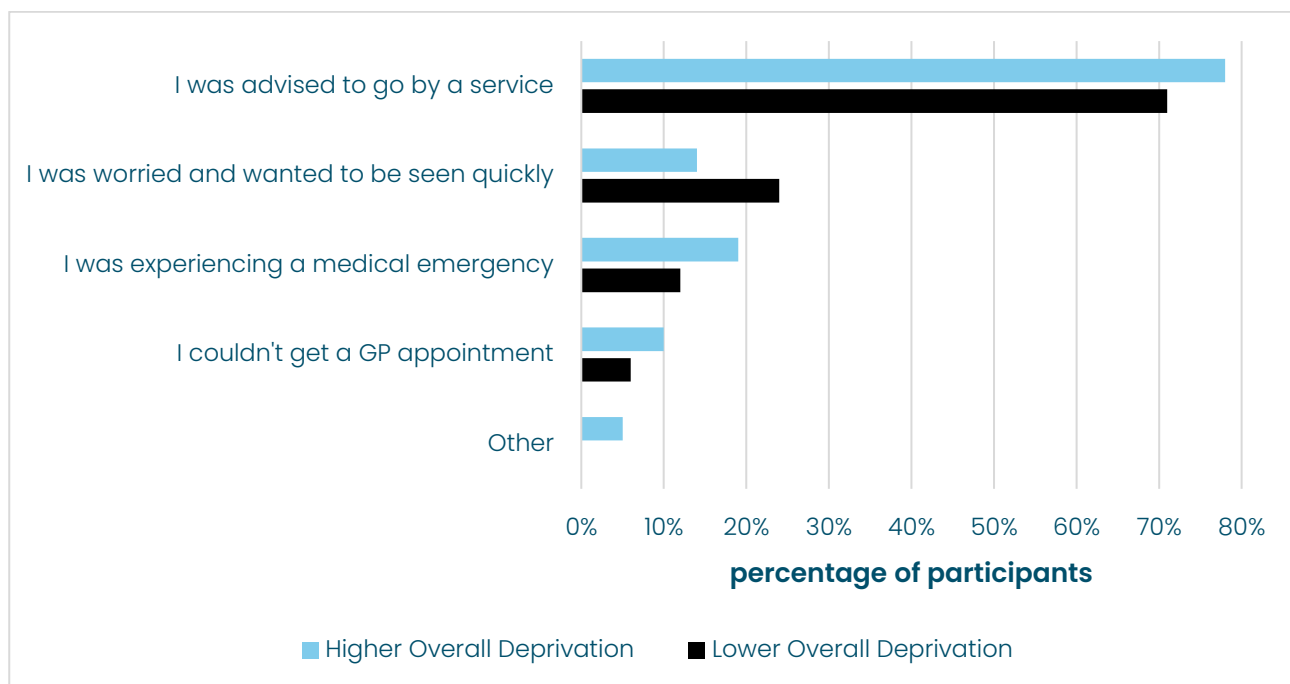
Figure 28: the percentage of participants by deprivation levels, urban classification, and rural classification.

Whilst our sample is not proportionally representative to people of the East Kent area attending A&E, the data collected across this sample shows that more people from urban areas are attending A&E than from rural areas. Multiple factors could contribute towards this, including variables that we did not measure during this study, such as the distances participants live in relation to their local emergency department or the quality of care participants perceive to be offered by different health services.

## Area of Overall Deprivation

**42%** of participants were from areas of higher overall deprivation, the majority of whom were from Thanet (**16%**). **34%** of participants were from areas of lower overall deprivation, the majority of whom were from Canterbury (**10%**).

When asking participants to reflect on their visit to A&E and tell us what led them to seek care there, participants from areas of higher overall deprivation were more likely to have been advised to visit by another service, to have gone to A&E because they were experiencing a medical emergency, and to have been unable to get a GP appointment than participants from areas of lower overall deprivation. Conversely, participants from areas of lower overall deprivation were more likely to have attended A&E because they were worried and wanted to be seen quickly than participants from areas of higher overall deprivation. The full range of responses by area of overall deprivation is displayed in *Figure 29*.



*Figure 29: the percentage of participants by what led them to seek care at A&E, split by area of overall deprivation.*

Participants from areas of lower overall deprivation were more likely to have been advised to attend A&E by their GP, by pharmacies and by UTCs than participants from areas of higher overall deprivation. Conversely, participants from areas of higher overall deprivation were more likely to have been advised to attend A&E by NHS 111, hospital wards and walk-in clinics than participants from areas of lower overall deprivation. The full range of responses by area of overall deprivation is displayed in *Figure 30*.

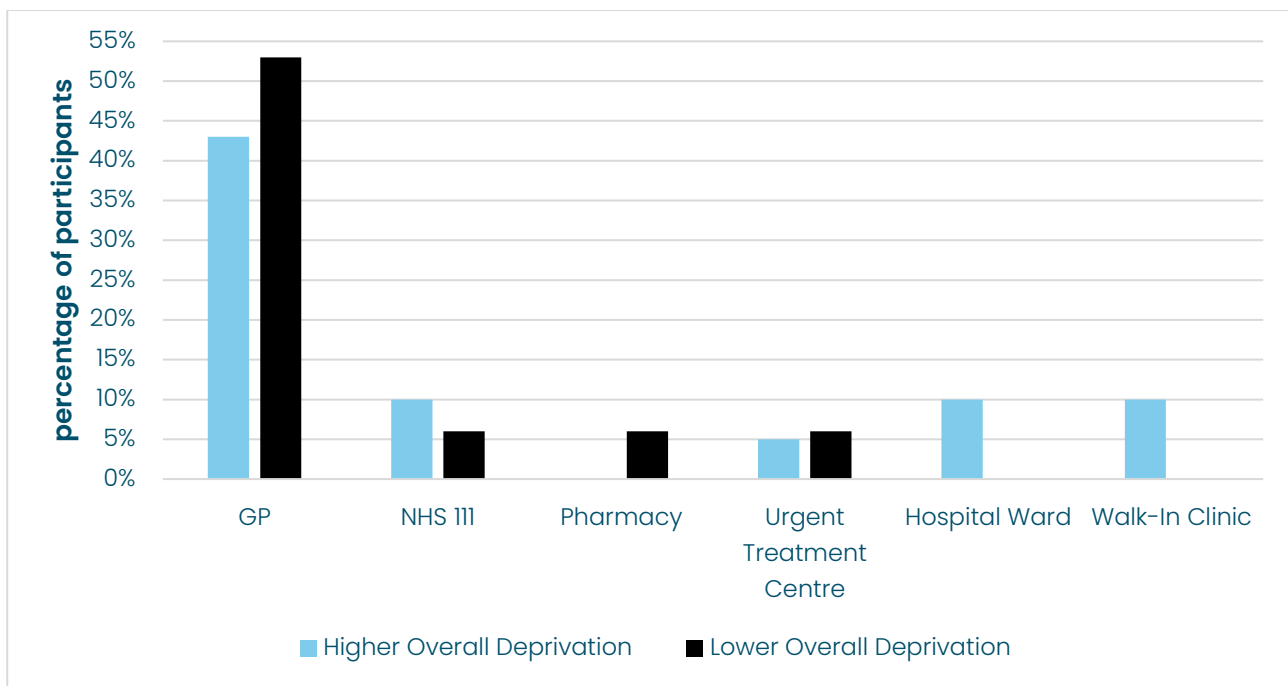


Figure 30: the percentage of responses to "I was advised to go by a service" by service type, split by area of overall deprivation.

When asking participants to tell us which services they had attempted to get help from in the days before their A&E visit, participants from areas of lower overall deprivation were more likely to have attempted to access their GP, walk-in clinics and mental health services before attending A&E than participants from areas of higher overall deprivation. Conversely, participants from areas of higher overall deprivation were more likely to have attempted to access NHS 111, UTCs, pharmacies and eConsult before attending A&E than participants from areas of lower overall deprivation.

Only participants from areas of higher overall deprivation responded that they did not attempt to access any other services before attending A&E. In addition, participants from areas of higher overall deprivation were more likely to respond that accessing another service beforehand was not applicable to their A&E attendance. The full range of responses by area of overall deprivation is displayed in *Figure 31*.

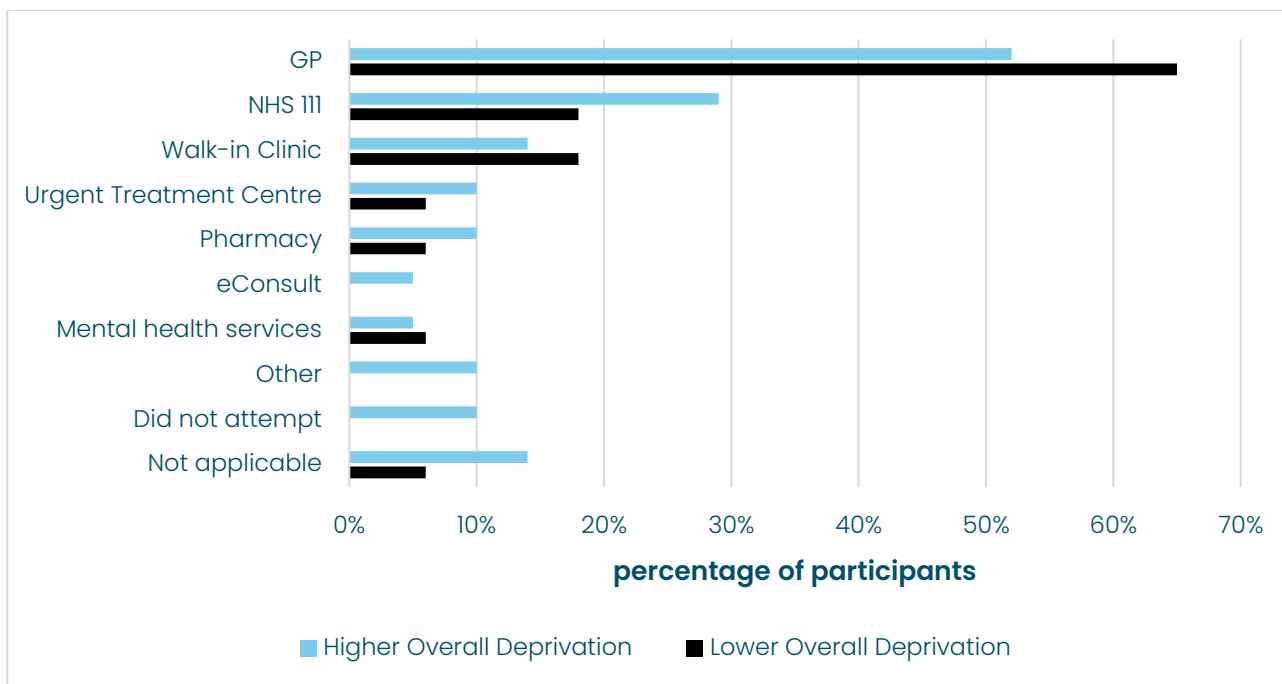


Figure 31: the percentage of participants by what services had been attempted to access before visiting A&E, split by area of overall deprivation.

Finally, when asking participants to reflect on their visit to A&E and tell us whether they thought their visit could have been avoided if another service had been available or accessible, participants from areas of lower overall deprivation were more likely to think that their attendance was avoidable than participants from areas of higher overall deprivation. More participants from areas of higher overall deprivation thought that their attendance was unavoidable or were unsure whether their attendance could have been avoided than participants from areas of lower overall deprivation. The full range of responses by area of overall deprivation is displayed in Figure 32.

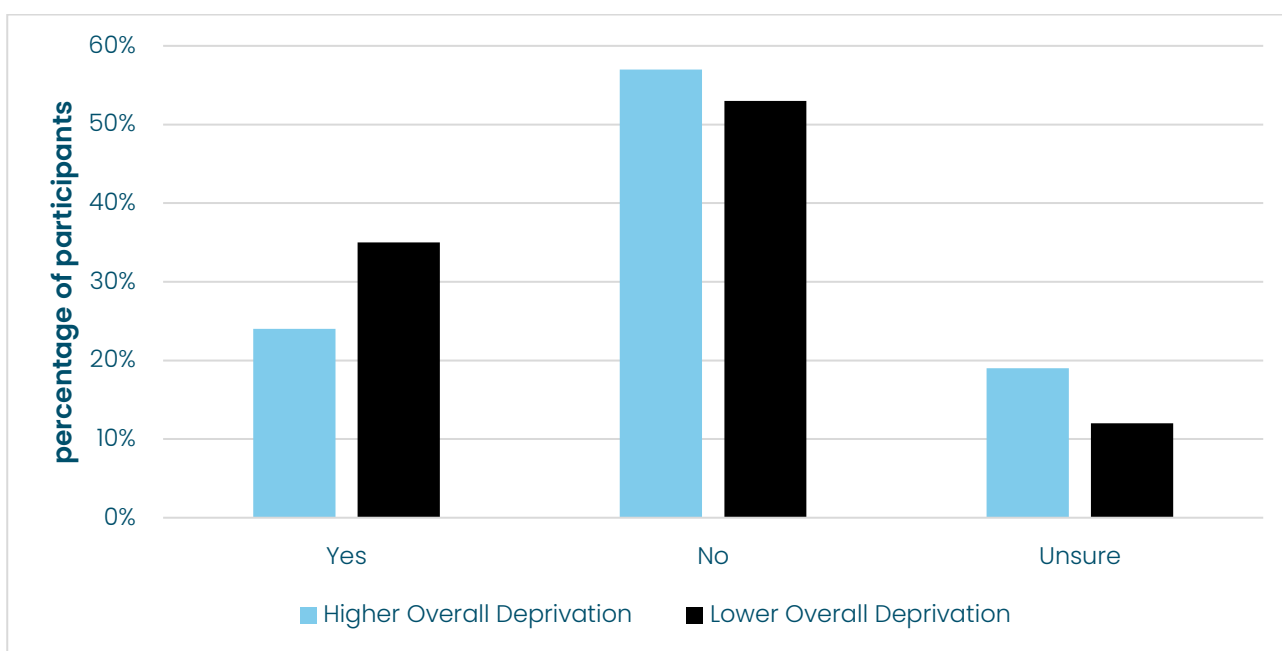
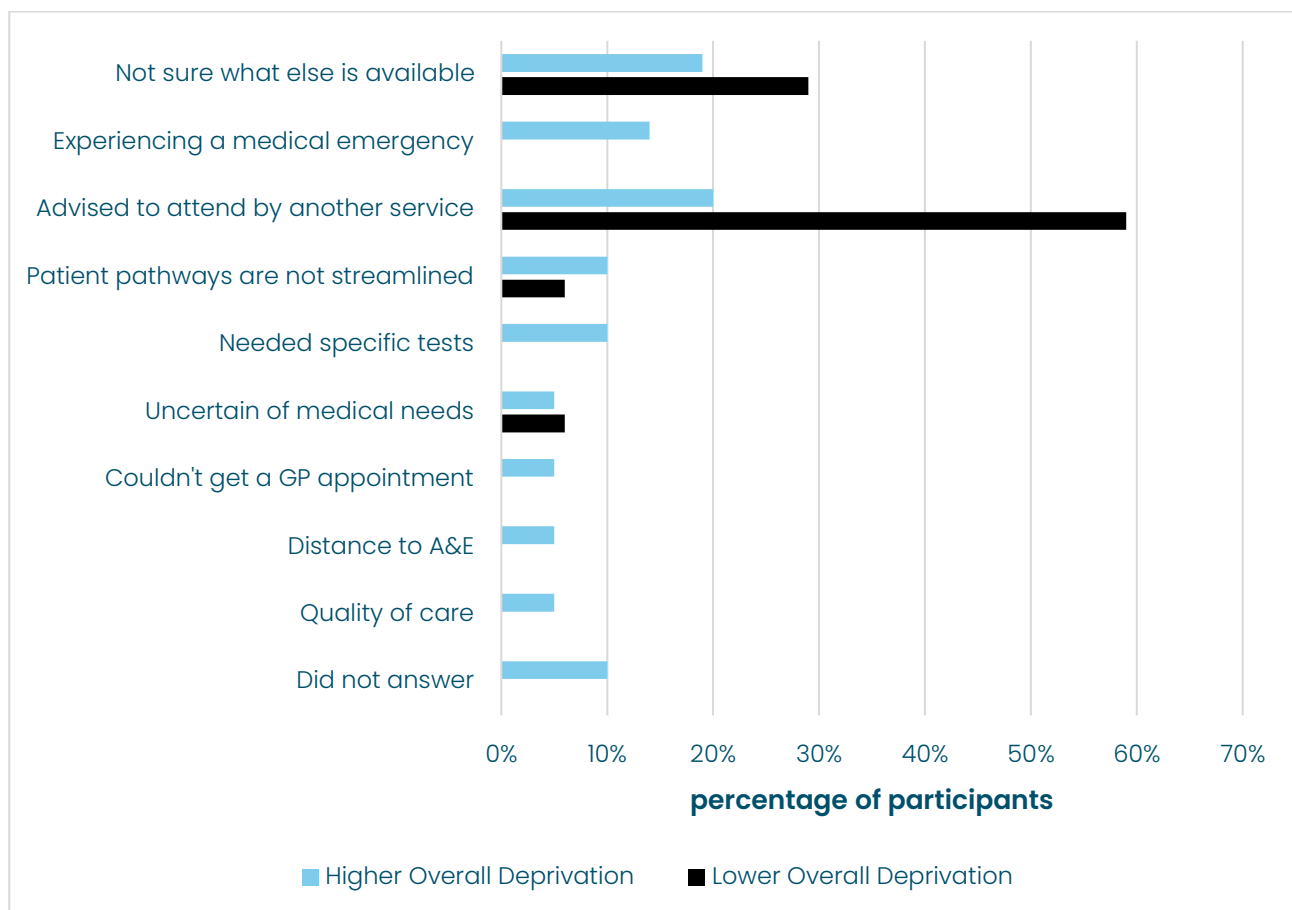


Figure 32: the percentage of participants by response to "do you feel that your visit to A&E could have been avoided if another service had been available or accessible", split by area of overall deprivation.

When participants expanded upon their rationale, there was a difference in the number of participants that believed the avoidability of their A&E visit was drawn from having been advised to attend by another service. Participants from areas of lower overall deprivation were more likely to think that the avoidability of their attendance was due to this than participants from areas of higher overall deprivation. Similarly, more participants from areas of lower overall deprivation thought that the avoidability of their attendance was due to being unsure of what else was available for them to access than participants from areas of higher overall deprivation.

Participants from areas of higher overall deprivation were more likely to think that the avoidability of their A&E visit was due to whether they were experiencing a medical emergency, how efficient their A&E department was, whether they needed specific tests to be completed, whether they were able to get a GP appointment, how far their A&E department was from them and what the quality of care they received at A&E was like. The full range of responses by area of overall deprivation is displayed in *Figure 33*.

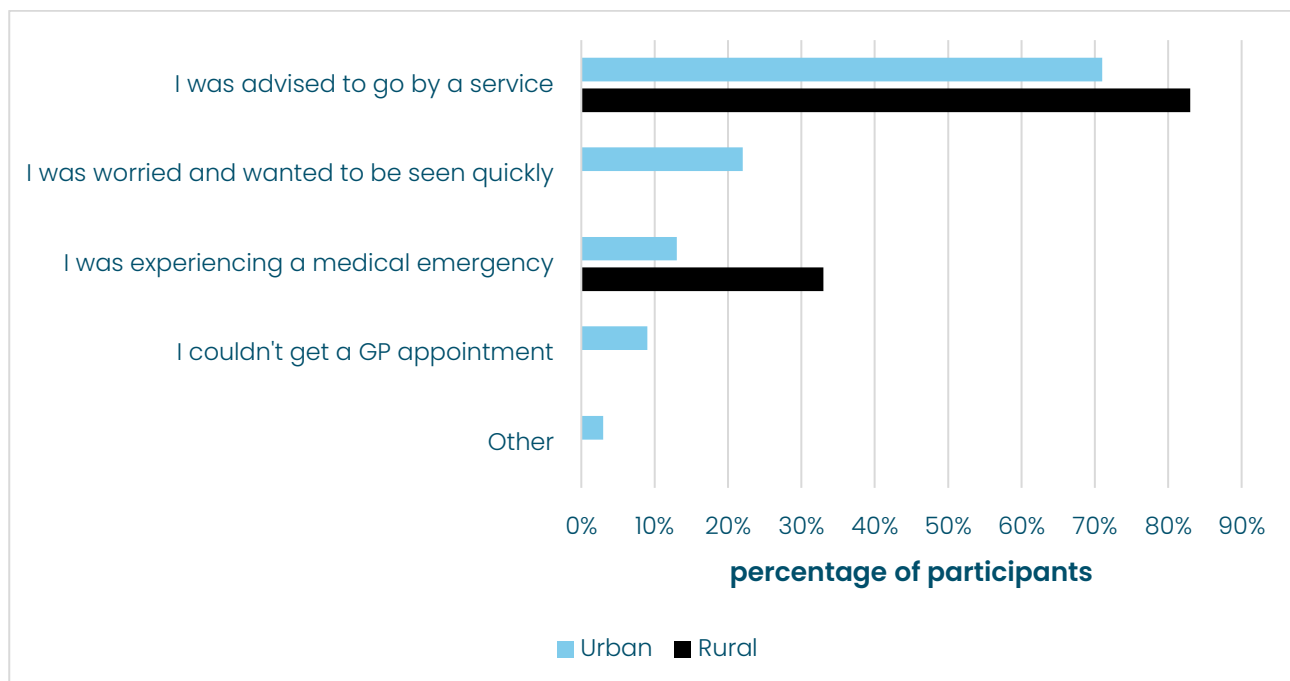


*Figure 33: the percentage of participants by theme for "do you feel that your visit to A&E could have been avoided if another service had been available or accessible", split by area of overall deprivation.*

## Urban/Rural Area

**64%** of participants were from urban areas, the majority of whom were from Thanet (**20%**). **12%** of participants were from rural areas, with **4%** from Ashford, **4%** from Dover and **4%** from Folkestone & Hythe.

When asking participants to reflect on their visit to A&E and tell us what led them to seek care there, participants from rural areas were more likely to have been advised to visit by another service and to have to have gone to A&E because they were experiencing a medical emergency than participants from urban areas. Conversely, participants from urban areas were more likely to have gone to A&E because they were worried and wanted to be seen quickly and to have been unable to get a GP appointment than participants from rural areas. The full range of responses by urban/rural area is displayed in *Figure 34*.



*Figure 34: the percentage of participants by what led them to seek care at A&E, split by urban/rural area.*

Participants from rural areas were more likely to have been advised to attend A&E by their GP than participants from urban areas. This was also the only service that advised participants from rural areas to attend A&E. Participants from urban areas were more likely to have been advised to attend A&E by a range of different services, including GPs, NHS 111, pharmacies, UTCs, hospital wards and walk-in clinics. The full range of responses by urban/rural area is displayed in *Figure 35*.

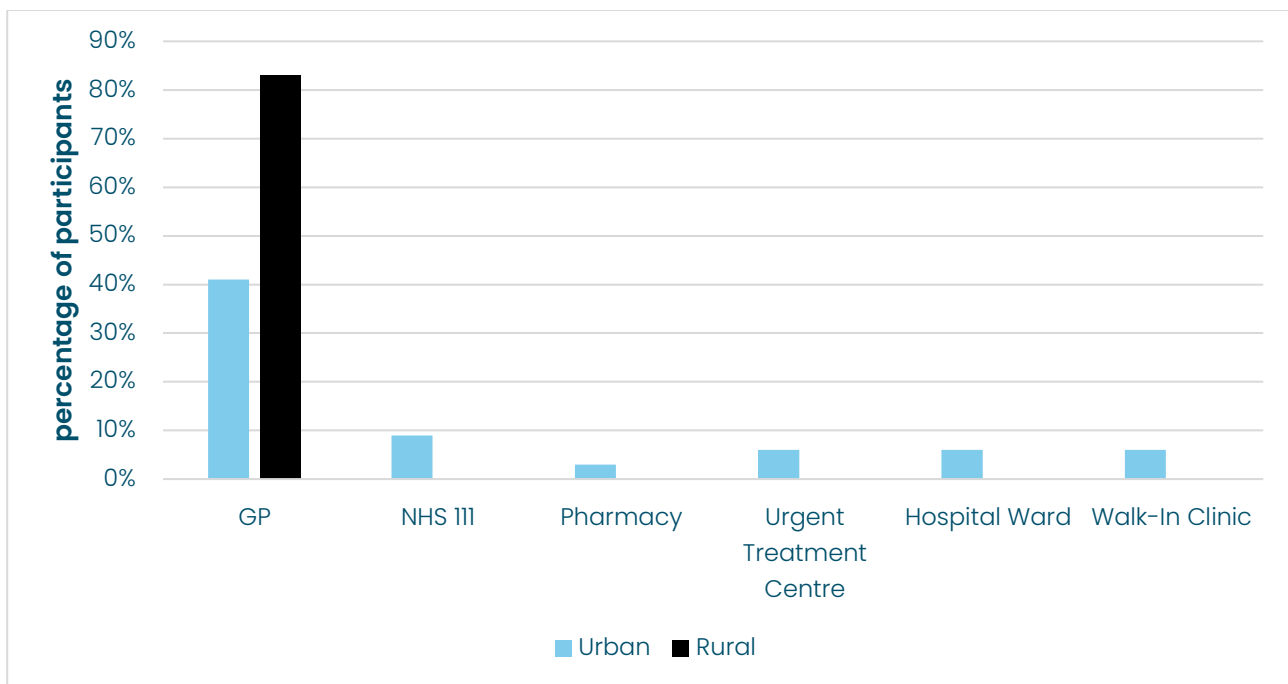


Figure 35: the percentage of responses to "I was advised to go by a service" by service type, split by urban/rural area.

When asking participants to tell us which services they had attempted to get help from in the days before their A&E visit, participants from rural areas were more likely to have attempted to access their GP than participants from urban areas. Conversely, participants from urban areas were more likely to have attempted to access NHS 111, walk-in clinics, UTCs, pharmacies, eConsult and mental health services than participants from rural areas.

Only participants from urban areas responded that they did not attempt to access any other services before attending A&E. In addition, participants from rural areas were more likely to respond that accessing another service beforehand was not applicable to their A&E attendance. The full range of responses by urban/rural area is displayed in Figure 36.



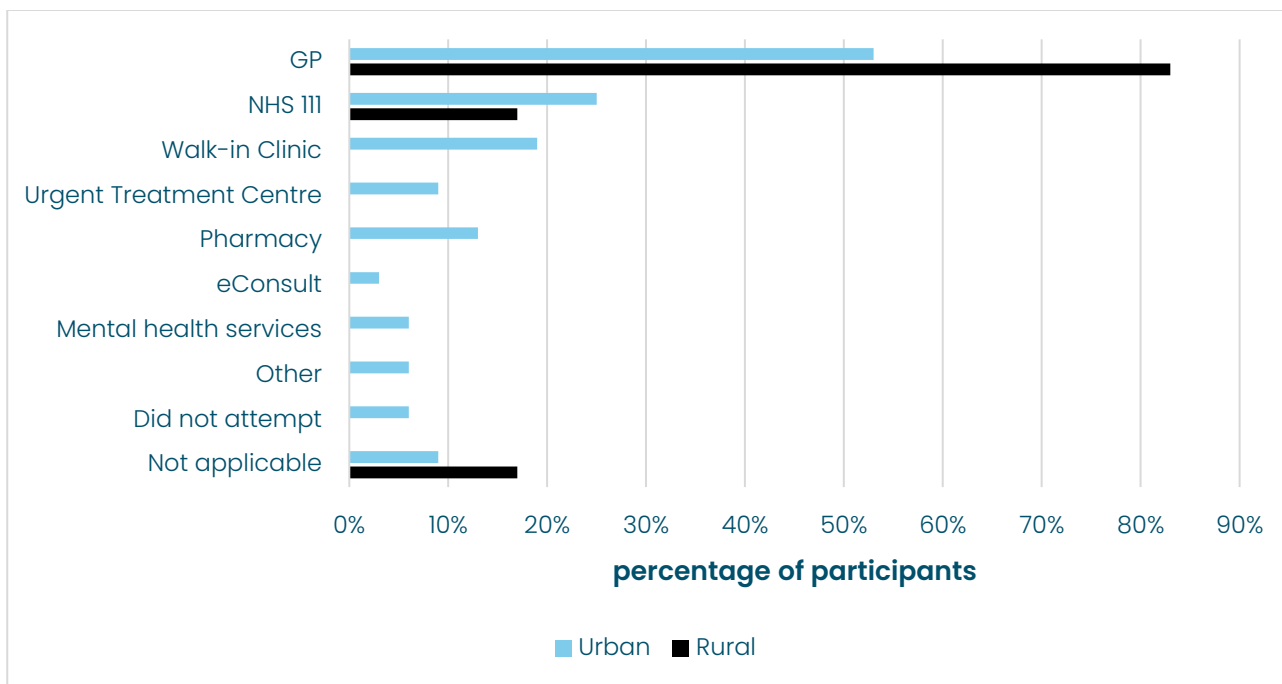


Figure 36: the percentage of participants by what services had been attempted to access before visiting A&E, split by urban/rural area.

Finally, when asking participants to reflect on their visit to A&E and tell us whether they thought their visit could have been avoided if another service had been available or accessible, participants from rural areas were more likely to think that their attendance was avoidable than participants from urban areas. None of the participants from rural areas were unsure whether their attendance could have been avoided. The full range of responses by urban/rural area is displayed in Figure 37.

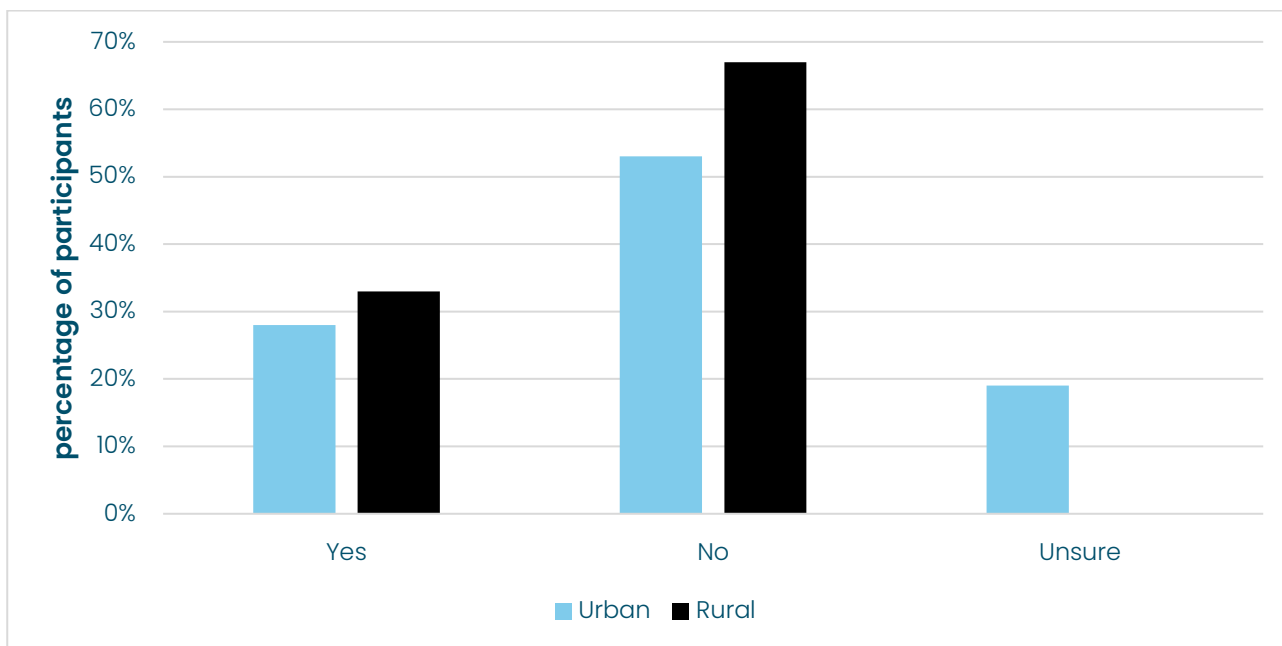
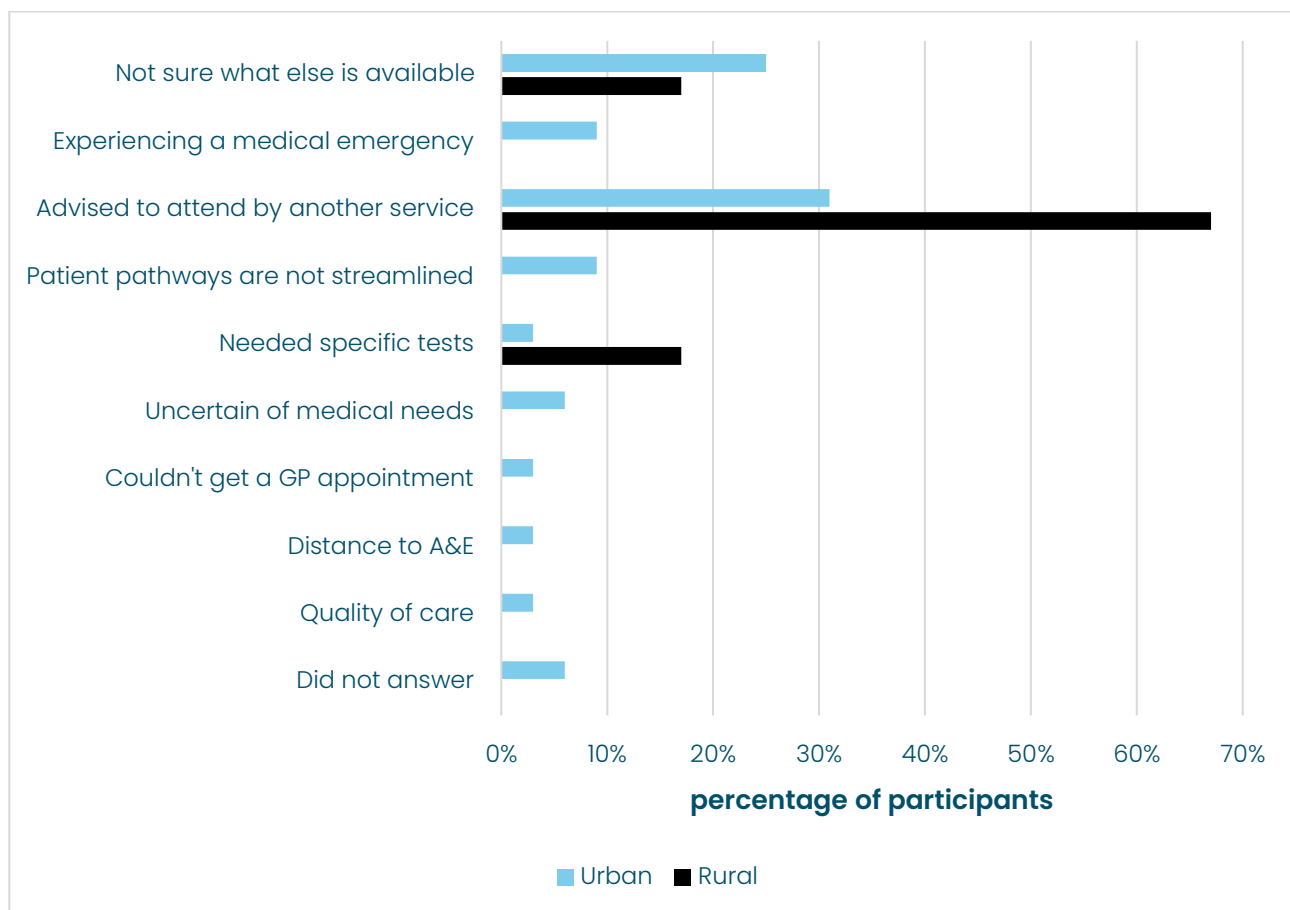


Figure 37: the percentage of participants by response to "do you feel that your visit to A&E could have been avoided if another service had been available or accessible", split by urban/rural area.

When participants expanded upon their rationale, **67%** of those from rural areas put their justification down to having been advised to attend A&E by another service compared to just **31%** of those from urban areas. Similarly, there was a difference in the number of participants from rural areas who put their justification down to needing specific tests (**17%**) compared to those from urban areas (**3%**).

Participants from urban areas were more likely to think that the avoidability of their A&E visit was due to not knowing what else was available for them to access than participants from rural areas. Participants from urban areas were also more likely to think that the avoidability of their A&E visit was due to whether they were experiencing a medical emergency, how efficient their A&E department was, whether there was uncertainty of medical needs, whether they were able to get a GP appointment, how far their A&E department was from them and what the quality of care they received at A&E was like. The full range of responses by area of overall deprivation is displayed in *Figure 38*.



*Figure 38: the percentage of participants by theme for "do you feel that your visit to A&E could have been avoided if another service had been available or accessible", split by urban/rural area.*

## Conclusion

This report set out to explore the drivers behind A&E attendances at the William Harvey Hospital in Ashford and the Queen Elizabeth The Queen Mother (QEQM) Hospital in Margate by capturing the experiences of 50 participants. Against a backdrop of rising pressures on emergency departments nationally and regional reviews into Urgent Treatment Centres (UTCs), this study contributes to the growing body of research that challenges simplified assumptions about “inappropriate” A&E use.

National data has highlighted a persistent and worsening strain on emergency services, with increased admissions and rising waiting times now commonplace. This study reaffirms those systemic challenges from a patient perspective. Most notably, almost three-quarters of participants (**74%**) were advised to attend A&E by another health service, with GPs cited as the most frequent referrer. This finding adds weight to prior research (see: [O’Cathain et al., 2014](#); [Hull et al., 2018](#)) suggesting that A&E attendances are often not influenced by individual choice alone, but rather a system that funnels patients towards emergency departments due to limited alternatives or constrained service capacity elsewhere.

Despite national concerns around inappropriate A&E use, only a small proportion of participants (**8%**) cited difficulty accessing a GP appointment as the reason for their attendance. Additionally, no participants selected the option “I didn’t know where else to go”, countering the narrative that A&E is used as a default due to poor health literacy. Instead, a recurring theme across all participants – regardless of whether they considered their A&E visit to be avoidable – was uncertainty about what services were available and accessible to them (“not sure what else is available”). This knowledge gap was also present across participants from urban and rural areas and areas of differing deprivation levels, highlighting the importance of clear service navigation and public awareness as part of system-wide solutions.

Participants from urban and higher overall deprivation areas were overrepresented in the sample, however they were more likely to report uncertainty in the avoidability of their A&E visits. Participants from rural and lower overall deprivation areas were more likely to report redirection to A&E by another service and that their attendances to A&E were avoidable (in comparison to participants from urban and higher overall deprivation areas). These insights align with the wider national literature showing that structural inequalities (particularly socioeconomic deprivation) are key determinants towards A&E attendance (see: [Scantlebury et al., 2015](#); [Calastri et al., 2025](#)).

In total, almost one-third of participants (**32%**) believed their A&E visit could have been avoided, while half considered it unavoidable (**52%**) and a further **16%** were unsure. These findings reflect a nuanced and layered decision-making process that participants appeared to adopt when reflecting on the avoidability of their A&E attendance that was often demonstrated in their responses to stem from a fragmented system where service pathways are unclear or lacking the appropriate capabilities.

This study calls attention to the need for improved clarity of service availability, accessibility and appropriateness outside of emergency departments; to the need for more responsive and integrated primary care alternatives that reduce patient redirection; and for a wider strategic focus on deprivation and urban/rural status in relation to emergency service uptake. Future service planning that addresses these systemic barriers could ensure that emergency departments reduce the number of avoidable attendances and ensure A&E remains a safety net for unavoidable emergencies.

# Learnings & Insights

While these insights are only based on a small and non-representative sample of participants from across the William Harvey Hospital and the Queen Elizabeth the Queen Mother (QEQM) Hospital, the following broad recommendations are proposed to support two of the three shifts outlined in the 10 Year Health Plan for England ([GOV.UK, 2025](https://www.gov.uk/government/consultations/10-year-health-plan-for-england)) – the shift from hospital to community care; and the shift from analogue to digital:

## 1) Consider targeting the public's awareness of community health and preventative care alternatives.

- An emergent theme was that participants were “not sure what else is available” as an alternative support service to attending A&E. This informed many participants reflections on their perceived avoidability of their A&E attendances.
- A reduction to avoidable attendances could be supported by focusing additional attention into communicating or campaigning the types of community health services and preventative care alternatives that people can access instead of A&E.
- Further research into the services that people do or do not already know about could be required to design communications campaigns around which services for which medical needs. Giving people targeted information on what service, where is it, how to access it, when is it available, and why it should be utilised could be beneficial to emphasis the breadth of options available in community health services.
- Alternatively, it may be preferable to put efforts into strengthening the offer of helping the public navigate to the most appropriate place.

## 2) Consider broadening the strategic focus on deprivation and urban/rural status in relation to A&E attendance.

- These findings contribute towards wider national data identifying links between socioeconomic deprivation and A&E attendances and urban/rural status and A&E attendances.
- Further research into how socioeconomic deprivation and urban/rural status affects A&E attendances could be beneficial if further associations can be identified.
- Dedicating strategic focus to these links could contribute towards a deeper understanding of the social and environmental factors contributing towards A&E attendance rates.

### 3) Consider reviewing the protocols in place for GPs referring patients to A&E.

- Further research into the high levels of GPs advising participants to attend A&E could be supported through conducting a review of GP and primary care referral patterns (both formal and informal) within the East Kent system and looking to standardise referral thresholds to ensure consistent decision-making.
- Explore the possibility of direct referrals from practices and the impact this would have.
- **66%** of participants were advised to attend A&E by their GP and many participants described being redirected after already engaging with services, leading to duplications and avoidable instances.

## Acknowledgments

Healthwatch Kent would like to acknowledge and thank all those who took the time to participate in interviews and share their experiences for this research. Their contributions are both warmly received and greatly appreciated.

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## References

- British Medical Association (2025) *NHS backlog data analysis*. [Internet Source] Available: <<https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/nhs-backlog-data-analysis>>. Last accessed: 16.06.2025.
- Calastri, C., Buckell, J. & Crastes dit Sourd, R. (2025) Avoidable visits to UK emergency departments from the patient perspective: A recursive bivariate probit approach. *Health Policy*. (154). DOI: [10.1016/j.healthpol.2025.105265](https://doi.org/10.1016/j.healthpol.2025.105265).
- Cowling, T.E., Cecil, E.V., Soljak, M.A., Lee, J.T., Millett, C., Majeed, A., Wachter, R.M. & Harris, M.J. (2013) Access to Primary Care and Visits to Emergency Departments in England: A Cross-Sectional, Population-Based Study. *PLOS ONE*. (8:6). DOI: [10.1371/journal.pone.0066699](https://doi.org/10.1371/journal.pone.0066699).
- Deeny, S., Gardner, T., Al-Zaidy, S., Barker, I. & Steventon, A. (2017) *Briefing: Reducing hospital admissions by improving continuity of care in general practice*. [Internet Source] Available: <<https://www.health.org.uk/sites/default/files/ReducingAdmissionsGPContinuity.pdf>>. Last accessed: 16.06.2025.
- Dolton, P. & Pathania, V. (2016) Can increased primary care access reduce demand for emergency care? Evidence from England's 7-day GP opening. *Journal of Health Economics*. (49) pp193–208. DOI: [10.1016/j.jhealeco.2016.05.002](https://doi.org/10.1016/j.jhealeco.2016.05.002).
- GOV.UK (2019) *Indices of Deprivation: 2019 and 2015*. [Internet Source] Available: <[https://dclgapps.communities.gov.uk/imd/iod\\_index.html#](https://dclgapps.communities.gov.uk/imd/iod_index.html#)>. Last accessed: 26.06.2025.
- GOV.UK (2025) *Fit For The Future: 10 Year Health Plan for England*. [Internet Source] Available: <<https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future>>. Last accessed: 09.07.2025.
- Higgins, J.P.T., Morgan, R.L., Rooney, A.A., Taylor, K.W., Thayer, K.A., Raquel, A., Silva, R.A., Courtney-Lemeris, C., Aki, E.A., Bateson, T.F., Berkman, N.D., Glenn, B.S., Hróbjartsson, A., LaKind, J.S., McAleenan, A., Meerpohl, J.J., Nachman, R.M., Obbagy, J.E., O'Connor, A., Radke, E.G., Savović, J., Schünemann, H.J., Shea, B., Tilling, K., Verbeek, J., Viswanathan, M. & Sterne, J.A.C. (2024) A tool to assess risk of bias in non-randomized follow-up studies of exposure effects (ROBINS-E). *Environment International*. DOI: [10.1016/j.envint.2024.108602](https://doi.org/10.1016/j.envint.2024.108602).
- Hull, S., Homer, K., Boomla, K., Robson, J. & Ashworth, M. (2018) Population and patient factors affecting emergency department attendance in London: retrospective cohort



- analysis of linked primary and secondary care records. *British Journal of General Practice*. pp157-167. DOI: [10.3399/bjgp18X694397](https://doi.org/10.3399/bjgp18X694397).
- Hunter, C., Chew-Graham, C., Langer, S., Stenhoff, A., Drinkwater, J., Guthrie, E. & Salmon, P. (2013) A qualitative study of patient choices in using emergency health care for long-term conditions: The importance of candidacy and recursivity. *Patient Education and Counselling*. (93) pp335-341. DOI: [10.1016/j.pec.2013.06.001](https://doi.org/10.1016/j.pec.2013.06.001).
- Huntley, A., Lasserson, D., Wye, L., Morris, R., Checkland, K., England, H., Salisbury, C. & Purdy, S. (2014) Which features of primary care affect unscheduled secondary care use? A systematic review. *BMJ Open*. (4:5). DOI: [10.1136/bmjopen-2013-004746](https://doi.org/10.1136/bmjopen-2013-004746).
- Ismail, S.A., Gibbons, D.C. & Gnani, S. (2013) Reducing inappropriate accident and emergency department attendances: a systematic review of primary care service interventions. *British Journal of General Practice*. (63:617) pp813-820. DOI: [10.3399/bjgp13x675395](https://doi.org/10.3399/bjgp13x675395).
- NHS Kent and Medway (2025) *East Kent Urgent Treatment Centres Engagement Report*. [Internet Source] Available: <<https://www.haveyoursayinkentandmedway.co.uk/east-kent-urgent-treatment-centres>>. Last accessed: 01.07.2025.
- O’Cathain, A., Knowles, E., Turner, J., Maheswaran, R., Goodacre, S., Hirst, E. & Nicholl, J. (2014) Explaining variation in emergency admissions: a mixed-methods study of emergency and urgent care systems. *National Institute for Health and Care Research*. (2:48). DOI: [10.3310/hsdr02480](https://doi.org/10.3310/hsdr02480).
- ONS Geography (2025) *Web map for Rural Urban Classification (RUC) of Lower layer Super Output Areas (LSOAs), England and Wales, 2021*. [Internet Source] Available: <<https://geoportal.statistics.gov.uk/maps/d33a519fe4064de4b6b6ea41d5e284b3/explore?location=51.352933%2C1.185874%2C10.07>>. Last accessed: 26.06.2025.
- Rudge, G.M., Mohammed, M.A., Fillingham, S.C., Girling, A., Sidhu, K. & Stevens, A.J. (2013) The Combined Influence of Distance and Neighbourhood Deprivation on Emergency Department Attendance in a Large English Population: A Retrospective Database Study. *PLOS ONE*. (8:7). DOI: [10.1371/journal.pone.0067943](https://doi.org/10.1371/journal.pone.0067943).
- Scantlebury, R., Rowlands, G., Durbaba, S., Schofield, P., Sidhu, K. & Ashworth, M. (2015) Socioeconomic deprivation and accident and emergency attendances: cross-sectional analysis of general practices in England. *British Journal of General Practice*. (65:639) pp649-654. DOI: [10.3399/bjgp15X686893](https://doi.org/10.3399/bjgp15X686893).
- Tammes, P., Purdy, S., Salisbury, C., MacKichan, F., Lasserson, D. & Morris, R.W. (2017) Continuity of Primary Care and Emergency Hospital Admissions Among Older

Patients in England. *Annals of Family Medicine*. (15:6) pp515-522. DOI: [10.1370/afm.2136](https://doi.org/10.1370/afm.2136).

The King's Fund (2024) *What's going on with A&E waiting times?* [Internet Source] Available: <<https://www.kingsfund.org.uk/insight-and-analysis/long-reads/whats-going-on-with-ae-waiting-times>>. Last accessed: 16.06.2025.

# Appendices

## Appendix A – Conversational Framework

### A&E Attendances – Conversational Framework

- 1) Thinking about your visit to A&E, what led you to seek care there? (tick multiple)
  - I was experiencing a medical emergency
  - I didn't know where else to go
  - I couldn't get a GP appointment
  - I was advised to go (e.g. eConsult, NHS 111, GP, friend/family)
  - Please specify: \_\_\_\_\_
  - I was worried and wanted to be seen quickly
  - Other (please specify): \_\_\_\_\_
  
- 2) What symptoms were you presenting before deciding to attend A&E? (tick multiple)
  - Pain or infection
  - Injury or wounds (trauma)
  - Adverse reaction to food/alcohol or vomiting
  - Flu symptoms and/or headache
  - Mental health issues
  - Other symptoms (e.g. skin-related, tooth-related): (please specify)  
\_\_\_\_\_
  
- 3) How long had you been experiencing symptoms for? (free text field)  
\_\_\_\_\_
  
- 4) In the days before your A&E visit, did you try to get help from any other service? (tick multiple)
  - GP
  - NHS 111
  - eConsult
  - Pharmacy
  - Mental health service
  - Didn't try to get help elsewhere
  - Other (please specify): \_\_\_\_\_
  - Not applicable
  
- 5) Do you feel that your visit to A&E could have been avoided if another service had been available or accessible? (tick one)
  - Yes
  - No
  - Not sure

Why? \_\_\_\_\_

6) Is there anything else you would like to share about your A&E experience or how services could be improved?

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\*Space for any additional information shared\*

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## Appendix B – Demographic Questions

<p><b>Which district do you live in?</b></p> <p><input type="checkbox"/> Ashford  <input type="checkbox"/> Canterbury  <input type="checkbox"/> Dartford  <input type="checkbox"/> Dover  <input type="checkbox"/> Folkestone and Hythe  <input type="checkbox"/> Gravesham  <input type="checkbox"/> Maidstone  <input type="checkbox"/> Medway  <input type="checkbox"/> Sevenoaks  <input type="checkbox"/> Swale  <input type="checkbox"/> Swanley  <input type="checkbox"/> Thanet  <input type="checkbox"/> Tonbridge and Malling  <input type="checkbox"/> Tunbridge Wells  <input type="checkbox"/> None of the above                  Specified: _____  <input type="checkbox"/> Prefer not to say</p>	<p><b>Do any of these apply to you?</b> <input type="checkbox"/> Prefer not to say </p> <p><u>Disability</u>  <input type="checkbox"/> Yes <input type="checkbox"/> No Specified: _____  <u>Mental health issue</u>  <input type="checkbox"/> Yes <input type="checkbox"/> No Specified: _____  <u>Long-term health condition</u>  <input type="checkbox"/> Yes <input type="checkbox"/> No Specified: _____  <u>Neurodiversity</u>  <input type="checkbox"/> Yes <input type="checkbox"/> No Specified: _____</p>
<p><b>What is your postcode?</b></p> <p>_____</p> <p><input type="checkbox"/> Prefer not to say</p>	<p><b>What age group are you in?</b></p> <p><input type="checkbox"/> 0-9      <input type="checkbox"/> 45-54  <input type="checkbox"/> 10-17    <input type="checkbox"/> 55-64  <input type="checkbox"/> 18-24    <input type="checkbox"/> 65-74  <input type="checkbox"/> 25-34    <input type="checkbox"/> 75-84  <input type="checkbox"/> are you 25? <input type="checkbox"/> 85-94  <input type="checkbox"/> 35-44    <input type="checkbox"/> 95+  <input type="checkbox"/> prefer not to say</p>
<p><b>How would you describe your gender?</b></p> <p><input type="checkbox"/> Female  <input type="checkbox"/> Male  <input type="checkbox"/> Non-binary  <input type="checkbox"/> Prefer to self-describe:                  _____  <input type="checkbox"/> Prefer not to say</p>	<p><b>Ethnicity</b></p> <p><u>Asian/Asian British</u>  <input type="checkbox"/> Asian British  <input type="checkbox"/> Bangladeshi  <input type="checkbox"/> Indian  <input type="checkbox"/> Nepalese  <input type="checkbox"/> Pakistani  <input type="checkbox"/> Any other Asian/Asian British background:                  _____</p> <p><u>Black/African/Caribbean/Black British</u>  <input type="checkbox"/> Black British  <input type="checkbox"/> African  <input type="checkbox"/> Caribbean  <input type="checkbox"/> Any other Black/Black British background:                  _____</p> <p><u>Mixed/multiple ethnic group</u>  <input type="checkbox"/> White &amp; Asian  <input type="checkbox"/> White &amp; Black African  <input type="checkbox"/> White &amp; Black Caribbean  <input type="checkbox"/> Any other mixed/multiple ethnic background:                  _____</p> <p><u>Other ethnic group</u>  <input type="checkbox"/> Arab  <input type="checkbox"/> Any other ethnic group:                  _____</p> <p><u>White</u>  <input type="checkbox"/> White British  <input type="checkbox"/> Gypsy or Irish Traveller  <input type="checkbox"/> Irish  <input type="checkbox"/> Roma  <input type="checkbox"/> Any other White/White British background:                  _____  <input type="checkbox"/> Prefer not to say</p>
<p><b>Is your gender identity the same as your sex recorded at birth?</b></p> <p><input type="checkbox"/> Yes  <input type="checkbox"/> No  <input type="checkbox"/> Prefer not to say</p>	<p><b>Do you consider any of these to be a disability?</b></p> <p><input type="checkbox"/> Mental Health  <input type="checkbox"/> Long Term condition  <input type="checkbox"/> Neurodiversity</p>
<p><b>What is your sexual orientation?</b></p> <p><input type="checkbox"/> Heterosexual or straight  <input type="checkbox"/> Gay or lesbian  <input type="checkbox"/> Bisexual  <input type="checkbox"/> Pansexual  <input type="checkbox"/> Asexual  <input type="checkbox"/> Queer  <input type="checkbox"/> Prefer to self-describe:                  _____  <input type="checkbox"/> Prefer not to say</p>	<p><b>Are you currently homeless or at risk of becoming homeless in the near future?</b></p> <p><input type="checkbox"/> Currently homeless  <input type="checkbox"/> At risk of becoming homeless in the near future  <input type="checkbox"/> No  <input type="checkbox"/> Other  <input type="checkbox"/> Not sure  <input type="checkbox"/> Prefer not to say</p>
<p><b>What is your employment status?</b></p> <p>_____</p> <p><input type="checkbox"/> Prefer not to say</p>	<p><b>In the past six months, have you struggled to pay for basic necessities?</b></p> <p><input type="checkbox"/> Never  <input type="checkbox"/> Rarely  <input type="checkbox"/> Sometimes  <input type="checkbox"/> Often  <input type="checkbox"/> Always  <input type="checkbox"/> Don't know  <input type="checkbox"/> Prefer not to say</p>
<p><b>Are you a carer for another person?</b></p> <p><input type="checkbox"/> Yes  <input type="checkbox"/> No  <input type="checkbox"/> Not sure  <input type="checkbox"/> Prefer not to say</p>	<p><b>Is English your first language?</b></p> <p><input type="checkbox"/> Yes  <input type="checkbox"/> British Sign Language (BSL)  <input type="checkbox"/> No                  Please specify:                  _____  <input type="checkbox"/> Prefer not to say</p>
<p><b>What is your present religion, if any?</b></p> <p>_____</p> <p><input type="checkbox"/> Prefer not to say</p>	<p><b>Are you a refugee, asylum seeker or migrant?</b></p> <p><input type="checkbox"/> Yes  <input type="checkbox"/> No  <input type="checkbox"/> Not sure  <input type="checkbox"/> Prefer not to say</p>
<p><b>What is your highest level of education?</b></p> <p>_____</p> <p><input type="checkbox"/> Prefer not to say</p>	<p><b>What is your highest level of education?</b></p> <p>_____</p> <p><input type="checkbox"/> Prefer not to say</p>

# If you would like to chat with us about the report you can reach us through the following routes:

**healthwatch**  
Kent



**Online:**

[www.healthwatchkent.co.uk](http://www.healthwatchkent.co.uk)

**Have  
your  
say**



**By Telephone:**

Healthwatch Kent Freephone  
0808 801 01 02



**By Email:**

[info@healthwatchkent.co.uk](mailto:info@healthwatchkent.co.uk)

**Talk  
to us...**



**By Text:**

Text us on 07525 861 639. By texting 'NEED BSL', Healthwatch's British Sign Language interpreter will make contact and arrange a time to meet face-to-face

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