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NHS Patient Survey Programme

2017 Adult Inpatient Survey

Statistical release

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Contents

Summary of findings

The 2017 adult inpatient survey received feedback from 72,778 patients who received inpatient care in an NHS hospital during July 2017. The report shows that many aspects of patient experience have remained relatively stable overall since 2009, though there have been some improvements across certain areas. However, patients' experiences of information and discharge from hospital remain poor.

Adult inpatients can be admitted to hospital either as emergency patients, where there has been an accident or a sudden deterioration in physical health, or as elective patients, where admission has been planned in advance. The adult inpatient survey asks patients who have been admitted to an NHS hospital about the quality of their experience as an inpatient, covering issues such as communication with staff and involvement in their care, privacy and experience of hospital discharge.

Gradual improvements over time are most evident for questions about interactions and relationships between staff and patients, including quality of communication between staff and patients, and confidence and trust in doctors and nurses. Communication around the operations and procedures patients undergo also appears to be an area that has improved over time.

Results have stagnated for questions asking about: noise at night on wards, emotional support while in hospital, information around new medications prescribed before leaving hospital and information about care post discharge (the latter remaining the weakest aspect of inpatient experience).

We analysed results to check for differences in patient experience between different groups of patients. As found in results for the 2016 survey, patients with a mental health condition consistently reported poorer experiences while being cared for as inpatients. This continues a trend found in other NHS Patient Surveys covering experiences of patients using accident and emergency (A&E) services and young inpatients.[1,2] This year, younger patients were also more negative about most aspects of their care, including feeling they were treated with respect and dignity, as were patients with dementia or Alzheimer's disease.

Improvements over time

Over time, there have been consistent improvements for a set of questions focusing on how well doctors and nurses cared for patients. A higher proportion of patients said they 'always' had confidence in nurses this year (78% in 2017 compared with 72% in 2009, with an increase of one percentage point since 2016) and doctors (80% in 2017 compared with 78% in 2009). Fewer patients in 2017 told us that doctors had spoken in front of them 'as if they weren't there' compared with 2009 (23% compared with 29% in 2009) and fewer said the same of nurses (17% in 2017 compared with 23% in 2009). More patients also felt that nurses 'definitely' answered important questions in a way that they could understand (69% in 2017 compared with 64% in 2009, with an increase of one percentage point since 2016).

If patients had an operation or procedure while in hospital, more patients in 2017 were positive about the quality of communication around these events. In 2017, 81% of respondents said they 'completely' received answers to any questions they had about procedures in a way they could understand (increasing from 75% in 2009, and 78% in 2016). Compared to 2009, more respondents were also 'completely' told how they could expect to feel after the operation (62% in 2017, compared with 55% in 2009 and 58% in 2016).

Since 2009, patients have also reported greater feelings of privacy when discussing their condition in hospital (75% in 2017 'always' had privacy compared with 69% in 2009).

While there has been no significant increase from the previous survey, since 2009, there has been a gradual increase in ratings for quality (23% said food was 'very good' compared with 19% in 2009) and room or ward cleanliness (70% thought facilities were 'very clean' compared with 63% in 2009).

Areas for improvement

There has been a very small improvement over the previous year for patients not being 'bothered' by noise at night by staff (80% in 2017, 79% in 2016). However, a large proportion of patients (40%) are still affected by noise from other patients, and over time this is mostly unchanging.

Since 2009, there has been almost no change to perceptions of levels of emotional support offered during a patients stay. In 2017, 16% said they did not receive enough emotional support, while a further 28% felt they got this only 'sometimes'. While there has been a small statistically significant increase in the proportion of patients who definitely had hospital staff to talk to about their worries and fears (38% in 2017), there has also been a significant increase in those who told us they did not have this support (25% in 2016, and 27% in 2017). Trend analysis has shown that since 2009 there has been no real change in these results.

Preparation for, and information around, leaving hospital remains one of the weakest areas of patient experience for adult inpatients. Nineteen per cent of respondents thought hospital staff did not take their family or home situation in to account when planning their discharge, while a quarter (25%) of patients thought their family (or someone else close to them) were not given all the information they needed to care for them after leaving hospital. Less than two-thirds of patients (62%) left hospital with written information telling them how to look after themselves post discharge, a figure which has deteriorated since 2013 (67%).

The amount of information given to patients about new medications prescribed while in hospital is largely unchanged from last year, or previous years. Nine per cent of patients were not told about the purpose of new medications in a way they could 'completely' understand (consistent with 2009 levels). Nine per cent of patients were also not told how to take their medication in a way they could understand, which again remains at 9% as in previous years. Patients not being informed of the side effects of new medication still remains high at 43%, despite a small decrease from the previous year (44%, 2016).

Results for integrated care questions remain stable in 2017; with two in ten patients (20%) not receiving the help and advice about additional equipment or home adaptations after leaving hospital that they would like. Nineteen per cent told us staff did not discuss whether they might need any further health or social care services after leaving hospital, when they would have liked this. Seventeen per cent said they left hospital not knowing what would happen 'next' with their care after they left hospital, and 22% said they did not receive enough help from health or social care professionals to help recovery or to manage their conditions. Twenty-four per cent were not told who to contact if they were worried about their condition after they left hospital, though there has been a very small amount of improvement over time (26% in 2009).

How experience varies for different patient groups

Similar to 2016, subgroup analysis this year showed that inpatients with a pre-existing mental health condition report a poorer experience of care across most areas of the NHS patient experience framework; information sharing, respect and dignity, coordination of care, confidence and trust, respect for patient centred needs and values, and perceptions of overall experience of care. This is consistent with results of those who had the ICD-10 code V (mental and behavioural disorder), which consistently showed a poorer experience across most themes.

Patients who have dementia or Alzheimer's disease were reported to have poorer than average experiences of information sharing and communicating with staff while in hospital. Results for their experiences of feeling staff respected their preferences and needs, and for feeling they were treated with respect and dignity overall were also more negative.

Younger patients (16 to 35) also reported poorer than average experiences when it came to having their preferences and needs respected, having enough emotional support, confidence and trust in the staff treating them, feeling they were treated with dignity and respect, and coordination of their care when leaving hospitals.

Introduction

This year marks the 70th anniversary of the NHS, and the challenges trusts face this year remain largely the same as in previous years; the struggle to meet steadily increasing demand. While the NHS has been awarded an additional £6.3 billion (2017 to 2018), inclusive of £2.8 billion revenue funding for day-to-day services and £3.5 billion in capital investment in buildings and equipment, funding growth, as of November 2017, was much slower than in previous years.[3,4] At the same time all services have needed to continue to make large efficiency savings to make sure the NHS can continue to care for those who need it most. While funding is set to accelerate in coming years, the surveyed patients featured in this release were in hospital during July 2017, before additional funding was announced or introduced.[5]

CQC's State of Care 2016/2017 quoted Aneurin Bevan, who as far back as 1948 voiced concerns about "the increasing demands made on our hospitals by the aged sick".[6] Today, there are still pressures on the system from caring for older patients, alongside the challenges of caring for those with increasingly complex conditions: long-term degenerative conditions, cancer, diabetes, and obesity. At the same time, bed occupancy in acute and general hospitals has remained above the recommended 85%, at 89% during summer 2017 and further rising to 93% during the winter of 2017/2018.[7,8]

Despite these challenges, in 2017 CQC rated the majority of hospital services as good, with six per cent of services rated outstanding. However, there still remains a great deal of variation in the quality of care in and between services. CQC also highlighted concerns around lack of integration between health and social care services, particularly around supporting patients after they are discharged from hospital.

Importance of patient experience

Understanding what a stay in hospital is like for patients provides key information about the quality of services across England. This understanding can be used to encourage improvements both nationally and locally. The importance of positive patient experience is now well recognised across the NHS. The NHS Constitution commits the NHS to encouraging people to feed back on their experiences and using this to improve services. The NHS Patient Experience Framework, published by the NHS National Quality Board in 2012, outlines elements that are important to patients' experiences of NHS services. This includes: respect and involvement, coordinated and integrated care, information and communication, physical comfort, emotional support and the involvement of family or friends.[9]

The Department of Health and Social Care's (DHSC) NHS Mandate 2018 to 2019 published in March 2018, identified objectives NHS England should strive for. Helping to 'create the safest, highest quality health and care service' is an objective that will in part be assessed through assessments of patient experience.[10]

Domain 4 of the NHS Outcomes Framework also highlights the importance of hospitals providing positive experiences of care; with a particular focus on hospitals being responsive to inpatients' needs.[11]

Research, including that carried out in the NHS Patient Survey Programme, has identified many aspects of care that are important to people using services. These include: candour, good communication with knowledgeable staff, and being involved in decisions around their treatment and discharge.[12] Evidence from academic research suggests that when people are involved in their own care, decisions are made more effectively and health outcomes improve.[13] Patient experience is also positively associated with patient safety, clinical effectiveness and staff wellbeing.[14] These benefits are recognised by the National Institute for Health and Care Excellence (NICE), which provides guidance for healthcare professionals to improve patient experience.[15]

Other countries also see the value in measuring patient experience in their national healthcare systems. For comparisons with other inpatient surveys see Appendix B.

About the adult inpatient survey

The adult inpatient survey is part of a wider programme of NHS patient surveys, which covers a range of topics including maternity care, children's inpatient and day case services, accident and emergency (A&E) and community mental health. To find out more about the survey programme and to see the results from previous surveys, please see the links in the further information section (Appendix C).

The adult inpatient survey has been running annually since 2004. Wherever possible, questions remain the same over time to measure change. However, when necessary, changes are made to reflect changes in policy and methodological best practice, and to reflect feedback from stakeholders to make sure that questions stay relevant.

Inpatient services

NHS acute inpatient care is provided to people whose condition requires them to stay at least one night in a NHS hospital. Patients may be admitted to hospital on a planned basis through a waiting list, or they may attend as an unscheduled emergency admission.

The questionnaire for the 2017 adult inpatient survey is broadly similar to the 2016 questionnaire. However, six new questions were added, 11 removed and two modified. A full list of these can be found in Appendix D.

This 2017 Statistical Release presents the key results from the 2017 adult inpatient survey and highlights statistically significant differences compared to 2016. Long-term trends dating back to 2009 are identified where appropriate. Results for all questions patients were asked are published on our website, www.cqc.org.uk/inpatientsurvey.

Who participated in the survey?

The 2017 inpatient survey involved 148 NHS acute and NHS foundation trusts in England that sent questionnaires to a total of 183,692 patients.[*] Responses were received from 72,778 people, which is an adjusted response rate of 41%. Trusts selected a sample of patients who received care in hospital during July 2017 by including every consecutive discharge counting back from 31 July until they had selected 1,250 patients.[†] Fieldwork for the survey (the period during which questionnaires were sent out and returned) took place between August 2017 and January 2018.

[*] This excluded mental health, ambulance services, and community health trusts.
[†] With the exception of the following trusts: Birmingham Woman's and Children's Hospital NHS Foundation Trust, The Clatterbridge Cancer Centre NHS Foundation Trust, and Liverpool Woman's NHS Foundation Trust, that sampled 739, 634, and 1,069 patients respectively. As specialist trusts they have relatively low through puts of patients; to sample over a longer time period to achieve the full 1,250 sample would introduce difficulties in making inferences from their data.

Certain groups of patients were excluded from the survey before trusts drew their samples, including:

- Patients who had died.
- Children or young people under 16 years old during July 2017.
- Women using obstetrics or maternity services, including those who had a spontaneous miscarriage.
- Patients admitted for planned termination of pregnancy.
- Psychiatry patients (patients who received treatment for a mental health condition).
- Day case patients (patients who arrived and left hospital on the same day).
- Private patients (non-NHS).
- NHS patients treated at private hospitals.
- Any patients who were known to be inpatients at the time samples were drawn.
- Patients without a UK postal address.
- Patients who opted out of having their details used for anything except clinical care.

Policy context

This section sets out some of the broader policy and contextual issues relevant to the care of adult inpatients by the NHS.

Increased demand and bed occupancy

In July 2017, NHS acute hospitals in England admitted 1.19 million patients, an increase from the same period in 2016 (1.18 million)[*].[16,17] From 2016 to 2017 there were 19.7 million 'finished consultant episodes', the number of time periods spent in the care of a consultant during a hospital stay), in NHS hospitals, which is a 33.4% increase from 10 years ago.[18] Demand is increasing over time and during a time where capacity is being reduced.[19] Overnight hospital bed occupancy in April 2017 to March 2018 remained above 89% per quarter, with one trust reaching 100% between January and March 2018.[7,20] The National Audit Office has suggested that hospitals with average bed occupancy levels above 85% can expect to have regular bed shortages, periodic bed crises and increased numbers of health care-acquired infections.[21,8] Academic research supports this, showing that high levels of bed occupancy are associated with high hospital mortality rates and missing targets.[22]

'Finished admission episodes', (the first finished consultant episode of a hospital stay) admitted through accident and emergency departments have increased 39% over a ten-year period.[23] The consequences of these demands and capacity were shown during winter 2017/18 when The National Emergency Pressures Panel recommended hospitals extend deferral of all non-urgent inpatient elective care, resulting in some patients' scheduled care being postponed. [24,25]

Waiting times

The [NHS Constitution](#) states that patients should wait no longer than the maximum waiting time of 18 weeks for non-urgent referrals. Urgent suspected cancer referrals have a maximum wait time of two weeks. This means that patients have the right to start their non-emergency, NHS consultant-led treatment in a maximum wait time from referral, unless they choose to wait longer or it is clinically appropriate to do so.

It is a statutory requirement that hospitals see 92% of referrals in the designated maximum waiting time.[26] The proportion of patients seen in 18 weeks of referral dropped from 91.3% in July 2016 to 89.9% in July 2017. In total, there were more than 320,500 patients waiting to begin their treatment at the end of July 2016. The figure has risen to more than 390,000 at the end of the same time in 2017.[27]

Delayed transfers of care

Delayed transfers of care (DToC) occur when patients are ready to leave hospital, but are still occupying a bed. Sometimes called 'bed-blocking', DToC can cause unnecessarily long stays in hospital and affect waiting times of other patients in need of a bed.[28] Between April 2016 and March 2017 the daily average of delayed transfers of care was 14.9 per 100,000 patients, compared with 12.0 between 2015

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[*] Includes all 'First Finished Consultant Episodes': elective, non-elective, ordinary, and day case.

and 2016[*].[29] Between the first quarter of 2016/17, the percentage of DToCs caused by the NHS decreased from 59.8 in the first quarter of 2016/17 to 55.8 in the last quarter. In comparison, DToCs caused by social care increased from 32.7% in the first quarter to 36.2% in the fourth quarter.[29]

The National Institute for Health and Care Excellence (NICE) recommends that from admission, or earlier if possible, hospital and community-based multidisciplinary teams should work together to identify and address factors that prevent a safe and timely transfer of care.[30] NICE patient experience quality statement 12 states that patients should experience coordinated care with clear and accurate information exchange between relevant health and social care professionals.[31] For adults living with social care needs, NICE recommends that a single health or social care practitioner should be responsible for coordinating the patient's discharge from hospital, enabling good communication and information sharing as well as continuity of care.

Integrated care

In the NHS Five Year Forward View, a commitment was made to deliver care that meets patients' needs now and in the future. To do this, services have a statutory duty to work together, integrate care and provide bespoke health and social care to those who need it.[32] The NHS Constitution pledges that all NHS patients will receive care coordinated around and tailored to their needs and preferences.[33] The aim of this action is to cut emergency admissions by providing better services outside of hospital, prevent hospital admissions or receive the same care in a different setting. This is a common theme in initiatives for integrated services, including the government's Better Care Fund.

The NHS is continuing to support integrated care models, and has seen a decrease in the number DToCs as a result of social care. From April 2016 to March 2017, the daily average per 100,000 was 6.3, when compared with 4.6 of the same period 2015 to 2016[†].[29] Awaiting care packages is the main cause for the number of delayed days.[‡] Table 1 shows the total number of delayed days split by reason for the delay. The data suggests that while services are being encouraged to provide integrated care, they did not appear ready to meet current demand. At the beginning of 2017, the NHS Mandate set out a target to reduce the number of DToC attributable to the NHS. Since July 2017, the number of DToC days has steadily decreased, with the percentage attributable to social care services decreasing, but has yet to hit the target.[34] In 'Building bridges, breaking barriers', CQC identified communication between providers as a barrier to person-centred integrated care and made a number of recommendations based on better communication between providers.[35] CQC's programme of local system reviews has also highlighted the

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[*] Only those aged 18 or more.
[†] Only those aged 18 years or more. Inclusive of social care, and both NHS and Social care contributed.
[‡] A delayed day occurs when a patient has been delayed one day after they were medically fit to be transferred/ discharged. If the patient is delayed for a further day, then another delayed day occurs. The total number of delayed days for a single patient is the number of days from when they were medically ready to be transferred to the date they were transferred or discharged

challenges that older people face when moving between health and social care services, with current capacity challenges in the adult social care market.

Table 1: Total delayed days by reason 2016/17

Reasons	Delayed Days	Proportion of total delays
		%
Awaiting care package in own home	456,447	20.3
Awaiting further non-acute NHS Care	386,028	17.1
Awaiting completion of assessment	380,832	16.9
Awaiting nursing home placement or availability	342,982	15.2
Patient or family choice	245,033	10.9
Awaiting residential home placement or availability	231,994	10.3
Awaiting public funding	81,327	3.6
Housing	52,431	2.3
Awaiting community equipment and adaptation	52,121	2.3
Disputes	24,641	1.1

Source: NHS England, Delayed Transfers of Care Statistics for England 2016/17

Staffing levels

NHS hospitals should be staffed with the appropriate number and mix of clinical professionals needed to deliver good quality care and keep patients from avoidable harm.[36] While there is no mandated patient-staff ratio in England, NICE provides recommendations for safe staffing for nursing in adult inpatient wards in acute hospitals. [37,38] These recommendations rely on professional judgment of safe staffing levels. In 2015, the Chief Nursing Officer for England, Professor Jane Cummings stated staffing levels "must take account of all the staff involved, not just nurses…it is also about how much time nurses spend with or supporting patients".[39]

The National Quality Board recommends 'a systematic approach should be adopted using an evidence-informed decision support tool triangulated with professional judgement and comparison with relevant peers' to inform safe staffing levels in a service provider'.[40]

While staffing levels have a relationship with patient outcomes, it is in the interest of the NHS to maintain safe levels of staffing.[41,42] Academic research supports that patient satisfaction is positively associated with good nursing care.[43] In March 2017 there were 30,613 full-time NHS vacancies[*]; this was up from 26,424 in March 2016.[44] The majority of these vacancies are nurses and midwifes. Figure 1 shows the number of NHS staff vacancies in the 12 months between April 2016 to March 2017. Registered nurses and midwives are constantly the highest number of vacancies. In The State of Health Care and Adult Social Care in England 2016/17, CQC –stated that "staff have to work under great pressure to deliver the quality of

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[*] Includes: additional clinical services, additional professional scientific and technical, administrative and clerical, allied health professional, estates and ancillary, healthcare scientists, medical and dental, and nursing and midwifery registered. Excludes student staff.

care that people have the right to expect" in the context of staff recruitment difficulties.

Figure 1: NHS Staff vacancies from April 2016 and March 2017
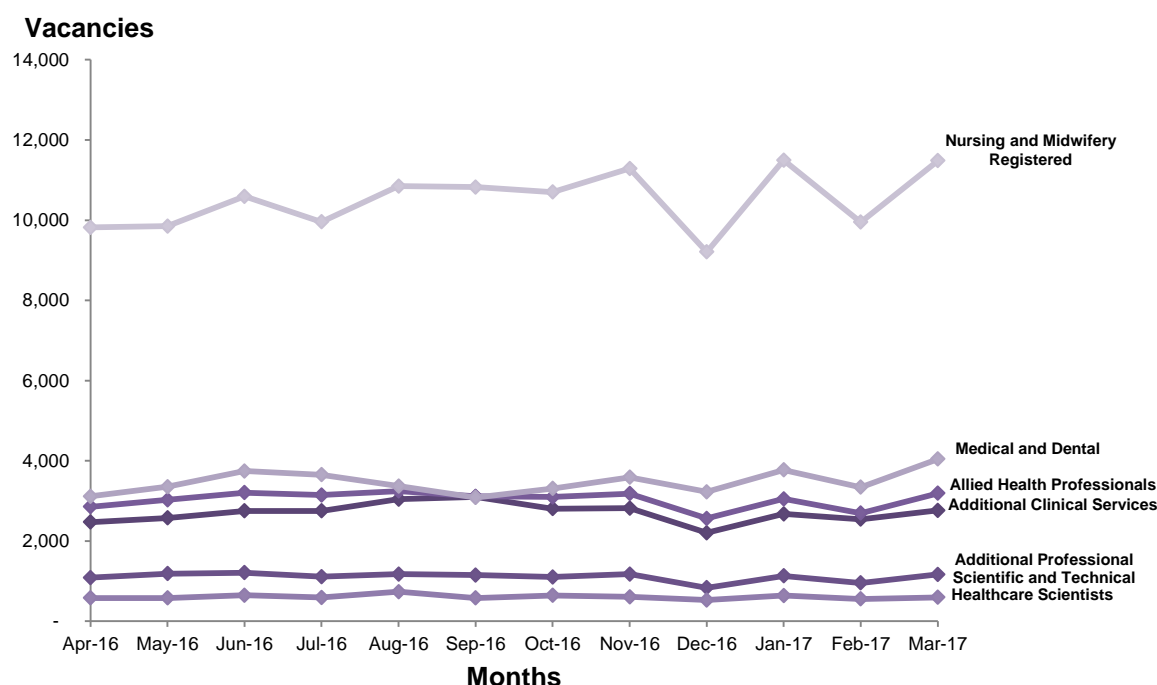
Note: Produced from provisional experimental data, using administrative data collected by NHS Digital. This excludes: administrative and clerical staff, estates and ancillary staff, and student staff

Long-term conditions

A new question was introduced in the 2017 survey allowing better focus on patients' different long-term conditions. The following policy context focuses on some of the individual long-term conditions identified in this question.

Cancer

In 2017, MacMillan Cancer Support began campaigning to improve the future cancer workforce career pathways, existing staff skills and confidence, and their understanding of cancer.[45] This campaign supports Health Education England's initiative to improve the prevention, diagnosis, survival, and experience of people living with cancer.[46] While this initiative is aimed at all NHS clinical staff, constant and caring cross-service care is emphasised.

In academic research shared decision making about care is associated with patient outcome and experience.[47,48] In 2016, 78% of respondents of the National Cancer Patient Experience Survey said they were 'definitely' involved as much as they wanted to be in decisions about their care.[49]

Dementia

In 2014, our report 'Cracks in the Pathway' noted variations in the quality of care for people living with dementia who were in hospital or care homes.[50] The report highlighted that there was a lack of opportunity for patients' families or friends to be involved in their care, and poor assessment of care needs and information sharing across organisations. They also reported issues in some areas of care not meeting patients' mental health, emotional or social needs.

In 2015, the Prime Minister's 'Challenge on Dementia 2020' policy paper set out a vision of care and support for people with dementia. This vision was of high-quality compassionate care from diagnosis through to end of life care, applying to all care settings, whether at home, hospital or in a care home.[51] In 2016 the implementation plans for this vision were released. One aim highlighted the need for more staff training to create a dementia-friendly environment.

NICE advises acute trusts should make sure that all people using the service who have suspected or known dementia should have access to dementia specialist treatment, as well as follow the patient's existing planned care.[52] The diagnosis of dementia can be scary to a patient, but a diagnosis does enable the patient to seek and receive appropriate care while living with the condition. NHS Improvement recommends using the This is Me booklet on admission to a service and that it be kept for subsequent visits. It is intended to support person-centred care by recording details on the person's cultural and family background, preferences, routines and personality.

Diabetes

NICE recommends that patients living with diabetes should be supported to actively participate in their care.[53] As with guidance for patients living without diabetes, NICE reiterates that patients with the condition should receive care that is individual to their needs.

NICE recommends that inpatients living with type one diabetes should expect care which takes account of and integrates with the patient's pre-existing medication (insulin) and dietary requirements, if it is safe to do so and the patient is willing.[54] The National Diabetes Inpatient Audit 2016 found that 38% of participants experienced medication errors during their inpatient episode, and that these errors occur more frequently on surgical wards.[55]

Learning disability

The Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD) found that people living with a learning disability have a significantly lower median age of death than the UK population.[56] A common factor contributing to premature death of people living with a learning disability is lack of reasonable adjustments in their care. CIPOLD report highlights the lack of coordination across and between disease pathways, service provider, and care continuity.[56] Two recommendations from this report are: clear identification of people living with a learning disability to make reasonable adjustments in care, and a named healthcare coordinator to be allocated to people with complex health needs.[56]To aid acknowledgement of reasonable adjustments for a person with a learning disability many organisations are promoting the use of a 'hospital passport', which is presented to care staff for reference of how to communicate effectively and make the individual comfortable during their hospital stay. However, it was found that this passport-type document was only used in a fifth of cases, according to the CIPOLD report.[56]

Lack of effective communication is a common complaint in care of people with a learning disability.[57,58] 'Healthcare for all', the independent Inquiry into Access to Healthcare for People with Learning Disabilities, recommends that healthcare professionals at undergraduate and postgraduate level should receive training in handling patients with a learning disability in a care setting. In 2016, NHS England developed the Accessible Information Standard. This put the duty on all health and social care organisations to make sure that their written and verbal communications are accessible to all disabled people, including people with a learning disability.[59] Research has found that behaviour support training of staff treating people with 'intellectual disabilities' is potentially more cost-effective than untrained staff.[60]

Mental health

The NHS Mandate sets out the need for the NHS to deliver improvements in the way it treats long-term conditions and addresses health inequalities. NICE guidance states each patient should be acknowledged as an individual, taking account of their current health and experiences that may affect their health condition, and that providers should adopt an individual approach to a patient's care.[31] This includes patients' mental health requirements being considered when receiving treatment for physical conditions when in acute hospitals – as considered within this survey.

People with mental health problems have worse outcomes for their physical health care and those with physical conditions often have mental health needs that go unrecognised.[61] NHS England's objective continues to be to put mental health on a par with physical health, and have equivalent access to services for people with mental health conditions that treat their physical health problems.[62] The mandate goes on to set out that more power and control of care should be devolved to communities supporting bespoke out-of-hospital care for these patients.[62]

The British Medical Association's report 'Breaking down barriers- the challenge of improving mental health outcomes', highlights that lack of care integration contributes to poorer outcomes for mental health patients, especially during a hospital episode.[63]

The [Five Year Forward View for Mental Health](#) supports the development and improvements in care for those living with a mental health condition. By 2020/21, all acute hospitals should have an all-age mental health liaison service in emergency and inpatient wards with 50% providing this service 24 hours a day as standard.[61] In 2016/17, 7% of acute hospitals provided a 24-hour mental health liaison service.[64]

Results from the survey

This section presents key results for the 2017 adult inpatient survey. It highlights statistically significant[*] differences between the results from the most recent survey (2017) and the results from the previous 2016 survey.

We also present the results that have changed markedly over time and identify long-term trends where appropriate. For the first time this year we have used 'p-charts' to display trends from 2009 onwards and to help us see where there have been notable changes in results over time. Due to the weighting methodology applied to the survey, this type of analysis can only go as far back as 2009, as this was the first year patients were asked to report on their admission method.

The P-charts in this report plot the percentage of the most positive responses to questions (top box responses), and show the 'expected limits' of variation in survey results, with the assumption that there has been no change in reality unless the results exceed expected limits.[65] This method is useful as it allows comparisons between a number of years of data, rather than testing for statistical significance between just two time points. The ability to see trends in survey results over multiple years provides users with greater confidence in interpreting patterns in the data as resulting from real change.

When results fall outside the expected limits they should be considered a notable change, meaning that the degree of change is greater than the standard variation or fluctuation you would expect to see around results year-on-year. When changes between survey results fall outside of the expected limits, it suggests an underlying phenomenon at play or that there has been a real change in behaviour. Where results remain within the 'expected limits', this indicates there is no underlying pattern in the results. Where p-chart results are not reported, this is because results did not fall outside of expected limits. Below is an example of a P-chart which fluctuates from below expected limits in 2009 to above expected.

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[*] Five per cent or less probability that the result could have been observed when there has been no underlying change.

P-chart example
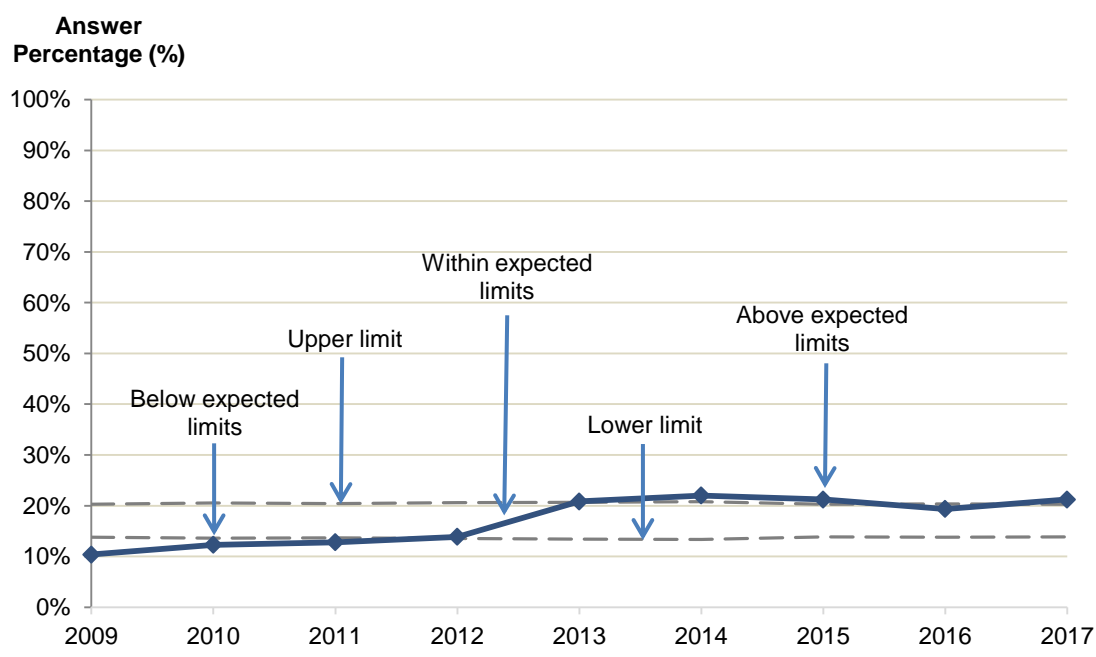
All charts are available in the open data source files on the CQC website.

We have also included analysis that compares how different subgroups of patients rated their inpatient experience. The Equality Act 2010 requires that public bodies have due regard to eliminate discrimination, and to advance equality of opportunity by fostering good relations between people who share certain protected characteristics and those who do not. The protected characteristics are age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex sexual orientation, marriage, and civil partnership. The Act provides an important legal framework that should improve the experience of all patients using NHS services.

The analysis modelled the mean scores[*] of different subgroups – age, gender, religion, sexual orientation, ethnicity, long-term health conditions (redeveloped for 2017), diagnosis (ICD-10 chapter codes), route of admission, length of stay, medical or surgical treatment type and 'proxy response' (whether the questionnaire was completed by someone other than the patient) – for a set of composites based on the NHS Patient Experience Framework.

1.   Information, communication, and education (Q30, 36, 56, 64)
2.   Respect for patient-centred values (Q23, 26, 34, 39 and 48)
3.   Emotional support (Q37 and 38)

[*] The sum of question scores divided by the number of questions in the composite.

4.	Confidence and trust (Q24, 27 and 35)
5.	Coordination and integration of care (Q32, 54, 62, and 66)
6.	Food choice (Q20)
7.	Hydration (Q22)
8.	Respect and dignity (Q67)
9.	Overall question (Q68)

These findings will be presented throughout the report, and you can find more detail and a full summary of results in Section 10.

Survey results are organised under the following key themes:

1.	**Admission to hospital**

2.	**Accident and emergency department**

3.	**Planned admissions**

4.	**Hospital and ward**

5.	**Doctors and nurses**

6.	**Care and treatment**

7.	**Operations and procedures**

8.	**Leaving hospital**

9.	**Overall**

Responses to questions such as "don't know / could not remember" are not shown and excluded from percentage calculations. The wording for these responses is designed for when a respondent cannot remember, or does not have an opinion.

1. Admission to hospital

Questions about admissions to hospital allow us to find out about people's experiences from the start of their journey as an inpatient, and complement a more comprehensive coverage of the experience of accident and emergency (A&E) patients published in our Emergency Department survey.

The 2017 inpatient survey results indicate that most of the patients who responded to this survey were admitted to hospital as an emergency or urgent case (68%). This is an increase from 2009 (61%). The proportion of respondents who were admitted from a waiting list or planned in advance case continued to decrease from 36% in 2009 to 28% this year (2017).

Q1. Was your most recent hospital stay planned in advance or an emergency?
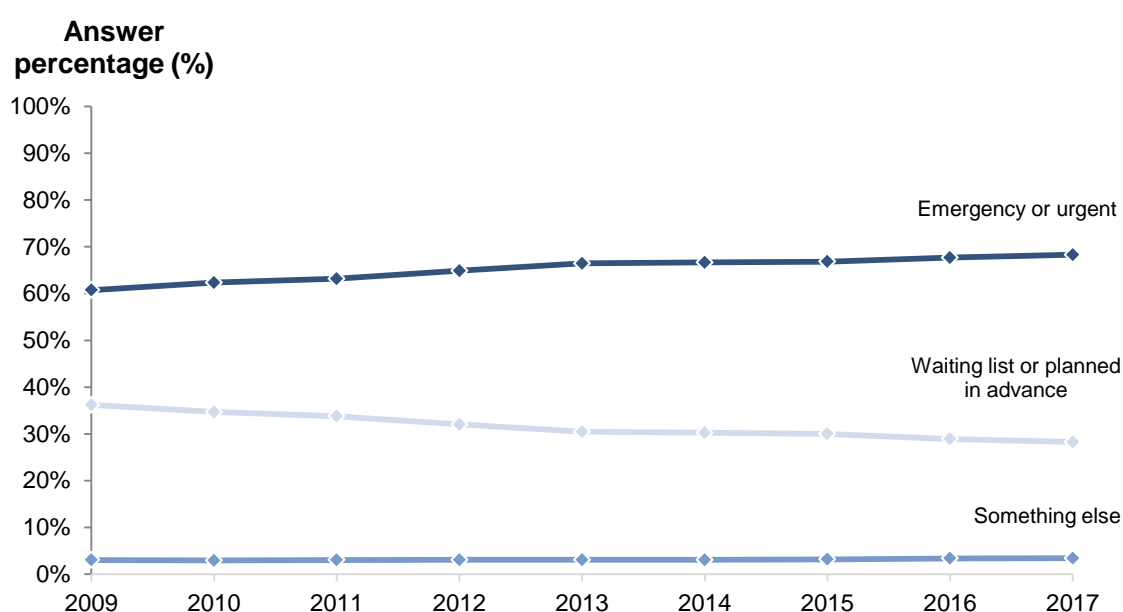
Number of respondents: 2009 (67,019) to 2017 (69,180)

Hospital Episode Statistics (HES) data shows that there were more planned elective admissions than non-elective or emergency admissions in July 2017, the sampling month. This is not thought to have an effect on the data because of the weighting method. The weighting method is detailed in the Quality and Methodology report.

2. Accident and emergency (A&E) department

The NHS Outcomes Framework states that NHS providers should aim to make sure that people have a positive experience of care (Domain 4), especially in improving people's experiences of accident and emergency services (Domain 4.3).[66] At the same time, data from NHS England has shown that demand on A&E services has increased year-on-year since 2003.[67] Academic research has provided some insight

into the association between service demand and patient experience, finding in some instances as demand increases, patient satisfaction decreases.[68]

Seventy-six per cent of respondents who were admitted to hospital via A&E thought they were given the right amount of information about their condition while in the A&E department, a significant increase from 74% in 2016. Eight per cent thought they were not given any information about their treatment or condition, a significant decrease of one percentage point. While those given the right amount of information is a statistically significant increase, this change is in the expected range of change (meaning it is within the two dashed lines), and does not indicate any meaningful positive change over the longer term.

Q3. While you were in the A&E Department, how much information about your condition or treatment was given to you? (Answer: 'Right amount')
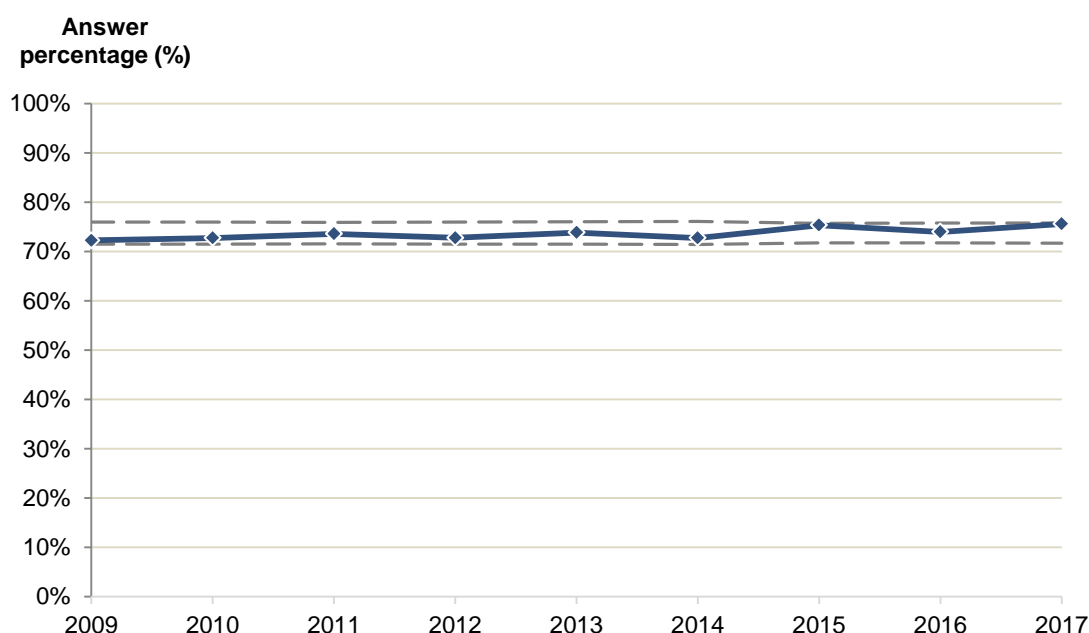
Number of respondents: 2009 (32,884) to 2017 (38,683)

When respondents were asked whether they were given enough privacy when being treated or examined in the A&E, 78% answered 'yes, definitely'. The graph below shows this trend over time from 2009. While there has been a modest increase in the percentage of people answering 'Yes, definitely,' this is not outside the expected limits of change. Two per cent of respondents said they were not given enough privacy.

Q4. Were you given enough privacy when being examined or treated in the A&E Department? (Answer: 'Yes, definitely')

Answer percentage (%)
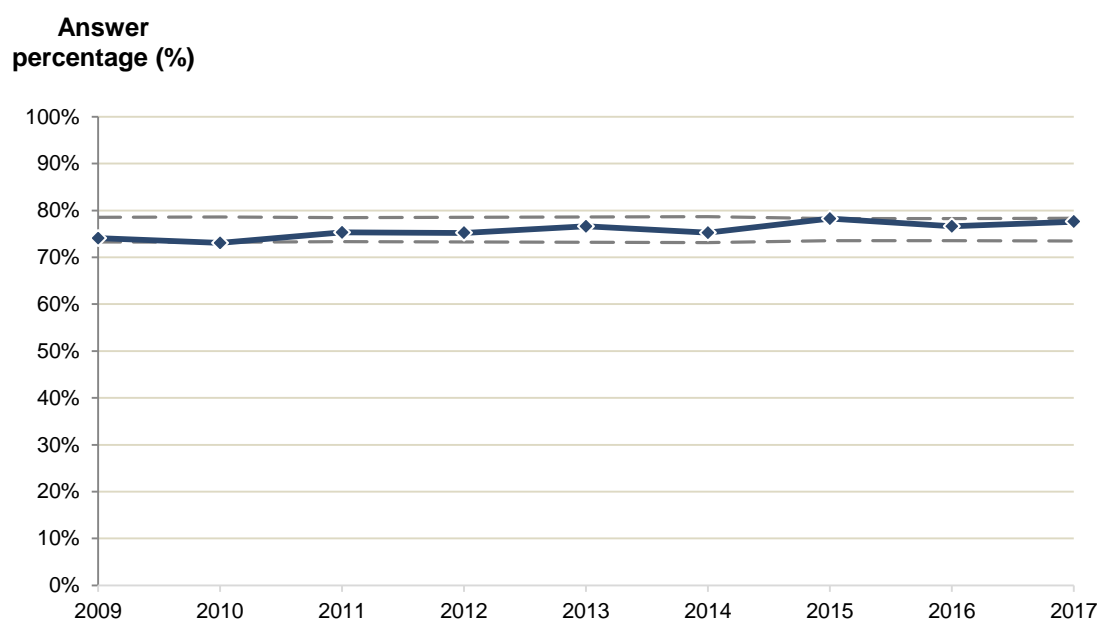
Number of respondents: 2009 (35,635) to 2017 (41,948)

Appendix E provides further details about data on A&E waiting times, which is collected by NHS England.

3. Planned admissions

NHS England has been set the objective to maintain timely access to quality services for all patients.[10] While the NHS has made improvements to reduce waiting times, NHS England's data show a decrease in performance against these targets.[27] One of the aims stated in the 2017 to 2018 NHS Mandate is to improve patients' experiences by providing information and choice of care and service providers. [69]

Just over a quarter of patients (27%) whose admission was planned, said they were offered a choice of hospital for their first appointment, 10% said they were not given a choice but would have liked one.

Similar to previous years, 74% of respondents were admitted to hospital as soon as they thought necessary and 80% of patients said their admission date was not changed by the hospital. The majority of respondents thought that the specialist they saw in hospital was given all the necessary information about their condition or illness (82% 'yes, definitely', and 15% 'yes, to some extent). The graph below shows this question's response since 2013, when the question was first used in the survey. There is a slight and gradual positive trend, and for the first time this year, the result has exceeded the expected limits for change. This means the result for 2017 sits

above the two dashed lines (the expected limits), and suggests there has been a meaningful positive change over the longer term.

Q8. In your opinion, had the specialist you saw in hospital been given all of the necessary information about your condition or illness from the person who referred you? (Answer: 'Yes, definitely')

Answer percentage (%)
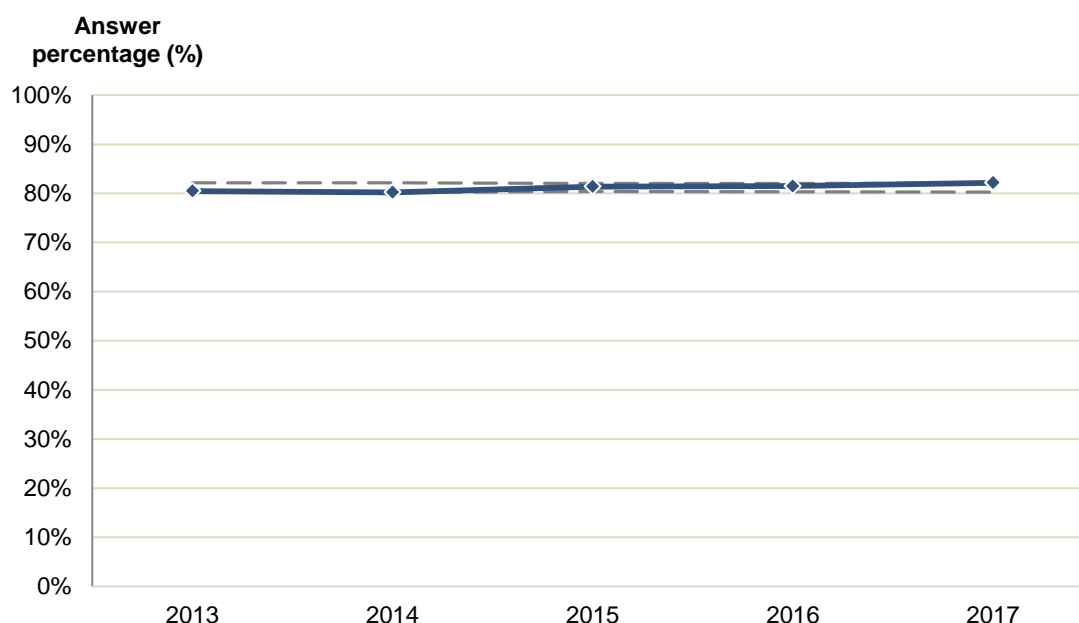
Number of respondents: 2013 (22,153) to 2017 (23, 973)

4. All types of admissions

Less than two thirds (63%) of respondents felt that they did **not** have to wait long to get a bed on a ward, after they arrived at hospital.

Q9. From the time you arrived at the hospital did you feel that you had to wait a long time to get to a bed on a ward?
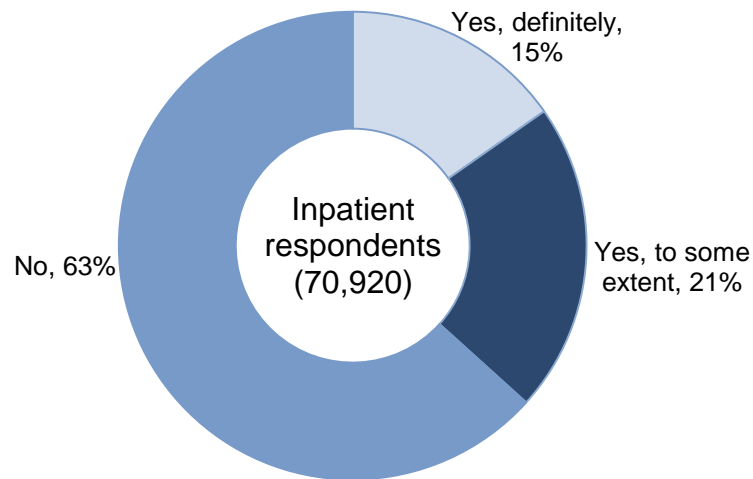
Note: Answered by all

This is a statistically significant increase from 2016 (61%), though trend analysis indicates there is no underlying real change over time as the results are not outside the expected limits of change in the p-chart. Since 2009, there has been a great deal of fluctuation with this result increasing or decreasing slightly each year, but not enough to breach the limits of the year-on-year variation you would expect without any real change in behaviour.

Q9. From the time you arrived at the hospital did you feel that you had to wait a long time to get to a bed on a ward?

Answer Percentage (%)

Note: Answered by all

When looking at the difference in waiting times between emergency and planned admissions, the data indicates that emergency patients waited longer to get a bed on a ward. With 18% of emergency admissions 'definitely' waiting a long time for a bed on a ward, compared with 7% of elective admission patients.

5. Hospital and ward

Mixed sex accommodation

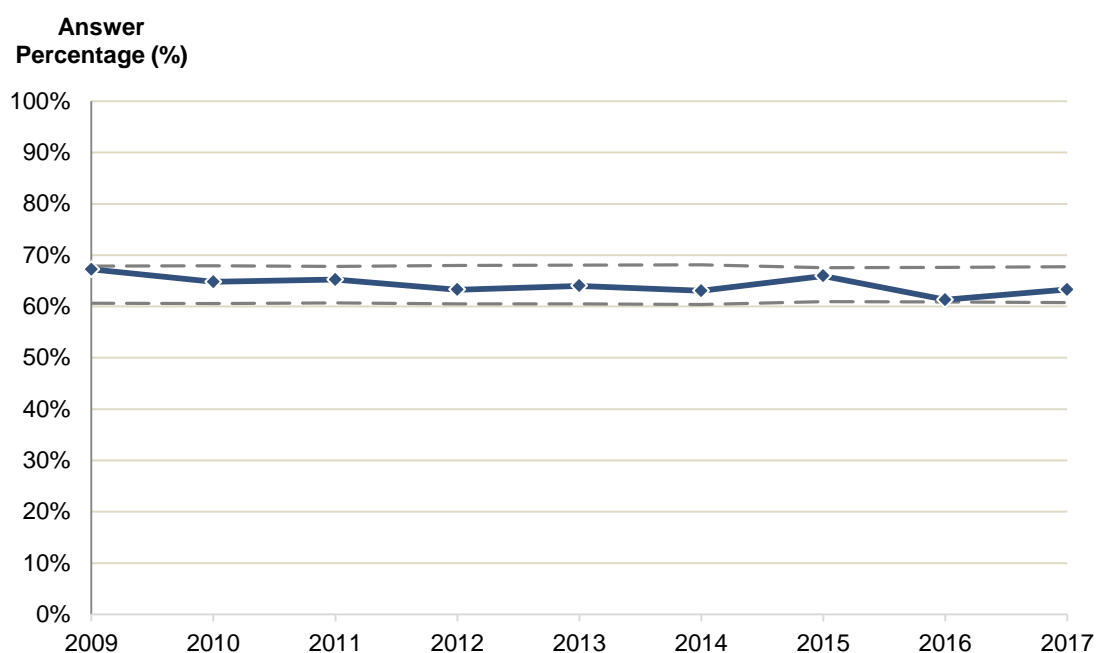The NHS Operating Framework for 2010/11 set out the then Department of Health's intention to eliminate mixed sex wards.[70] NHS trusts face a financial penalty with each breach of this policy[71]. According to NHS data in the month of July 2017 there were 899 of these breaches across 167 acute care providers.[72]

For this survey, 91% per cent of patients said they never shared a sleeping area with another patient of the opposite sex. This question has been modified for the 2017 survey and does not have any historical comparisons.

Moving wards and noise at night

Moving patients at night, while not against NHS statutory commitments, is not thought to be good care according to the Royal College of Physicians. The practise of moving patients at night has been shown to lengthen patients' hospital stay.[73] The report 'Hospitals on the edge, the time for action' identified patients being frequently transferred between wards during their stay as a risk to clinical continuity and is an

issue especially for older patients with multiple long-term conditions. They noted the effect especially of some of these transfers happening at night. The Royal College of Physicians asked trusts to make a commitment not to move patients at night unless it is urgently needed.[74] There are occasions when it is necessary to move a patient at night for clinical reasons, or because it is felt it will improve a patient's care.

Twenty two per cent of respondents said that they changed wards at night. Of those who changed wards at night, 55% said the staff 'completely' explained why they were being moved in a way the patient could understand. However, 18% did not understand why they were being moved. This is a new question for 2017 and has no historical comparison.

Q12. Did you change wards at night?
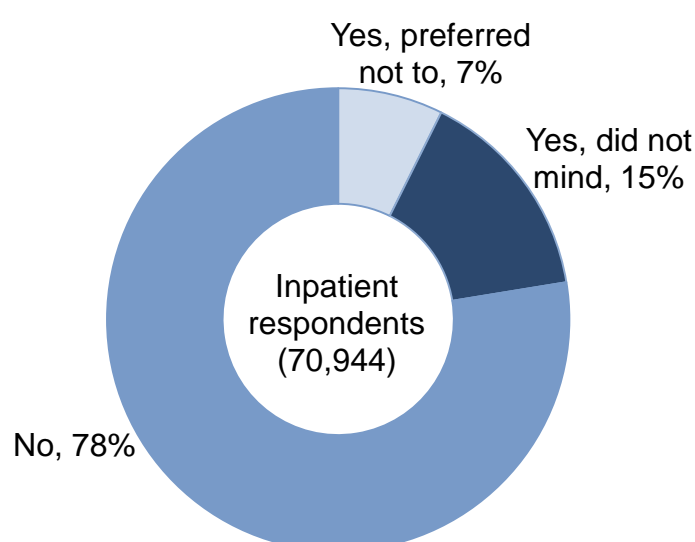
Note: answered by all

Disruption to sleep is known to interrupt recovery and increase the chances of poor health and wellbeing.[75] The NHS 'Friends and Family Test' has highlighted noise at night contributes to poor patient experience.[76] In 2017, NHS Improvement published guidance and a case study on how to reduce noise at night and disruption, highlighting that the most effective methods need joint effort from patients and staff. To assist this, methods such as 'quiet time' posters, drawing blinds and diming lights were suggested to promote better sleep quality.

Of our respondents, 40% were bothered by noise made at night by other patients. Twenty per cent of patients were bothered by noise at night from hospital staff, which is a small but significant decrease from 2016 (21%).

Cleanliness

The Code of Practice on the prevention and control of infections, under the Health and Social Care Act 2008, states that good infection prevention (including cleanliness) is

essential to make sure that people who use health and social care services receive safe and effective care.[77]

Over two-thirds of patients (70%) stated the room or ward they stayed in was "very clean", and 27% of respondents said facilities were "fairly clean". Since 2009, the proportion of patients reporting facilities were very clean has steadily increased and since 2015 has been greater than the expected limits. This indicates over this time period there has been a meaningful positive change with results exceeding the two dashed lines (expected limits) from 2015 onwards.

Q16. In your opinion, how clean was the hospital room or ward that you were in? (Answer: 'Very clean')
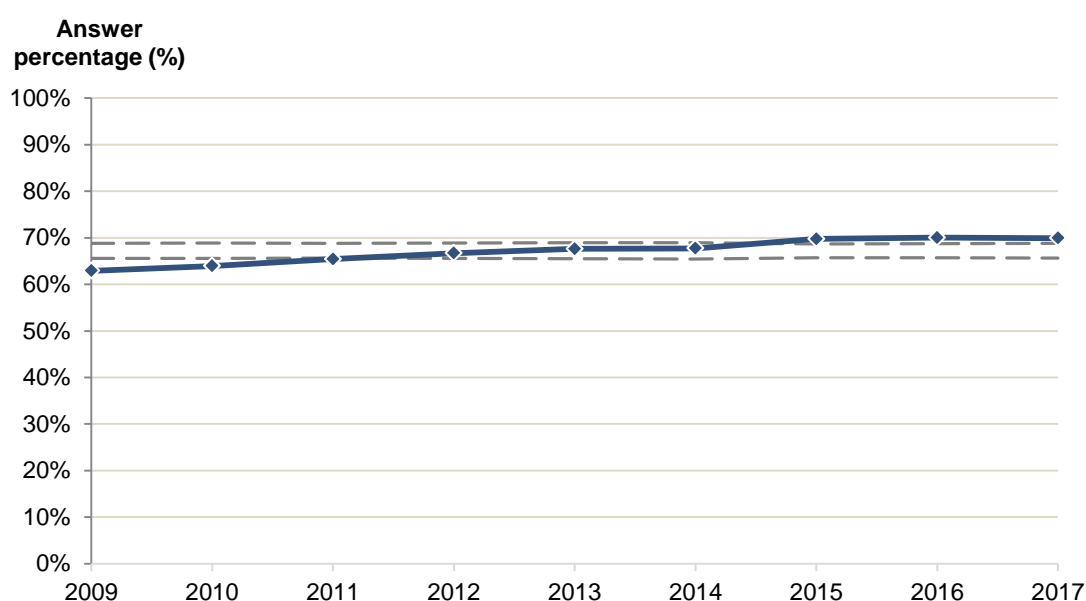
Number of respondents: 2009 (68,276) to 2017 (71,649)

Hygiene

Maintaining good patient hygiene is important to patient safety. Poor patient hygiene can cause skin complaints, infections and can be a source of low self-esteem.[78] Research by Downey and Lloyd (2008) found helping patients to maintain their personal hygiene needs contributes to the comfort, safety, wellbeing and dignity of the individual and helps to prevent the spread of infection. They concluded that nurses should show sensitivity and competency to be able to deal with the physical bodies and bodily functions and differences in cultural practices of individual patients to make sure that hygiene needs are met.[79]

When respondents were asked if they received enough help from staff to wash or keep themselves clean, 70% answered 'Yes, always'. This remains unchanged since 2016. One in ten patients said they did not receive this help.

Taking medication

In March 2017 the World Health Organization launched its third Global Patient Safety Challenge – Medication without harm. This aims to reduce injury and avoidable harm in healthcare systems by 50% in the next five years. A review commissioned by the then Department of Health (DH), in support of this campaign, estimates that 20% of all 237 million medication errors in the UK occur in secondary care with the majority of this error occurring at the administration of medications (79%).[80] In response, DHSC has suggested that all healthcare professionals should work closely together across all areas to address these errors that affect patient safety.[81]

NICE medication guidelines advise providers to make sure that they have robust and transparent processes in place, so that when a person is transferred from one care setting to another (for example, when a person is transferred from, or in, one care provider to another) the current care provider shares complete and accurate information about the person's medicines with the new care provider. [82]

NICE also recommends that patients prescribed medicines should be fully documented, and information on or advice about the patient's medicines should be fully discussed with the patient, carer, and family.[82] The Royal Pharmaceutical Society advises that where appropriate the patient should bring and self-administer their medicines in the care setting.[83]

When patients were asked, if they took their own medication to hospital, they were able to take it when needed, 64% of respondents said 'Yes, always'. This result is unchanged compared to 2016. More than two in ten patients, 22% said they were not able to take medication when it was needed.

The graph below compares results for this question for patients living with and without diabetes as this condition is now captured in the inpatient questionnaire. Over a quarter (28%) of patients living with diabetes that took medication in to hospital said they were not able to take it when they needed to. Of patients without diabetes, 23% were not able to take it when needed.

Q18. If you brought your own medication with you to hospital, were you able to take it when you needed to?
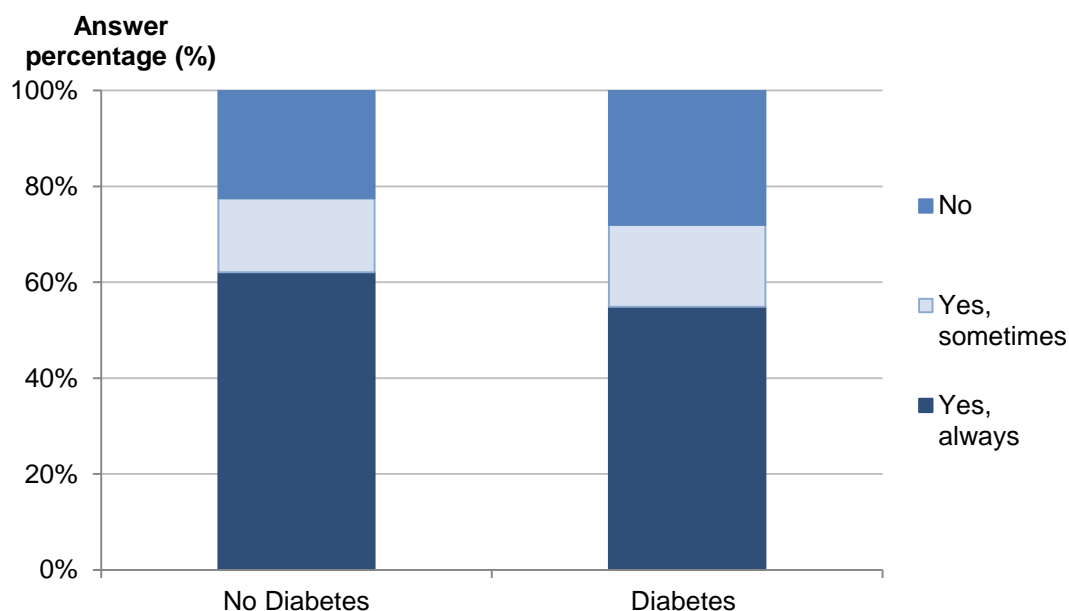
Number of respondents: 2017 (27,871)

Food and help with eating and drinking

In 2015, NHS England developed a [toolkit](#) to support NHS commissioners to reduce poor experiences of inpatient care. The toolkit identified food as an area where patients commonly report poorer experiences. NHS Choices have since provided food standards that a patient should expect and formulated a "food choice and quality indicator" for each hospital site based on patient experience scores.[84]

The graph below shows the percentage of respondents who were 'always' offered a choice of food. In 2009 this was 77% of patients compared with 79% in 2017. This is small increase, but is above the expected limits of change from 2015, indicating that there was a notable improvement from 2009 to 2017.

In 2017, 23% of patients rated their food as 'very good'. As with food choice, the proportions of the most positive responses to this question have slowly increased since 2009, with a step change in 2015. Thirteen per cent of respondents felt the food they received while in hospital had been 'poor'.

Q20. Were you offered a choice of food? (Answer: 'Yes, always')
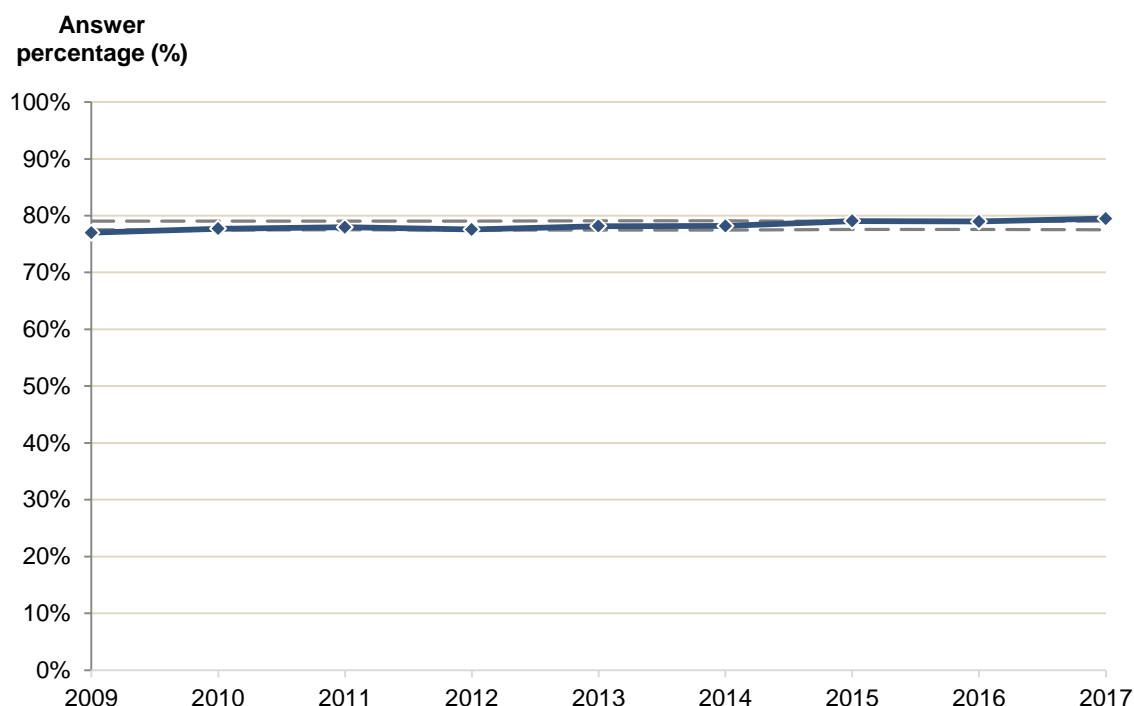
Number of respondents: 2009 (67,305) and 2017 (70,287)

Quality statement 10 in the NICE quality standard 15 (Patient experience in adult NHS services) encourages hospital staff to assess and address their patients' physical and psychological needs regularly, including nutrition, hydration, pain relief, personal hygiene and anxiety.

In part response to The Mid Staffordshire NHS Foundation Trust Public Inquiry, NHS England launched guidance to ensure patient care involves excellent nutrition and hydration.[85,86] The Royal College of Nurses states nutrition and particularly hydration are key principles to patient safety, providing practical guidance to identify dehydration and how to remedy and prevent it.[87,88]

Of those respondents who needed help eating their meals, 62% said they 'always' had enough help, whereas 17% said they did not receive enough help. This is broadly consistent with results for the previous eight surveys.

This year, for the first time, patients were asked whether they had enough to drink while in hospital. Nationally, 93% per cent said 'yes' they had. Whereas one per cent said they hadn't as they didn't get enough help to drink, five per cent said they hadn't because they were not offered enough drinks. In subgroup analysis this question showed groups of patients aged 16 to 35 years old, those who has ICD-10 code V (mental and behavioural disorder), and those with dementia had a poorer than average experience for this question.

5. Doctors and nurses

Doctors

The survey asks patients about their interactions with doctors while staying in hospital. The NHS Patient Experience Framework outlines those elements of care that are critical to the patient's experience of NHS services and states that "information, communication, and education on clinical status, progress, prognosis, and processes of care" are necessary "in order to facilitate autonomy, self-care and health promotion." The Royal College of Physicians acknowledges that while patient doctor communication has improved, it must continue to improve for better patient-centred care in the future.[89]

A number of questions from this section displayed a similar trend in which they appear to exceed expected limits from 2015, indicating a meaningful positive change from this point in time. Before the 2015 survey there were a number of events that could potentially have contributed to this improvement, for example there was a change to CQC inspection methodology with a new rating and inspection system implemented, embedding of changes two years from the Francis Inquiry Report, and publication of the NHS Five Years Forward View, which emphasised patient experience. [90,91] However, it is not possible to establish a causal relationship for this increased positive patient experience.

Questions that asked patients about their interactions with doctors have seen small but positive changes since 2009. For example, over two-thirds of respondents (68%) said they 'always' received an answer in a way they could understand when they had an important question to ask the doctor. However, six per cent said they did not receive an understandable answer from a doctor.

When patients were asked whether they had confidence and trust in the doctors treating them, 80% said they 'always' had this, an increase from 77% in 2014. Trend analysis shows this increase is above expected limits of change since 2016, indicating that there has been real (albeit small) positive change in this aspect of patient experience over time.

In the graph below we can see more than three-quarters of patients (77%) said their doctor did not talk in front of them as though they were not there in 2017. When examining this question's response over time we see the same trend as other questions on doctors' interactions, though slightly more pronounced. Positive responses (patient saying doctors did not talk this way in front of them) have steadily increased since 2009 (71%), with the previous three surveys showing evidence of positive change with results outside of expected limits.

Q25. Did doctors talk in front of you as if you weren't there? (Answer: 'No')

Answer
percentages (%)
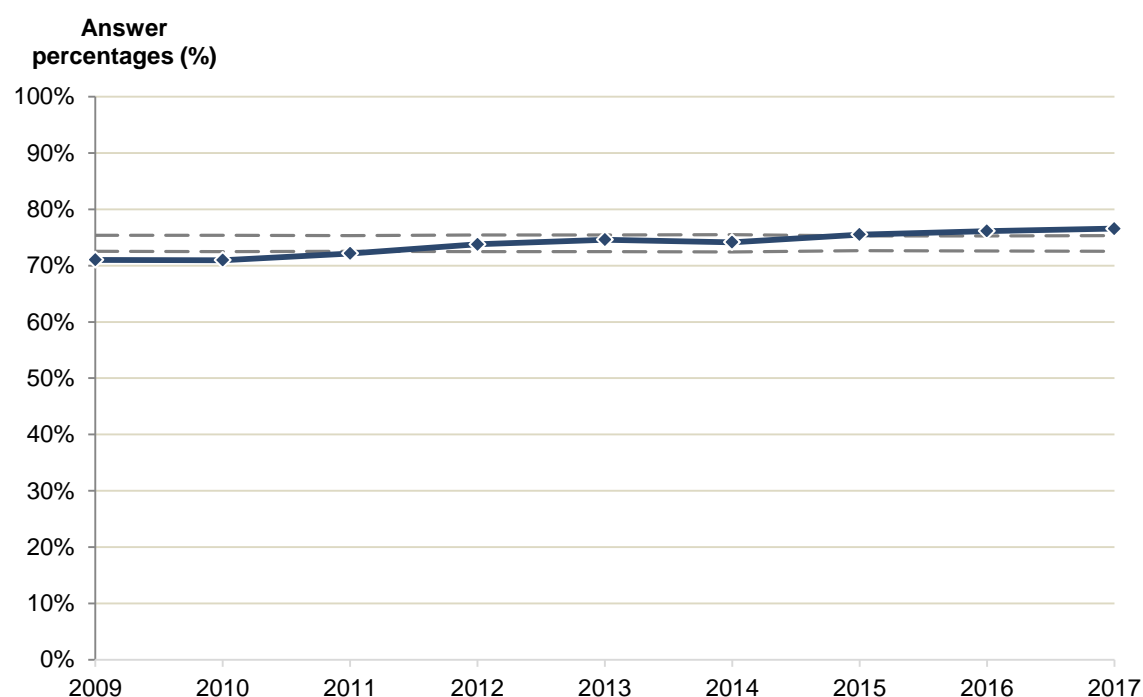
Number of respondents: 2009 (67,916), 2017 (71,020)

Nurses

Nursing and staffing levels have an effect on patient experience and patient outcome. The Royal College of Nurses provides guidance on nursing levels, advising that there is no 'gold standard ratio' of nurse to adult patients, but that staffing levels decisions should be informed by meeting patients 'needs'.[92] In their Leading change, adding value framework for nursing, midwifery and care staff, NHS England makes the commitment (commitment 9) that they will have the right staff in the right places and at the right time. They committed to make sure:

- The right staff are in the right place at the right time to provide safe, compassionate and effective care.
- Staffing decisions are based on evidence, account for the wider multi-professional team, and a proactive approach to improving outcomes.
- Staffing decisions take account of the local context.

The number of respondents who felt there were 'always or nearly always' enough nurses on duty to care for them was 59% in 2017, which is unchanged from the 2016 result. The graph below shows the trend for this response since 2009, where we can see that the proportion of respondents answering 'always or nearly always' has remained almost constant over time. In 2017, 11% of respondents said there were 'rarely or never enough nurses'.

Q29. In your opinion, were there enough nurses on duty to care for you in hospital? (Answer: 'There were always or nearly always enough nurses')

Answer percentage (%)
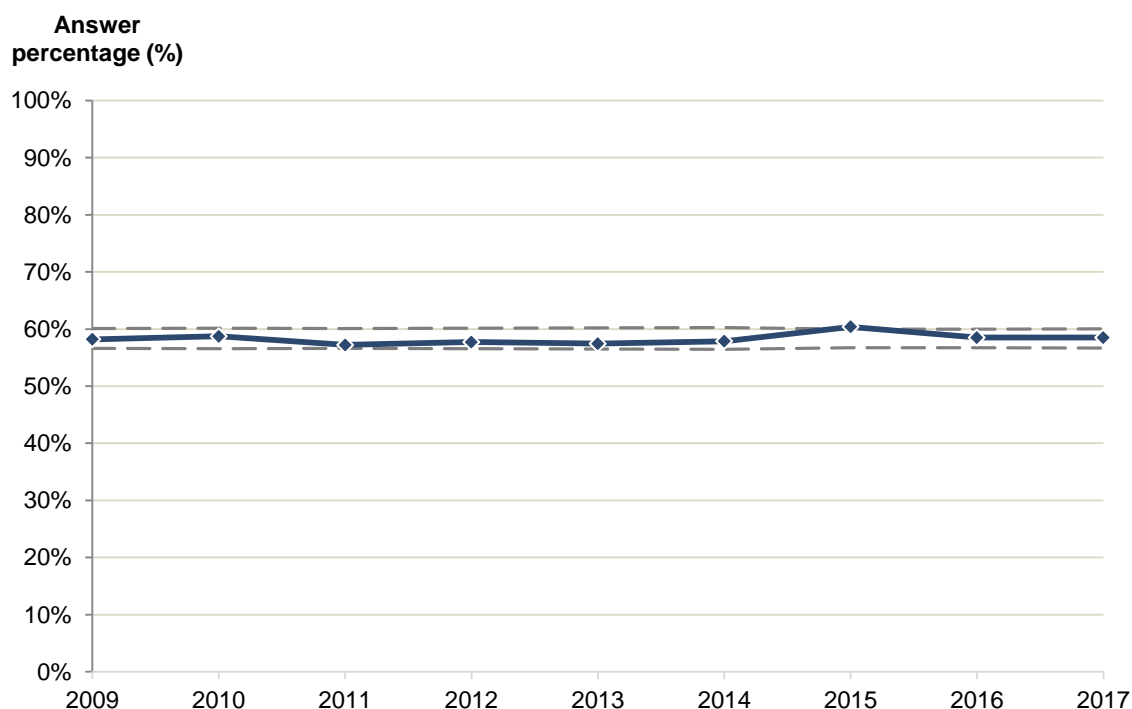
Number of respondents: 2009 (67,954), 2017 (71,151)

In 2017, half of patients (50%) said they 'always knew' who the nurse in charge of their care was, a further 30% said they knew this 'sometimes'. 2016 was the first year this question was asked and there has been a small but significant increase in those that answered 'yes, always' (49% in 2016).

Similar to doctors, patients were asked whether they had confidence and trust in the nurses treating them, this is displayed in the graph below. More than three quarters (78%) said 'yes, always' and 19% said 'yes, sometimes'. Since 2015, results for respondents answering 'yes, always' has been above the expected range of change, which suggests a meaningful positive change since 2015.

Q27: Did you have confidence and trust in the nurses treating you? (Answer: 'yes, always')
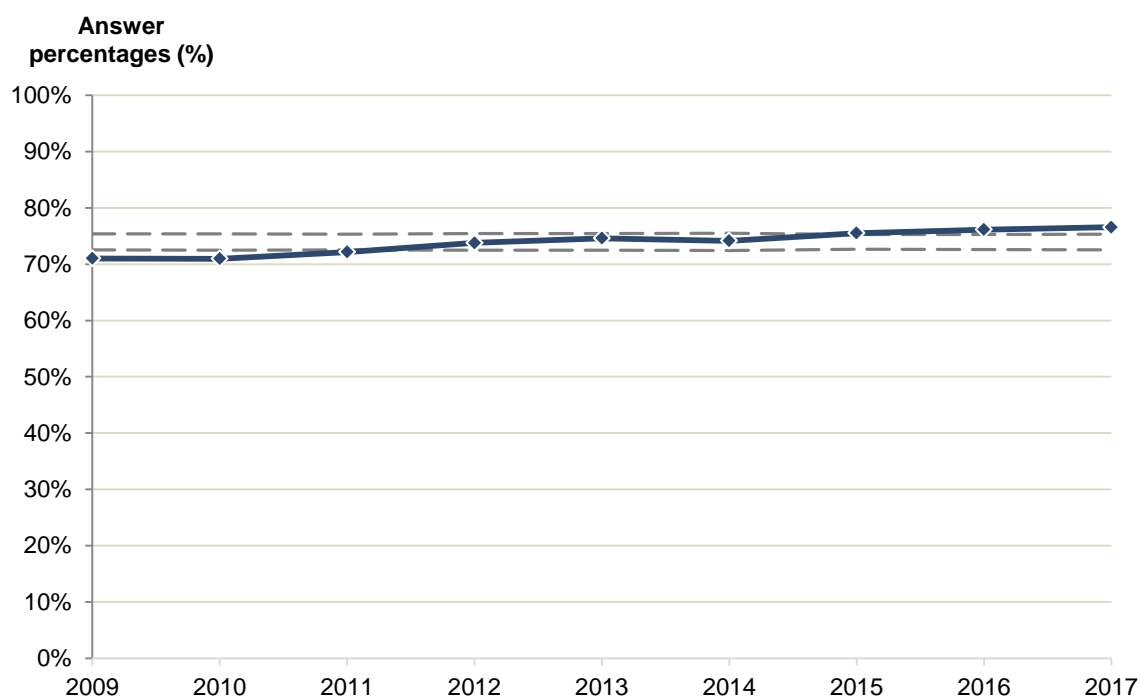
Number of respondents: 2009 (68,139), 2017 (71,315)

From looking at experiences of different patient groups in response to these questions on trust and confidence in doctors and nurses, younger patients (16 to 35 years old) reported poorer than average experience, in contrast to patients who are older than 65. Those who identified as having a mental health condition, and those who had an IDC-10 code V (mental and behavioural disorder) also had a poorer than average experience.

NICE quality statement 5 stresses the importance of patients being supported by healthcare professionals to understand relevant treatment options, including benefits, risks and potential consequences.

This year, 17% of respondents said that nurses talked in front of them as though they were not there, four per cent said this occurred 'always' and 13% said 'sometimes'. Eighty-three per cent said this did not happen to them.

Since 2009, there has been a positive trend results for in results for this question. From 2009 to 2011, the proportion of respondents who said nurses did not talk in front of them without acknowledging them was below expected limits, but from 2015 to 2017 this was above expected limits. This trend suggests there is an underlying change in behaviours leading to a more positive patient experience in this area.

Q28. Did nurses talk in front of you as if you weren't there? (Answer: 'No')

Answer
percentage (%)
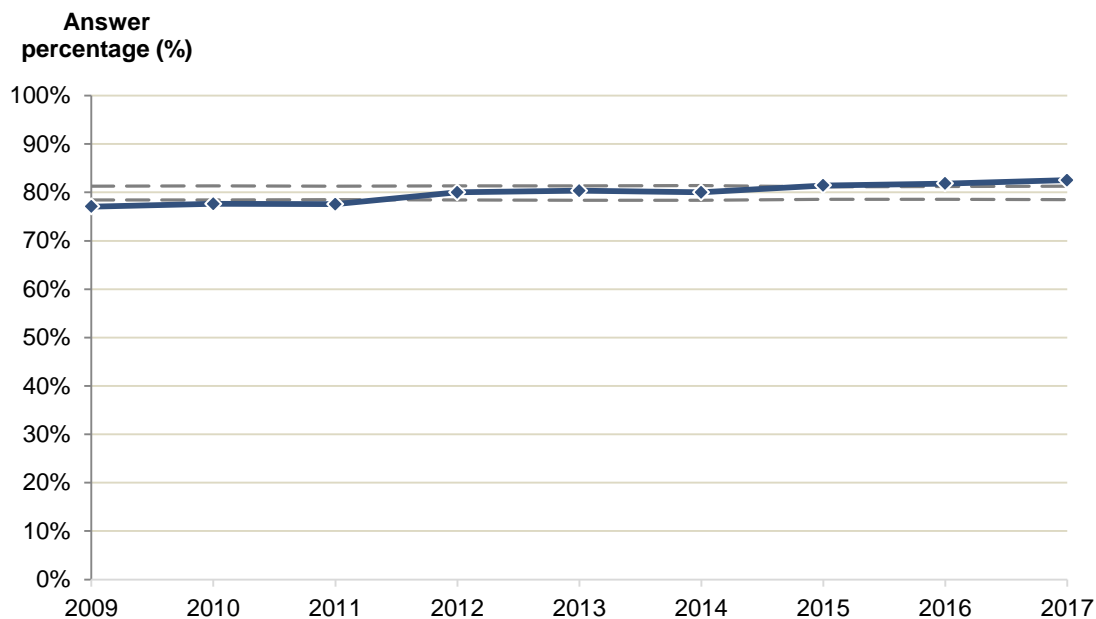
Number of respondents: 2009 (67,968), 2017 (71,194)

6. Care and treatment

Other clinical staff

Patients will often interact with other clinical staff while in hospital, such as speech therapists, psychologists, or physiotherapists. It is important that they are held to the same high standard of patient care as other healthcare professionals, including open discussion with the patient about their treatment.[15]

For the first time this year, patients were asked whether they had trust and confidence in the non-clinical staff that treated them. Over three quarters (76%) said they 'always' had this, while 19% said 'sometimes'.

Involvement of patients

NICE quality statement 6 states that patients should be actively involved in shared decision-making and supported by healthcare professionals to make fully informed choices about investigations, treatment and care that reflect what is important to them. Joseph Williams and others (2017) detail the benefits of 'Making Good Decisions in Collaboration (MAGIC)'.[93] This is a program to promote shared decision-making between clinicians and patients using a range of approaches to educate staff on how to approach these conversations with patients.

When respondents were asked whether they were involved as much as they wanted to be in the decisions surrounding their care, 56% said 'Yes, definitely', a statistically

significant increase from the previous year (55%, 2016), and 34% said 'Yes, to some extent'. The graph below shows the proportion of respondents saying 'yes, definitely' has increased from below the expected range in 2009 to 2011, leading to a result in 2015 greater than the expected limits. However, this declined in 2016 and continues to be within the expected limits in 2017.

Q34. Were you involved as much as you wanted to be in decisions about your care and treatment? (Answer: 'yes, definitely')

Answer percentage (%)
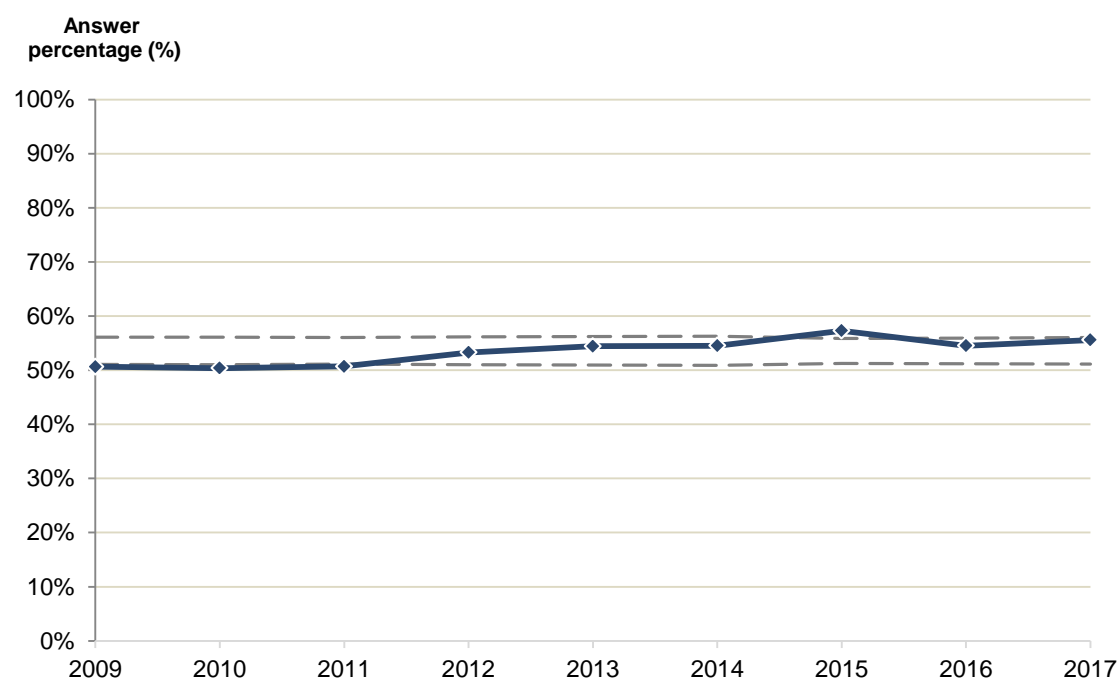
Number of respondents: 2009 (67,580), 2017 (70,759)

Of those respondents who said they had cancer in the previous five years, 60% thought they were 'definitely' involved in decisions about their care and treatment. As previously stated in the policy context, 78% of respondents to the National Cancer Patient Experience Survey thought they were 'definitely' involved as much as they wanted to be in their care and treatment. Direct comparisons between these surveys should be treated with caution as the target populations are different, and this question in the National Cancer Patient Experience Survey reflects on the entire period of cancer treatment care, rather than treatment in a single inpatient episode.

Over three quarters (78%) of respondents said they were given the 'right amount' of information about their treatment or condition. Eighteen per cent they did not receive 'enough' information, while 3% thought they were not given any information about their treatment or condition. Of those that believed they were not given any information, 42% had 'no' confidence in the decisions made about their condition or

treatment, while 84% of those given the 'right amount' of information 'always' had confidence in these decisions.[*]

Emotional support

In its report [The psychological and social needs of patients,](#) the British Medical Association (BMA) recommended that patients are treated with compassion, empathy and responsiveness to their needs, values and expressed preferences, and that they are given emotional support to relieve fear and anxiety. Patients' mental health needs should be considered by all hospital staff. The BMA stated that hospitals should have a liaison psychiatry service, also known as a psychological medicine service, to bridge the gap between physical and mental health care.[94]

In 2017, 38% of respondents said they 'definitely' had someone to talk to about their worries and fears during their hospital stay. Over a quarter (27%) felt they did not have anyone. Results for this question have remained similar since 2009. When asked whether the respondent felt they had enough emotional support while in hospital, 55% said 'yes, always', while 16% said 'no'. These results have also remained consistent since 2009.

Subgroup analysis of an emotional support composite has shown that elective admission patients feel they have more emotional support than average. Younger patients (aged 16 to 35) report feeling less supported. See [section 10](#) for the full results of this analysis.

Privacy

The [NHS Constitution states](#) that all patients have the right to privacy and confidentiality. [NICE quality statement 1](#) notes that every patient should be treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty.

The graph below shows the proportion of respondents from 2009 to 2017 who 'always' felt they were given enough privacy when discussing their condition or treatment while in hospital. Between 2009 to 2015, there has been a steady increase from below expected limits to a level consistently above expected limits since 2015.

[*] This figure is weighted by population weights only. Population weights weight on the sampling profile of each trust and takes account of non-response to the survey. Unlike other figures in this report, this statistic does not account for the 'average trust', which takes into account trust response rates.

Q39. Were you given enough privacy when discussing your condition or treatment? (Answer 'Yes, always')

Answer Percentage (%)
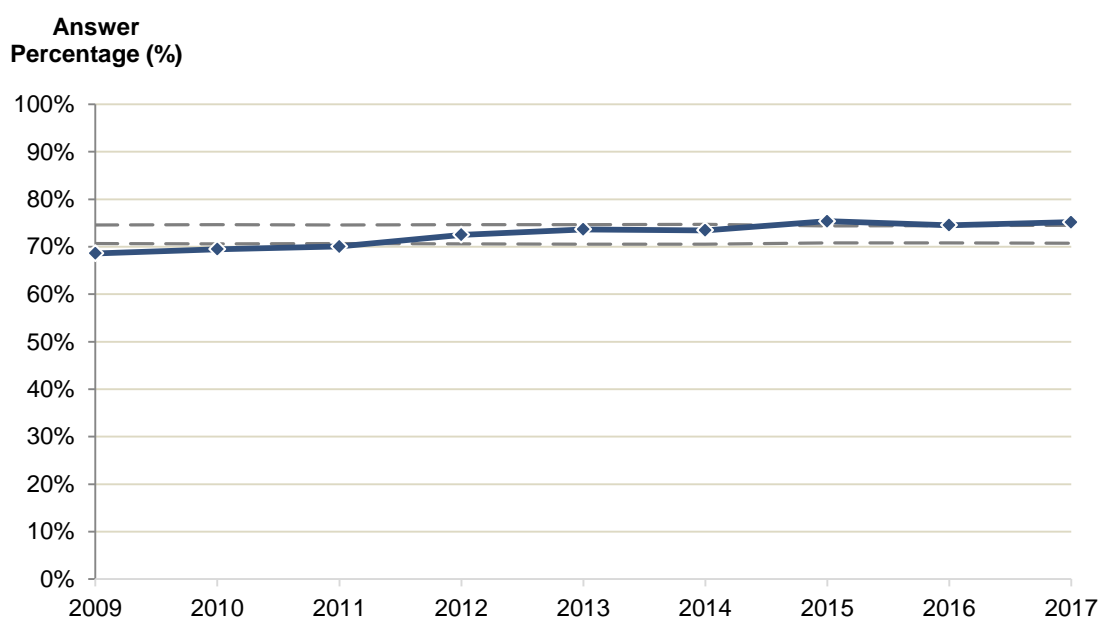
Number of respondents: 2009 (67,224), 2017 (70,596)

Responsiveness

The Royal College of Anaesthetists' (RCoA) Good Practice Guide stresses the duty of care for all healthcare professionals to effectively manage patient's pain. RCoA acknowledges that anaesthetists share the duty of care for each patient in a care episode, and that good information sharing and appropriate delegation is needed to effectively manage a patient's pain. Equally, failure for nurses to regularly monitor patient pain or administer pain relief in 30 minutes can be evidence that nurse staffing levels are not sufficient.[95]

Almost two thirds of respondents (65%) were in pain while in hospital. Of those who said that they had been in pain, 69% thought staff 'definitely' did everything they could to control their pain, and a further 24% thought they did 'to some extent'. There has been no notable change in results for this question since 2009.

Academic research has shown a correlation between call bell responsiveness and patient satisfaction; patients who are dissatisfied with the length of time it takes to respond to their call tend to be dissatisfied with all other aspects of their care while in hospital.[96]

This year respondents were asked whether they were able to get help from a member of staff in a reasonable time. Sixty-one per cent thought they were 'always' able to get help in a reasonable time, 32% thought this 'sometimes' and 7% thought 'no'. This question was introduced in 2017 and has no historical comparisons.

7. Operations and procedures

The [Good surgical practice] guidance from the Royal College of Surgeons states that effective communication and clarity of information exchange is essential for quality of care and patient safety, as well as meeting the standards of good medical practice.[97] Honest discussion with the patient about their treatment options, which reflects on the patient's preferences, will help to build an effective relationship with the patient and obtain informed consent.[98]

In parallel, the Royal College of Anaesthetists advises that patients should be fully informed about planned procedures and participate in a collaborative decision-making process, while all patients undergoing elective procedures should be provided with easily understood information covering their operation, anaesthesia and post-operative pain relief before being admitted to hospital.[99]

Fifty-eight per cent of respondents to the inpatient survey had undergone an operation or procedure. Of those, 81% thought staff answered their questions about the operation or procedure in a way they could 'completely' understand. This is a significant increase from 78% in 2016. Sixty-two per cent thought they were completely told how they would expect to feel after their operation by a member of staff. This is also a significant increase from 58% in 2016. Twelve per cent had not been told how they could expect to feel in 2017.

The graph below shows the percentage of patients who had an operation or procedure and thought the staff member 'completely' explained how the procedure or operation went in a way they could understand. In 2017, 69% thought staff 'completely' explained how the operation or procedure had gone. Since 2009, there has been a gradual improvement with this question. Since 2015, results have been notably more positive and above the expected limits of change.

Q47. After the operation or procedure, did a member of staff explain how the operation or procedure had gone in a way you could understand? (Answer: 'yes, completely')

Answer percentage (%)
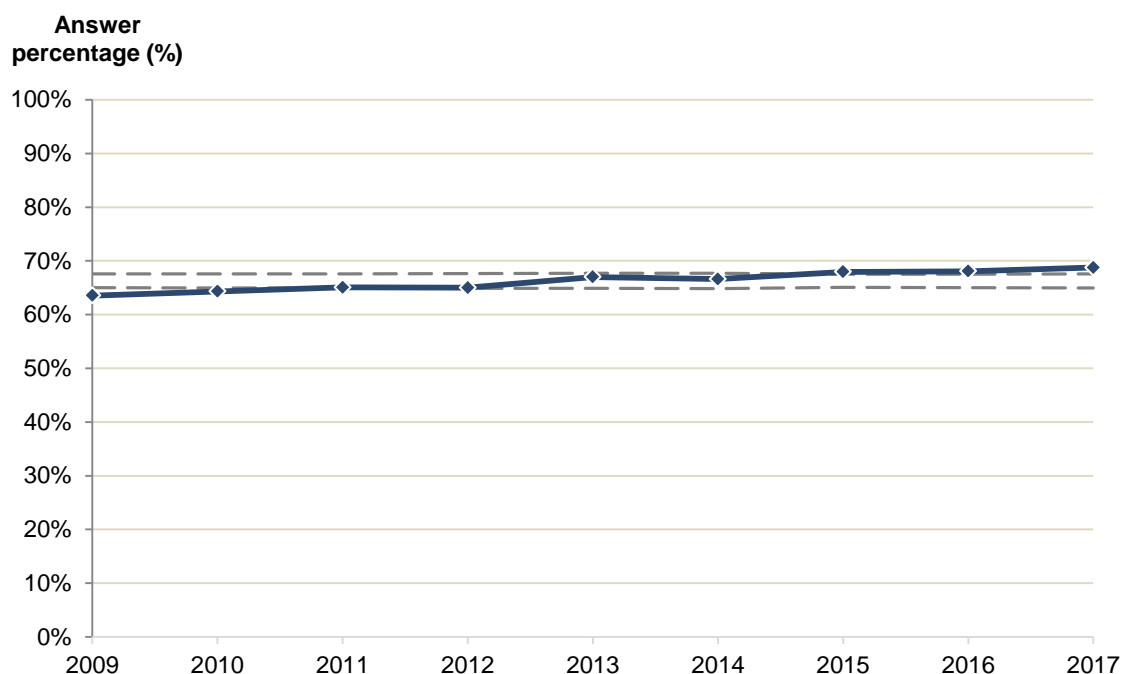
Number of respondents: 2009 (42,600), 2017 (40,725)

8. Leaving hospital

Involvement

All patients should be involved, as much as they would like to be, in decisions around leaving hospital and should receive the right information and support. The 2017 to 2019 Integration and Better Care Fund policy framework features patient-centred care as a necessary feature of effective integrated care. This is supported by National Voices who advocate every patient should agree with the statement "I can plan my care with people who work together to understand me".[100] This notion is also reflected in Quality Statement 9: tailoring healthcare services to the individual of the NICE guidance, where a patient should expect care that is tailored to their needs and personal preferences, taking in to account their circumstances, their ability to access services and their coexisting conditions.

In 2017, 54% of respondents thought they were 'definitely' involved in decisions about their discharge. While 16% felt they were not involved in decisions about leaving hospital. There has been no notable change in this question since 2009.

Discharge delays

Discharge delays are a concern in NHS hospitals and trusts incur financial and clinical costs when a patient's discharge is delayed. Hospital care is more expensive

than care in other settings, and it is therefore more desirable for a patient to be cared for in another setting, such as a care home or their own home, if it is appropriate to do so.[101] NICE states that when planning to discharge a patient, the hospital and community-based multidisciplinary teams should work together to address barriers to a safe discharge which include homelessness, suitable care home placement, and safeguarding issues.[102] CQC's programme of local system reviews of health and social care has highlighted the challenges that older people experience around discharges including delays, coordination and access to ongoing support.

Broadly in line with previous surveys, just over half of respondents (55%) thought they were 'definitely' given enough notice of when they were going to be discharged. Whereas 14% of respondents thought they were not. In 2009, these figures were 54% and 14% respectively.

Forty-one per cent of survey respondents said their discharge was delayed. The graph below shows the main reason for these delays that are related to the NHS. This year 72% had to wait for medicines, 16% waited to see the doctor and 12% had to wait for an ambulance. Delays owing to social care availability are not accounted for in this question.

Q51. What was the MAIN reason for the delay?
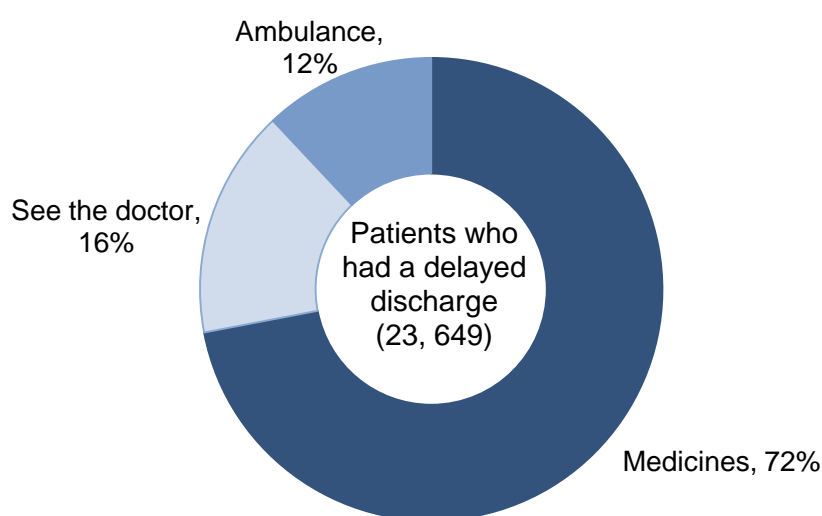
Note: Excludes those whose discharge was not delayed and those who were delayed for 'some other reason'.

Twelve per cent of delayed discharges were delayed up to an hour, which is a significant decrease from 14% in 2016, indicating there has been an increase in delay times. Just under a quarter (24%) were delayed for longer than four hours, which remains unchanged from the previous year.

Leaving hospital

Poor coordination around supported care plans for leaving hospital can reduce the quality of life for patients and carers and cause them distress. NICE guidance,

[Quality statement 3: coordinated discharge](#), advises service providers to coordinate the discharge of an adult with social care needs appropriately to the patient's needs.

As in previous years, most patients went home after leaving hospital (90%), and 5% were transferred to another hospital or a residential nursing home. Of those respondents who went home or stayed with family or friends after discharge, 53% thought they 'definitely' got the support they needed from health and social care professionals to help recover and manage their condition. However, 22% did not get this support but believed that this would have been useful.

Information at discharge

The [NHS Constitution](#) pledges that all patients should have easy access to reliable and relevant information about their condition, care, and support plan in a form they can understand. This will enable patients to participate fully in their own healthcare decisions.[33] NICE guidelines recommend that patients are given information (verbal and in written format) and that they receive the support and encouragement they need to be actively involved in their own care and to self-manage their conditions.[15]

The graph below shows the percentage of patients who left hospital and were given some written or printed information about what they should and should not do after leaving hospital. In 2017, 62% said they received such information, which is a decrease from 67% in 2013 which was above expected limits.

Q56: Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital? (Answer: 'Yes')
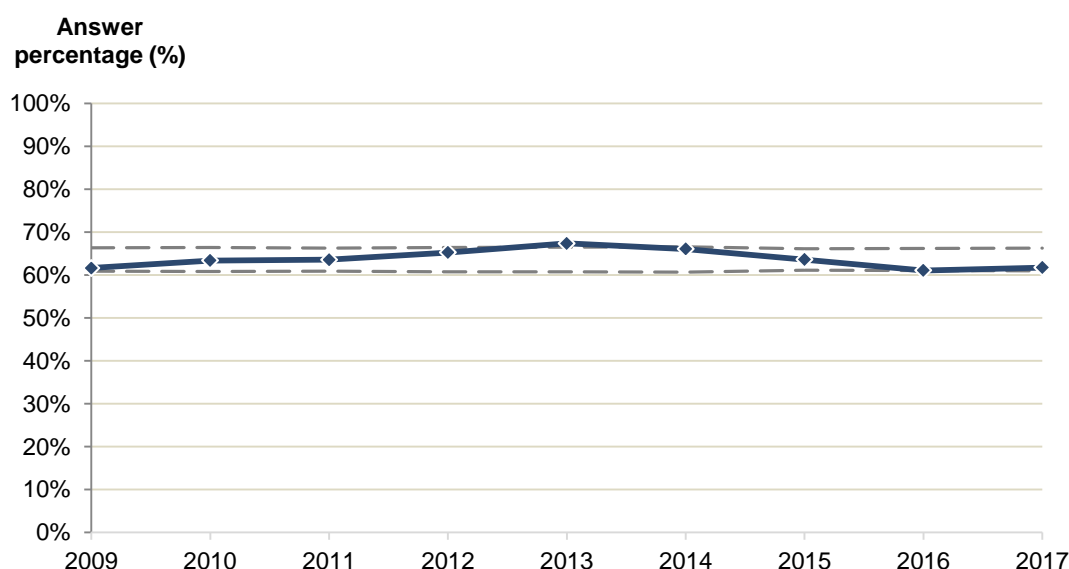
Number of respondents: 2009 (66,804), 2017 (69,939)

NICE [Quality statement 14](#) advises that patients are given clear advice on who to contact and how and when to make contact about their ongoing health care needs.

When the respondents were asked whether a member of staff told them who to contact if they were worried about their condition or treatment after they left hospital, 76% said 'yes'. This has remained similar since 2014.

The Royal Pharmaceutical Society sets the standard that patients should be given information about their medicines in a form they can understand before discharge or transfer of care.[83] NICE gives guidance that inpatients should receive the same pharmaceutical information as patients in other settings; this includes the methods of taking the medicine and side effects to look out for.[103]

The majority of patients who left hospital with medicines thought a member of staff explained the purpose of the medicine in a way that they can understand. Seventy-four per cent said the purpose was confirmed 'completely' and 17% said 'yes, to some extent'. However, 9% thought they were not told why they should take new medication.

Of those respondents who were given medicines to take at home, 43% said a member of staff did not tell them about any side effects to look out for. However, three quarters (75%) of patients, when asked whether a member of staff told them how they should take their medication, said 'yes, completely'. This is unchanged from 2016.

When respondents were asked whether a member of staff told them about any 'danger signals' to look out for at home, 42% felt they were given this information 'completely', while over a third (36%) thought they were not. This is a significant decrease from 2016 (38%).

Subgroup analysis of the 'Information, communication, and education' composite show that those with ICD-10 codes II (neoplasm, this group includes cancer patients), VII (diseases of the eye and adnexa) and IX (disease of the circulatory system) have an above average experience in this domain. Patients aged 80 years or more, or those with dementia or Alzheimer's disease, reported poorer than average experiences.

Information to family and friends

NICE quality statement 13 (quality standard 15) states that patients' preferences for sharing information with their partner, family members or carers should be established, respected and reviewed throughout their care. Failing to notify a patient's family, carer or someone close to them can have a direct effect on their recovery and wellbeing. NICE illustrates this point by warning that poor coordination of care can delay care transfers and re-admissions, and cause poor care and avoidable admissions to residential or nursing care.[103]

Fifty-nine per cent of respondents said that staff 'completely' took into account their family or home situation when planning their discharge; this is unchanged since 2013. In 2017, 19% of respondents said staff did not take their family or home situation into account.

Almost half (49%) of survey respondents thought doctors or nurses 'definitely' gave their family, friend, or carer all the information they needed to care for them. However, 25% thought this did not happen. This question was modified for this year's survey and has no historical comparisons.

Integrated care

Integrated care continues to be a target for effective care and good patient experience. A patient of the NHS has the right to expect care that is tailored to their needs and preferences.[104] Equally, the NHS Patient Experience Framework states an element of good patient experience is transition and continuity in helping the patient to care for themselves. However, in The State of Health and Adult Social Care 2016/2017 CQC raised concerns of the gap between patient needs and the service and care being provided.

When survey respondents were asked whether a member of staff discussed whether they may need any further health or social care services after leaving hospital, 81% of patients said 'yes'. However, 19% said 'no, but I would have liked them to'.

The subgroup analysis of the 'Coordination and integration of care' composite shows patients aged 16 to 50 typically reported a poorer than average experience of integration of care after they left hospital. Section 10 contains the full results of this analysis.

9. Overall

Respect and dignity

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, made it a statutory requirement that all people who use services or patients are treated with dignity and respect. This requirement supports CQC's regulation of services and failing to treat people who use services with respect and dignity can trigger regulatory action.[105] NICE quality standard 1 states that patients should be treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty. Furthermore, the NHS Constitution states that patients have the right to be treated with respect and dignity, and that the NHS should actively encourage feedback from patients on their care.

Since 2009, the percentage of respondents who said they were 'always' treated with respect and dignity in hospital has increased, 82% in 2017 compared with 78% in 2009. Trend analysis indicates that there has been an underlying behavioural change since 2009, where results were below expected limits, and has risen above expected limits since 2015.

Q67: Overall, did you feel you were treated with respect and dignity while you were in the hospital? (Answer: 'Yes, always')

Answer percentage (%)
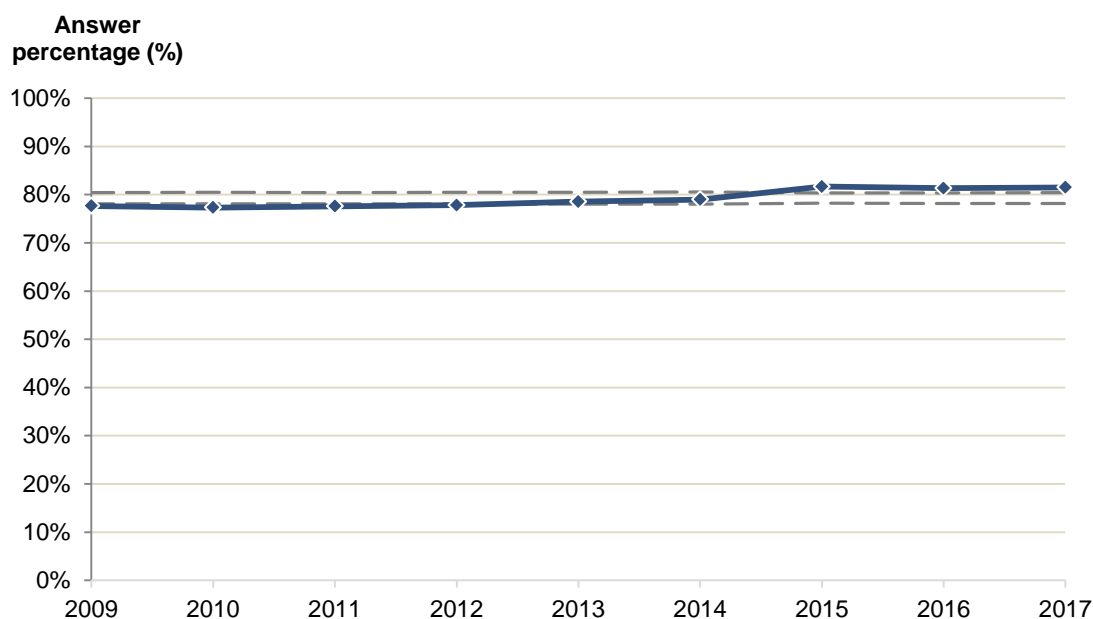
Number of respondents: 2009 (67,291), 2017 (71,099)

The subgroup analysis of this question has indicated that the following groups felt they were treated with less respect and dignity than other respondents.

- 16 to 35 year olds
- People with dementia or Alzheimer's disease
- People with a mental health condition
- ICD-10 code V (mental and behavioural disorder).

Respondents, who were 66 to 80 years old, or heterosexual, were more likely to report more positive experiences of dignity and respect.

This year we asked respondents whether they felt well looked after by non-clinical hospital staff, 84% said 'yes, always' and 2% said 'no'.

Patient feedback and complaints

In Equity and Excellence: Liberating the NHS (2010), DH committed to rate hospitals and clinical departments according to the care they provided. In support of this, the Friends and Family Test was developed and used by all trusts by 2013. The Friends and Family Test is a single question feedback tool for individual services to evaluate patient experiences and can be used to support local improvement. NICE advises that if necessary a patient should be given information about complaints procedures and help them to access these.[15]

The graph below shows the percentage of respondents who were asked to give their views on the quality of care they received. In 2017, 20% of respondents were asked to give their views, this was above the expected limits. We can see there was a real step change in the proportion of patients being asked to provide feedback in 2013, the year the Friends and Family Test was launched.[106] From 2013 to 2017 positive results broadly remained above expected limits. In 2017 the majority of respondents however (80%) felt they were still not asked to give their views on the quality of their care.

Q69: During your hospital stay, were you ever asked to give your views on the quality of your care? (Answer: 'Yes')

Answer Percentage (%)
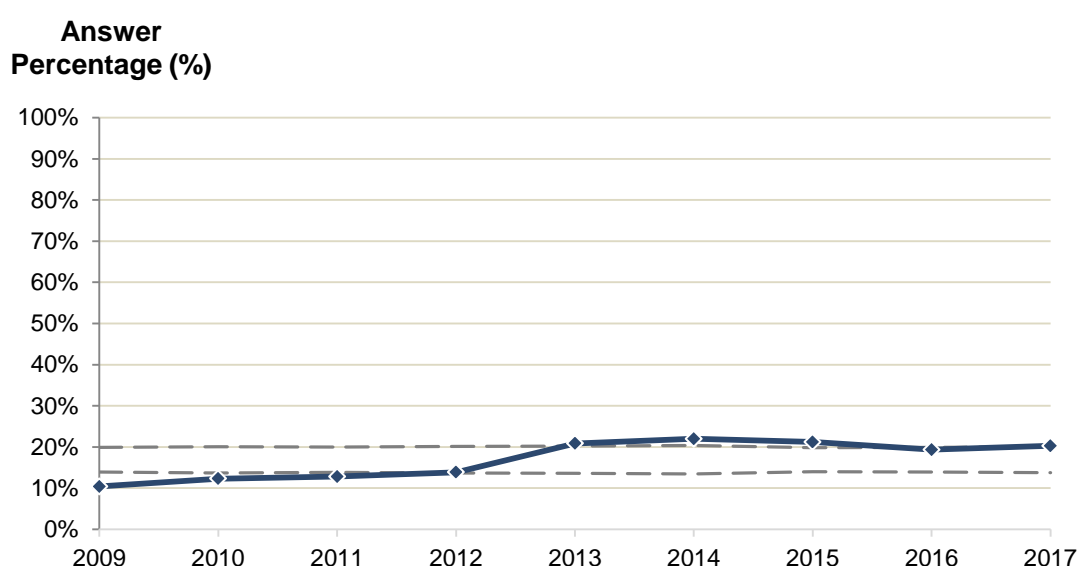
Number of respondents: 2009 (66,934), 2017 (60,975)

When respondents were asked whether they were given any information on how to complain to the hospital about the care they received 74% said 'no'. This is a significant decrease from 76% in 2016.

Overall experience

Respondents were asked to rate their overall hospital experience on a scale of zero to 10, where zero indicated a 'very poor' experience and 10 a 'very good' experience. In 2017, almost half (50%) of respondents rated their overall experience with a score of nine or above out of 10, compared with 48% in 2016 (a significant increase), shown in the graph below. Since 2012, when this question was first asked, there has been a positive gradual change, where the proportion of respondents rating nine or higher out of ten was above expected limits for change for 2017, this is also a statistically significant increase since 2016.

Q68: Overall… (Answer: '9 to 10' on a scale of '0 to10')

Answer percentage (%)
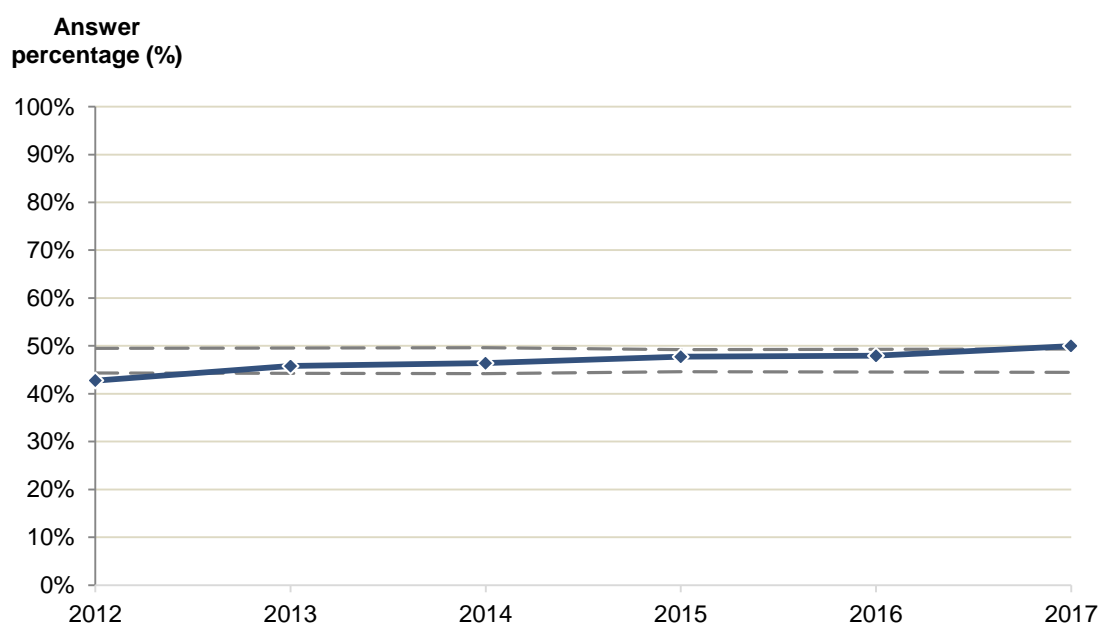
Number of respondents: 2009 (61,379), 2017 (69,496)

The subgroup analysis of this question showed that there was a poorer experience than average for the same subgroups who had a poorer than average experience of respect and dignity, including 16 to 35 year olds, people with dementia, and those with a mental health condition. There is also a better than average experience for the same subgroups highlighted in the respect and dignity analysis. Find a full analysis of this question in section 10.

10. How experience varies for different patient groups – subgroup analysis summary

Background

Additional analysis has been conducted to compare experiences of different subgroups of patients. This analysis uses multilevel model analysis, which compares the mean scores of a subset of questions by different groups.

The analysis modelled the mean scores of different subgroups – age, gender, religion, sexual orientation, ethnicity, (redeveloped for 2017) long-term health conditions, diagnosis (ICD-10 chapter codes), route of admission, length of stay, medical or surgical treatment type, and whether questionnaires were completed by patients themselves (or by a proxy respondent) – for a set of composites based on the NHS Patient Experience Framework.

1. Information, communication, and education (Q30, 36, 56, 64)
2. Respect for patient-centred values (Q23, 26, 34, 39 and 48)
3. Emotional support (Q37 and 38)
4. Confidence and trust (Q24, 27 and 35)
5. Coordination and integration of care (Q32, 54, 62, and 66)
6. Food choice (Q20)
7. Hydration (Q22)
8. Respect and dignity (Q67)
9. Overall question (Q68)

This section sets out the main differences between patient sub-groups. Detailed charts setting out all variables are shown in Appendix F: Subgroup analysis charts. See also Appendix G: ICD-10 Chapter codes.

For more information about the methodology used for the subgroup analysis, see the Survey methodology section.

Age

Overall, older patients reported more positive experiences and younger patients more negative ones. Patients aged 60 to 80 and 81and over tended to report more positive experiences, and younger respondents aged 16 to 35 reported more negative ones for themes of:

- Confidence and trust

- Coordination and integration of care

- Having had enough to drink while in hospital

- Being treated with respect and dignity

- Overall experience of care.

In addition, younger patients reported feeling less emotionally supported or feeling there was respect for their values, preferences and expressed needs, and patients aged over 81 years and over were more negative about their experiences of information and communication while in hospital.

Gender

In general there were almost no differences between male and female patient experience, with the exception of the **Information, communication, and education** composite, where females reported a below average experience.

Sexual orientation

Patient who would describe themselves as heterosexual or straight tended to have an above average experience in:

- Coordination and Integration of care

- Respect and dignity

- Respect for patient-centred values.

There is no overarching trend in the specific sexual orientation groups, other than those who respond as 'I would prefer not to say' had a poorer than average experience for **Confidence and trust**.

Ethnicity

There are few differences between ethnic groups. However, the 'Asian or Asian British' group appeared to have a below average experience in:

- Coordination and integration
- Overall experience of care
- Food choice.

Black or Black British patients reported poorer experiences for respect for patient centred values, preferences and needs and confidence and trust in staff.

Muslim patients reported above average experiences for respect for patient-centred values, needs and preferences and information, communication and education.

Long-term conditions

Patients that identified as having dementia or Alzheimer's disease had a poorer than average experience for:

- Information, communication, education
- Respect for patient-centred values
- Confidence and trust
- Hydration
- Respect and dignity
- Overall.

Those who did not have dementia or Alzheimer's disease consistently had a better than average experience in the composites and questions referred to above.

Respondents that declared they had a mental health condition had a poorer than average experience in composites:

- Information, communication, education
- Respect for patient-centred values
- Confidence and trust
- Coordination and integration
- Respect and dignity
- Overall.

In contrast, those that did not have a mental health condition had an above average experience for all stated composites and questions.

Patients with neurological conditions also reported poorer experiences for confidence and trust, respect and dignity, respect for patient-centred values and overall experience of care.

Appendix A: Survey methodology

As with all surveys in the NHS Patient Survey Programme, the inpatient survey used a postal questionnaire for survey data collection. The sample member received their first survey pack containing a questionnaire, covering letter, leaflet offering guidance on multi-language options for completing the questionnaire, and a flyer outlining the value of the data to CQC. This was followed by a reminder, then a final reminder containing another survey pack. The average time between each mailing was three weeks, allowing time to remove patients who had since died or had opted-out from mailings.

All patients aged 16 years or over at the time of their hospital stay were invited to take part if they were treated in the trust. Trusts drew a sample from their records of the sampling period (July 2017). The sample size was enough to allow analysis of results at individual trust level. Full details of the sampling are available in the instruction manual for the survey (see the links in Appendix C).

All trusts providing inpatient services were eligible to take part in the survey and no exclusions were applied during the running of the survey.

Fieldwork for the survey (the time during which questionnaires were sent out and returned) took place between August 2017 and January 2018.

Detailed demographic information for all patients who took part in the survey is available in the 'About the respondents' section in the Quality and Methodology report. According to the demographic, the information collected is similar to the 2016 survey, although there have been small changes in the age of respondents.

Age range of respondents

	Age of respondents from 2006 to 2015				
	16 to 35	**36 to 50**	**51 to 65**	**66 to 80**	**>80**
	%	%	%	%	%
2009	8	15	27	35	15
2010	8	14	26	36	16
2011	8	13	25	36	18
2012	7	13	25	37	19
2013	7	12	24	38	19
2014	6	11	23	39	20
2015	6	10	24	39	21
2016	5	9	23	41	22
2017	5	8	23	42	23

Overall, a higher proportion of respondents aged 66 or older responded in 2017 compared with the 2016 survey. A slightly lower proportion of respondents aged 16 to 65 responded in 2017 compared with 2016.

The year-to-year change in age profile is small, but shows that the respondent population is changing. As a result, the national statistics in this report have been adjusted for non-response in the sample for the survey.

There were no significant changes in the gender of respondents compared with those in the 2016 survey. There is a small, but significant, change in the ethnic group of respondents with a small decrease in White respondents, and a small increase in Arab or other ethnic groups.

The Quality and Methodology report also contains relevant background information to help readers to understand the survey data, including response rates, sampling errors and data limitations.

Analysis methodology

Weighting

Some trusts have a higher response rate than others and would, therefore, have a greater influence over the England average if a simple mean was calculated across all respondents. To avoid this, weights are applied to the data. By applying these weights, the responses from each trust have an equal influence over the England average, regardless of differences in response rates between trusts.

A new weighting method was applied to the inpatient survey this year. While the construction of 'trust weights' have remained the same as previous years, the weighting that accounts for individual trust demographics has altered from its previous construction.

'Trust weights' are useful for calculating national figures because they describe the results of the hypothetical 'average trust' for a given year. As they are intended to produce a single estimate, they do not take into account any of the individual level variables that are related to how people respond – such as age, gender, and route of admission. Further weighting this year compensates for such non-response. This method minimises changes to historical analysis as this weight will not change in future. Both sets of weights are then multiplied together to produce a single combined weight for the data tables that underpin the analysis.

This weighting has been applied to all questions except for demographic questions and filter questions. The demographic questions are presented without weights applied, as it is more appropriate to present the real percentages of respondents to describe the profile of respondents, rather than adjust figures.

Rounding

The tables present percentage figures rounded to the nearest whole number, so the values given for any question will not always add up to 100%. Please note that rounding up or

down may make differences between survey years appear bigger or smaller than they actually are.

Statistical significance

Statistical tests were carried out on the data to determine whether there had been any statistically significant changes in the results for 2017 compared with 2016.

A 'z-test' was used to compare data between the comparison years at the 95% confidence level. A statistically significant difference means it is very unlikely that we would have obtained this result by chance alone if there was no real difference.

Due to the large number of respondents, small changes in results between years may be statistically significant, but such small changes do not necessarily indicate a longer term trend. The use of 'p-charts' for this analysis shows whether change is in 'expected limits of variation'. Results outside these expected limits would suggest underlying behavioural or real change.

In other cases, even though there may be a visible change in the results between survey years, it is not significant. There are a number of reasons for this, such as:

- Rounding figures up or down makes a difference appear larger than it actually is.
- Generally speaking, the larger the sample size, the more likely that findings will be statistically significant and we can be more confident in the result. In contrast, the fewer people that answer a question, there has to be a greater difference to be statistically significant.
- The amount of variation also affects whether the difference is significant. 'Variation' means the differences in the way people respond to the question. If there is a lot of variance then differences are less likely to be statistically significant.

Subgroup analysis

Results for each demographic subgroup were generated as adjusted means (also known as estimated marginal means or population marginal means) using a multilevel model. These means were compared on composites of questions, illustrated in the charts. This kind of model takes into account trust clustering, as trusts are likely to have a big effect on reported patient experience at a national level. To assess whether experience differs by demographic factors, statistical significance tests were carried out; F tests were performed on each factor (fixed effect) as a predictor of the target variable. P-values were also generated which showed how likely it is that the differences between groups observed in the results could have arisen from a population where there were no actual differences. They relate to the demographic factor as a whole rather than to compare between specific categories in the factor. Variables were also checked for multicollinearity to ensure co-efficient estimates were not being influenced by additional factors.

Differences that are equivalent to at least 0.1 standard deviations from the overall mean of the target variable are treated as being noteworthy in this report.

Composites were created with questions about NHS patient experience framework. See Appendix F for the charts.

2017 is the second year this analysis has been performed. This analysis is not directly comparable to results of 2016 as the composite 'Information, Communication, Education' and 'Coordination and Integration' have omitted a question from the composite and additional subgroups have been added to the model.

Design and interpretation of the questionnaire

Changes made to the questionnaire in 2017 can be found Appendix D.

Appendix B: Comparisons with other data

Other countries have also conducted inpatient surveys. These surveys reflect people's experiences of different healthcare systems with different guidance and policies. Therefore, direct comparisons to this survey should be treated with caution because of differences in methodology and question design.

United Kingdom
Scotland

The Scottish Inpatient Experience is a biennial postal survey sent out in January each year to a random sample of people aged 16 years or over who had an overnight hospital stay between April and September of the previous year. The previous survey was carried out in 2016. The survey asks about patients' experiences of: admission to hospital; the hospital and ward environment, care and treatment including errors, operations, hospital staff, arrangements for leaving hospital, and care and support services after leaving hospital.

When asked to rate their overall inpatient experience, similar to England's results, most people responded positively.

Rating	Scotland (2016)	England (2017)
	%	%
0 (Negative)	1	1
1	1	1
2	1	1
3	1	2
4	2	2
5	6	4
6	4	5
7	10	11
8	23	23
9	21	22
10 (positive)	30	28

More information on the Scottish Inpatient Patient Experience survey is available at:
http://www.gov.scot/Topics/Statistics/Browse/Health/InpatientSurvey/Inpatient2016.

Northern Ireland

The previous Inpatient Experience Survey for Northern Ireland was carried out in 2014. This survey had many questions similar to the CQC Inpatient Survey questionnaire.

When respondents were asked about their overall experience in hospital, the majority of respondents gave a positive response.

Response	
	%
Very satisfied	52
Satisfied	36
Neither	6
Dissatisfied	3
Very dissatisfied	2

More information on the Northern Ireland Inpatient Patient Experience survey is available at:
https://www.health-ni.gov.uk/articles/inpatient-patient-experience-survey.

The rest of the world

Ireland

The first adult inpatient survey in Ireland was conducted in May 2017. This survey used similar methodology to the CQC Inpatient Survey 2017, with the addition of a web completion option. The 61 item questionnaire shares many questions with the CQC Inpatient questionnaire and some adjusting to Irish healthcare quality policy.

When asked to rate their overall inpatient experience from 0 to 10, similar to England's results, most people responded positively.

Rating	
	%
9-10 (very good)	54
7-8 (Good)	30
0-6 (Fair to poor)	16

More information of the Irish National Patient Experience Survey is available at:
https://www.patientexperience.ie/.

New Zealand

New Zealand's Health Quality and Safety Commission designed a 20 item adult inpatient survey that began in August 2014. This survey is conducted quarterly, providing patient experience data at the national and District Health Board level (similar to clinical commissioning groups (CCGs)).

The 20 items/questions cover four key domains of patient experience: communication, partnership, co-ordination, and physical and emotional need. Many of the questions are the same as those in the Inpatient Survey 2017.

When respondents were asked 'when you had important question to ask a doctor, did you get an answer that you could understand?' Similar to the English inpatient survey the majority of respondents answered 'always'.

Response	New Zealand (2015)	England (2017)
	%	%
Yes, always	76	68
Yes, sometimes	N/A	28
No	N/A	6

For more information on New Zealand's National Patient Experience Survey is available at:

https://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/patient-experience/adult-inpatient-experience/.

Appendix C: Further information and feedback

Further information

The 'technical document' describes the methodology for analysing the trust level results and a 'quality and methodology' document provides information about survey development and methodology: www.cqc.org.uk/inpatientsurvey.

Full details of the methodology for the survey, including questionnaires, letters sent to people who use services, instructions on how to carry out the survey and the survey development report, are available at: www.nhssurveys.org/surveys.

More information on the patient survey programme, including results from other surveys and a programme of current and forthcoming surveys can be found at: www.cqc.org.uk/surveys.

Further questions

This summary has been produced by CQC's Survey Team and reflects the findings of the adult inpatient survey 2017. The guidance above should help answer any questions about the programme. If you wish to contact the team directly, please contact Paul Williamson, User Voice Development Manager, Patient.Survey@cqc.org.uk.

Feedback

We welcome all feedback on the findings of the survey and the way we have reported the results – particularly from people using services, their representatives, and those providing services. If you have any views, comments or suggestions on how we could improve this publication, please contact Paul Williamson, User Voice Development Manager, Patient.Survey@cqc.org.uk.

We will review your feedback and use it as appropriate to improve the statistics that we publish across the NHS Patient Survey Programme.

If you would like to be involved in consultations or receive updates on the NHS Patient Survey Programme, please subscribe here.

National Statistics status

National Statistics status means that official statistics meet the highest standards of trustworthiness, quality and public value.

All official statistics should comply with all aspects of the Code of Practice for Official Statistics. They are awarded National Statistics status following an assessment by the Authority's regulatory arm. The Authority considers whether the statistics meet the highest standards of Code compliance, including the value they add to public decisions and debate.

It is a producer's responsibility to maintain compliance with the standards expected of National Statistics, and to improve its statistics on a continuous basis. If a producer becomes concerned about whether its statistics are still meeting the appropriate standards, it should discuss its concerns with the authority promptly. National Statistics status can be removed at any point when the highest standards are not maintained, and reinstated when standards are restored.

Appendix D: Changes for the questionnaire

The 2017 Adult Inpatient Survey has remained largely the same as the 2016 survey. However, there have been a number of changes to questions.

Six new questions were added.

Q12   Did you change wards at night?

Q13   Did the hospital staff explain the reasons for being moved in a way you could understand?

Q22   During your time in hospital, did you get enough to drink?

Q31   Did you have confidence and trust in any **other clinical staff** treating you (e.g. physiotherapists, speech therapists, psychologists)?

Q43   If you needed attention, were you able to get a member of staff to help you **within a reasonable time**?

Q71   Did you feel well looked after by the **non-clinical** hospital staff (e.g. cleaners, porters, catering staff)?

Eleven questions were removed:

Q12   During your stay in hospital, how many wards did you stay in?

Q13   **After you moved** to another ward (or wards), did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?

Q14   While staying in hospital, did you ever use the same bathroom or shower area as patients of the opposite sex?

Q18   How clean were the toilets and bathrooms that **you** used in hospital?

Q19   Did you feel threatened during your stay in hospital by other patients or visitors?

Q44   How many minutes after you used the call button did it usually take before you got the help you needed?

Q46   Beforehand, did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?

Q47   Beforehand, did a member of staff explain what would be done during the operation or procedure?

Q50   Before the operation or procedure, were you given an anaesthetic or medication to put you to sleep or control your pain?

Q51   Before the operation or procedure, did the anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain in a way you could understand?

Q73   During your time in hospital did you feel well looked after by hospital staff?

Two questions were modified:

Q11.   When you were **first** admitted to a bed on a ward, did you share a sleeping area, for example a room or bay, with patients of the opposite sex?

To:

Q11.   While in hospital, did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?

Q68.   Did the doctors or nurses give your family or someone close to you all the information they needed to help care for you?

To:

Q63.   Did the doctors or nurses give your family, friends or carers all the information they needed to help care for you?

The long-term health conditions questions were also re-developed:
From:

Q78   Do you have any of the following long-standing conditions?
(**Cross ALL boxes that apply**)

1 ☐	Deafness or severe hearing impairment	➔ **Go to 79**
2 ☐	Blindness or partially sighted	➔ **Go to 79**
3 ☐	A long-standing physical condition	➔ **Go to 79**
4 ☐	A learning disability	➔ **Go to 79**
5 ☐	A mental health condition	➔ **Go to 79**
6 ☐	A long-standing illness, such as cancer, HIV, diabetes, chronic heart disease, or epilepsy	➔ **Go to 79**

Q79 Does this condition(s) cause you difficulty with any of the following?
(**Cross ALL boxes that apply**)

1 ☐ Everyday activities that people your age can usually do

2 ☐ At work, in education, or training

3 ☐ Access to buildings, streets, or vehicles

4 ☐ Reading or writing

5 ☐ People's attitudes to you because of your condition

6 ☐ Communicating, mixing with others, or socialising

7 ☐ Any other activity

8 ☐ No difficulty with any of these

To:

Q73 Do you have any physical or mental health conditions, disabilities or illnesses that have lasted or are expected to last for 12 months or more? Include problems related to old age.

1 ☐ Yes
2 ☐ No

Q74 Do you have any of the following?
Select **ALL** conditions you have that have lasted or are expected to last for 12 months or more.

1 ☐ Breathing problem, such as asthma

2 ☐ Blindness or partial sight

3 ☐ Cancer in the last 5 years

4 ☐ Dementia or Alzheimer's disease

5 ☐ Deafness or hearing loss

6 ☐ Diabetes

7 ☐ Heart problem, such as angina

8 ☐ Joint problem, such as arthritis

9 ☐ Kidney or liver disease

10 ☐ Learning disability

11 ☐ Mental health condition

12 ☐ Neurological condition

13 ☐ Another long-term condition

Find more details about changes to this year's questionnaire in our development report for the NHS adult inpatient survey 2017 on the NHS Surveys website, www.nhssurveys.org/surveys/1102.

Appendix E: Other sources of information related to survey results

NHS Outcomes Framework indicators

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

For more information about the NHS Outcome Framework, please visit the NHS Digital and GOV.UK websites:

http://content.digital.nhs.uk/m/nhsof

https://digital.nhs.uk/media/33830/NHS-Outcomes-Framework-Indicators-November-2017-Summary-Dashboard/default/nhs-out-fram-ind-nov-17-dash https://beta.digital.nhs.uk/.

Waiting times

For further information on waiting times in accident and emergency (A&E), please see NHS England's statistical release on A&E Attendances and Emergency Admissions. The data includes the count of patients who waited more than four hours from arrival to admission, transfer or discharge:

https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/.

For further information on elective admission waiting times, please see NHS England's statistical release on hospital activity:

https://www.england.nhs.uk/statistics/statistical-work-areas/hospital-activity/quarterly-hospital-activity/qar-data/.

The data does not measure people's experiences of waiting times and is, therefore, not directly comparable.

Counts of nurses

For further information on counts of qualified nursing staff (including qualified nursing, midwifery and health visiting staff) please see the NHS Digital's Information Centre's statistical release on NHS Workforce Statistics. The data does not measure people's experiences of nurse counts and is not directly comparable. The data includes the count of total qualified nursing staff:

http://content.digital.nhs.uk/workforce.

Delayed transfers of care

For further information on levels of delayed transfers of care, please see NHS England's statistical release. The data does not measure people's experiences of delays and is therefore not directly comparable. The data includes the count of patients with a delayed transfer of care and information on the cause of those delays: https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/.

Why we ask the questions

The inpatient questionnaire is continuously developed to make sure that it covers as much about people's experiences of their care and treatment as is reasonable in a limited survey. While originally developed before the publication of many standards on patient experience, the survey aligns, as far as possible, with good practice in patient experience, taking into account the NHS Patient Experience Framework and quality standard developed by NICE outlined below.

NHS Patient Experience Framework

In October 2011, the NHS National Quality Board (NQB) agreed on a working definition of patient experience to guide the measurement of patient experience across the NHS. The NHS Patient Experience Framework outlines those elements that are of critical importance to patients' experiences of NHS Services. For further information on the NHS patient experience framework, please see:

https://www.gov.uk/government/publications/nhs-patient-experience-framework

https://www.gov.uk/government/news/a-framework-for-nhs-patient-experience.

Quality standard for patient experience in adult NHS services

The National Institute for Health and Care Excellence (NICE) has a Quality Standard for patient experience in adult NHS services, which outlines 14 quality statements about patient experience. The standard aims to provide the NHS with clear commissioning guidance on the components of a good patient experience. The quality standard gives evidence-based statements for commissioners that provide the foundation for an 'NHS cultural shift' to a patient-centred service. For further information on the NICE quality standard, please see:

https://www.nice.org.uk/guidance/qs15.

Appendix F: Subgroup analysis charts

Key:
Above mean score
Below mean score

Information, communication, and education: difference from mean score by subgroup with 95% confidence interval

Difference from mean score

Difference from mean score
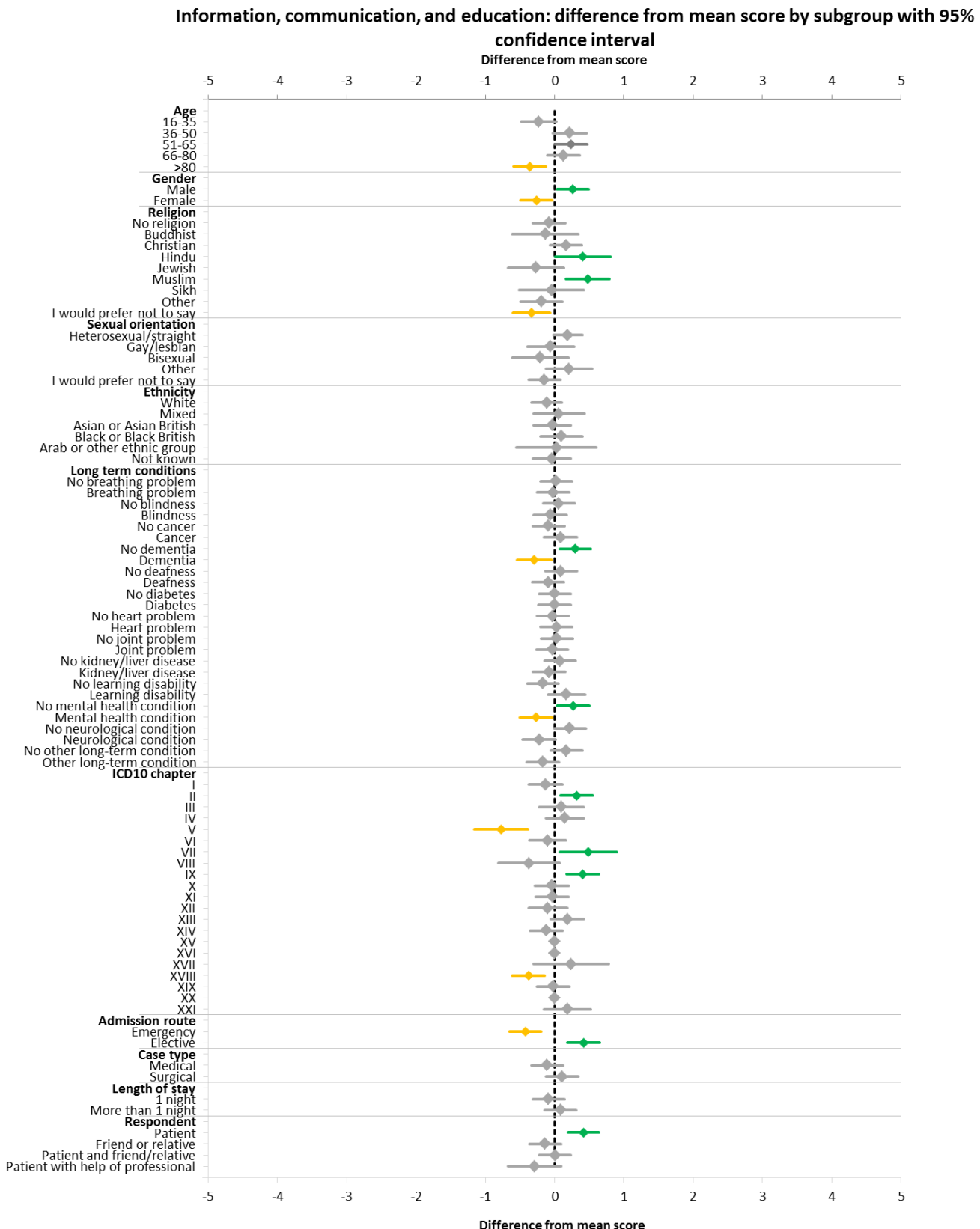
Respect for patient-centred values, preferences, and expressed needs: difference from mean score by subgroup with 95% confidence interval
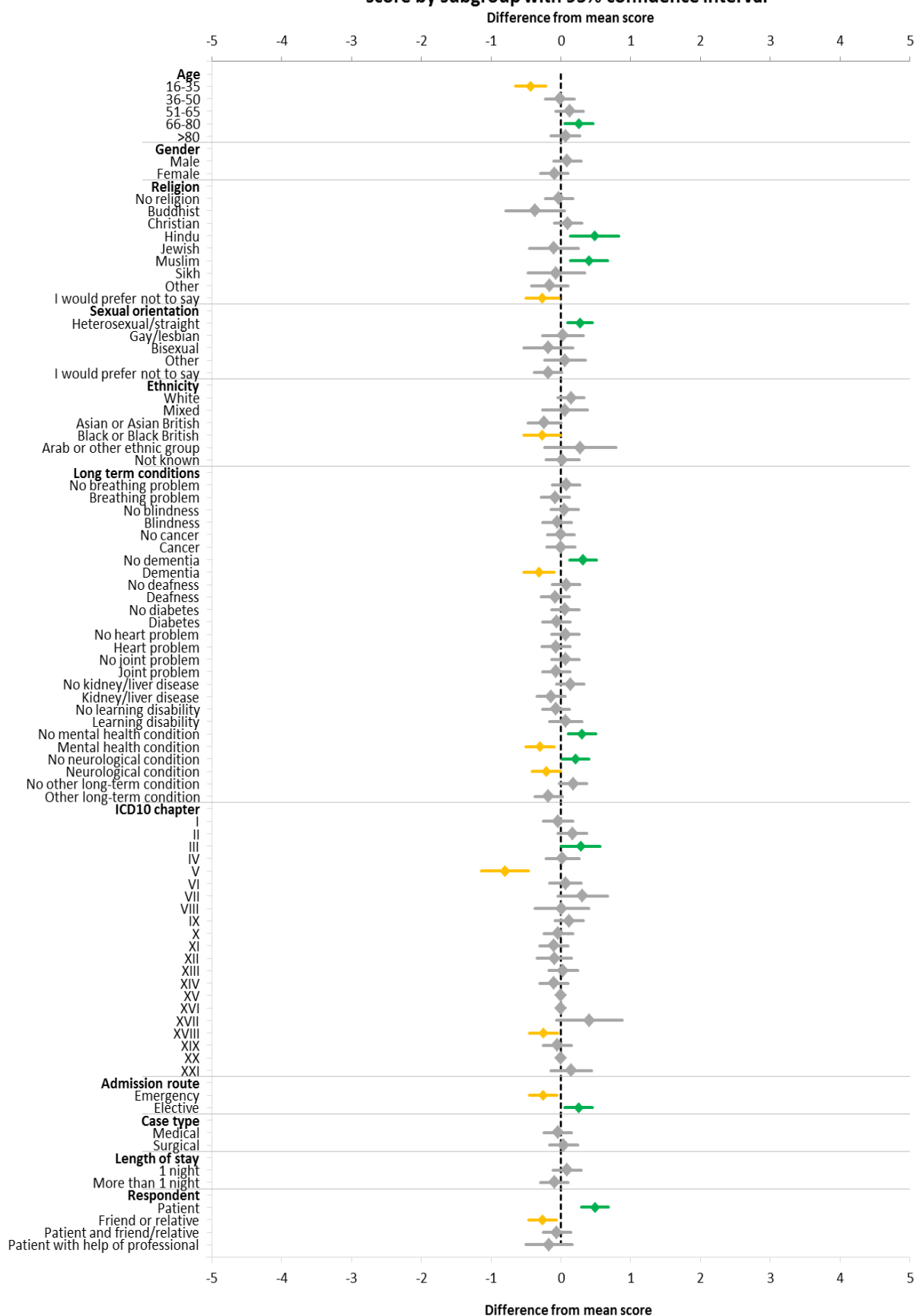
Emotional support: difference from mean score by subgroup with 95% confidence interval

Confidence and trust: difference from mean score by subgroup with 95% confidence interval

Difference from mean score

Age
- 16-35
- 36-50
- 51-65
- 66-80
- >80

Gender
- Male
- Female

Religion
- No religion
- Buddhist
- Christian
- Hindu
- Jewish
- Muslim
- Sikh
- Other
- I would prefer not to say

Sexual orientation
- Heterosexual/straight
- Gay/lesbian
- Bisexual
- Other
- I would prefer not to say

Ethnicity
- White
- Mixed
- Asian or Asian British
- Black or Black British
- Arab or other ethnic group
- Not known

Long term conditions
- No breathing problem
- Breathing problem
- No blindness
- Blindness
- No cancer
- Cancer
- No dementia
- Dementia
- No deafness
- Deafness
- No diabetes
- Diabetes
- No heart problem
- Heart problem
- No joint problem
- Joint problem
- No kidney/liver disease
- Kidney/liver disease
- No learning disability
- Learning disability
- No mental health condition
- Mental health condition
- No neurological condition
- Neurological condition
- No other long-term condition
- Other long-term condition

ICD10 chapter
- I
- II
- III
- IV
- V
- VI
- VII
- VIII
- IX
- X
- XI
- XII
- XIII
- XIV
- XV
- XVI
- XVII
- XVIII
- XIX
- XX
- XXI

Admission route
- Emergency
- Elective

Case type
- Medical
- Surgical

Length of stay
- 1 night
- More than 1 night

Respondent
- Patient
- Friend or relative
- Patient and friend/relative
- Patient with help of professional

Difference from mean score

Coordination and integration of care: difference from mean score by subgroup with 95% confidence interval

Difference from mean score

-5 -4 -3 -2 -1 0 1 2 3 4 5

Age
16-35
36-50
51-65
66-80
>80
Gender
Male
Female
Religion
No religion
Buddhist
Christian
Hindu
Jewish
Muslim
Sikh
Other
I would prefer not to say
Sexual orientation
Heterosexual/straight
Gay/lesbian
Bisexual
Other
I would prefer not to say
Ethnicity
White
Mixed
Asian or Asian British
Black or Black British
Arab or other ethnic group
Not known
Long term conditions
No breathing problem
Breathing problem
No blindness
Blindness
No cancer
Cancer
No dementia
Dementia
No deafness
Deafness
No diabetes
Diabetes
No heart problem
Heart problem
No joint problem
Joint problem
No kidney/liver disease
Kidney/liver disease
No learning disability
Learning disability
No mental health condition
Mental health condition
No neurological condition
Neurological condition
No other long-term condition
Other long-term condition
ICD10 chapter
I
II
III
IV
V
VI
VII
VIII
IX
X
XI
XII
XIII
XIV
XV
XVI
XVII
XVIII
XIX
XX
XXI
Admission route
Emergency
Elective
Case type
Medical
Surgical
Length of stay
1 night
More than 1 night
Respondent
Patient
Friend or relative
Patient and friend/relative
Patient with help of professional

-5 -4 -3 -2 -1 0 1 2 3 4 5

Difference from mean score

Q20 Were you offered a choice of food: difference from mean score by subgroup with 95% confidence interval

Difference from mean score

Difference from mean score

Q22 Did you get enough to drink: difference from mean score by subgroup with 95% confidence interval

Difference from mean score

| | -5 | -4 | -3 | -2 | -1 | 0 | 1 | 2 | 3 | 4 | 5 |

Age
16-35
36-50
51-65
66-80
>80
Gender
Male
Female
Religion
No religion
Buddhist
Christian
Hindu
Jewish
Muslim
Sikh
Other
I would prefer not to say
Sexual orientation
Heterosexual/straight
Gay/lesbian
Bisexual
Other
I would prefer not to say
Ethnicity
White
Mixed
Asian or Asian British
Black or Black British
Arab or other ethnic group
Not known
Long term conditions
No breathing problem
Breathing problem
No blindness
Blindness
No cancer
Cancer
No dementia
Dementia
No deafness
Deafness
No diabetes
Diabetes
No heart problem
Heart problem
No joint problem
Joint problem
No kidney/liver disease
Kidney/liver disease
No learning disability
Learning disability
No mental health condition
Mental health condition
No neurological condition
Neurological condition
No other long-term condition
Other long-term condition
ICD10 chapter
I
II
III
IV
V
VI
VII
VIII
IX
X
XI
XII
XIII
XIV
XV
XVI
XVII
XVIII
XIX
XX
XXI
Admission route
Emergency
Elective
Case type
Medical
Surgical
Length of stay
1 night
More than 1 night
Respondent
Patient
Friend or relative
Patient and friend/relative
Patient with help of professional

Difference from mean score

Q67 Did you feel you were treated with respect and dignity: difference from mean score by subgroup with 95% confidence interval

Difference from mean score

Q68 Overall...:difference from mean score by subgroup with 95% confidence interval

Difference from mean score

Age
16-35
36-50
51-65
66-80
>80
Gender
Male
Female
Religion
No religion
Buddhist
Christian
Hindu
Jewish
Muslim
Sikh
Other
I would prefer not to say
Sexual orientation
Heterosexual/straight
Gay/lesbian
Bisexual
Other
I would prefer not to say
Ethnicity
White
Mixed
Asian or Asian British
Black or Black British
Arab or other ethnic group
Not known
Long term conditions
No breathing problem
Breathing problem
No blindness
Blindness
No cancer
Cancer
No dementia
Dementia
No deafness
Deafness
No diabetes
Diabetes
No heart problem
Heart problem
No joint problem
Joint problem
No kidney/liver disease
Kidney/liver disease
No learning disability
Learning disability
No mental health condition
Mental health condition
No neurological condition
Neurological condition
No other long-term condition
Other long-term condition
ICD10 chapter
I
II
III
IV
V
VI
VII
VIII
IX
X
XI
XII
XIII
XIV
XV
XVI
XVII
XVIII
XIX
XX
XXI
Admission route
Emergency
Elective
Case type
Medical
Surgical
Length of stay
1 night
More than 1 night
Respondent
Patient
Friend or relative
Patient and friend/relative
Patient with help of professional

Difference from mean score

Appendix G: ICD-10 chapter codes

Chapter code	Disease/Health problem
I	Certain infectious and parasitic diseases
II	Neoplasms
III	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism
IV	Endocrine, nutritional and metabolic diseases
V	Mental and behavioural disorders
VI	Diseases of the nervous system
VII	Diseases of the eye and adnexa
VIII	Diseases of the ear and mastoid process
IX	Diseases of the circulatory system
X	Diseases of the respiratory system
XI	Diseases of the digestive system
XII	Diseases of the skin and subcutaneous tissue
XIII	Diseases of the musculoskeletal system and connective tissue
XIV	Diseases of the genitourinary system
XV	Pregnancy, childbirth and the puerperium
XVI	Certain conditions originating in the perinatal period
XVII	Congenital malformations, deformations and chromosomal abnormalities
XVIII	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified
XIX	Injury, poisoning and certain other consequences of external causes
XX	External causes of morbidity and mortality
XXI	Factors influencing health status and contact with health services
XXII	Codes for special purposes

For more information visit the World health Organization's website, or the ICD-10 User guide.

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