NHS Patient Survey Programme

2016 Adult Inpatient Survey

Statistical release

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Independent data analysis

Contents

Summary of findings

The 2016 adult inpatient survey received feedback from 77,850 patients who received care in an NHS hospital during July 2016. The report shows that the results for many aspects of patients' experiences of care have remained relatively stable since 2006. This report presents the 2016 results for questions that have showed substantial improvement or decline over time, identifying long-term trends where appropriate. It also presents results that have a significant bearing on national policy and compares the experiences of patients with some of the protected characteristics under the Equality Act 2010.

Results for all questions in the 2016 survey are published in the Open data section on our website, www.cqc.org.uk/inpatientsurvey.

The analysis of 10 year trend data shows that the 2016 inpatient survey indicate that results for many questions remain largely unchanged. However, there are small significant improvements, particularly around the quality of communication and confidence in medical staff.

Whilst longer term trends are positive (2006 to 2016) and indicate overall improvement, there are a substantial number of areas where results have declined in the last year (between 2015 and 2016). This is particularly around patients feeling involved in their care, waiting for a bed on a ward, and care after leaving the hospital. There were also significant differences in experience between particular subgroups across a number of themes including age, religion, sexual orientation, long term conditions and diagnosis. Results also indicate that more patients are being admitted to hospitals for urgent and critical care, 61% of patients were admitted as an emergency (53% in 2006) and 24% were admitted to critical care areas (19% in 2006).

Improvements over time

Over the last ten years, there have been consistent small improvements in the quality of communication between medical professionals and patients. Patients' confidence in doctors and nurses remains high, increasing from 75% of patients who *always* had confidence in nurses in 2006 to 80% in 2016. More patients report that doctors do not talk in front of them as if they were not there, rising from 71% in 2006 saying 'no', to 78% in 2016. Questions that asked about information given before and after operations or procedures all showed either small improvements or unchanged results since last year. Communication around pain relief and the effects of general anaesthetics has improved this year (86%), up 1 percentage point since 2015 (85%), and up 3 percentage points since 2006 (83%).

People's perceptions of the standard of hospital cleanliness continue to remain high. Seventy-two per cent of respondents in 2016 said their room or ward was 'very clean', which is an increase of 18 percentage points over the past 10 years (54% in

2006), three percentage points in the last five years (67% in 2011) and the same as 2015. Sixty-four per cent of patients thought their toilets and bathrooms were 'very clean' which is consistent with 2015. Patients are also more positive about the food offered in hospitals, with 24% reporting that it is 'very good' (20% in 2006, and 23% in 2015).

Declines over time

There are several instances where survey results have declined since last year, disrupting the overall upward trend since 2006. Though these declines are generally small, taken together they appear to show a change in patients' experience of their care. Patients this year reported feeling less involved in aspects of their care and treatment; just over half (56%) felt involved in decisions about their treatment, which is 3 percentage points down from last year. It is a similar situation for involvement in discharge decisions, with 55% of respondents saying they 'definitely' felt involved, down 1 percentage point since 2015.

Information sharing when leaving hospital has also declined in 2016. Sixty-four per cent of patients said they received enough information when leaving the hospital, a decline of 2 percentage points since last year. Fewer people this year were told about the side-effects of medication when they got home, with 38% of patients reporting 'yes, completely', compared to 40% in 2015.

Many patients were also facing longer waiting times in 2016. Fourteen per cent of patients said they had to wait a long time for a bed, up 2 percentage points from last year. There has also been an increase in the time it takes to be seen after pressing the call button; 17% of patients waited more than 5 minutes, which is 3 percentage points up from 2006.

Integrated care is another area of concern. In the 2015 statistical release, we reported that support after leaving the hospital was a key area for improvement. In 2016, just over half (55%) of the patients surveyed said they received enough support from health and social care workers to manage their conditions. Twenty-one per cent of patients said they did not receive enough support, which is a two per cent increase from 2015.

How experience varies for different patient groups

A subgroup analysis showed that patients with a mental health condition and those with a disease of the nervous system report a poorer experience of care across all areas of the NHS patient experience framework; information sharing, respect and dignity, coordination of care, confidence and trust and emotional support. This is consistent with results found as part of the 2015 Adult Inpatient survey where we conducted analysis to compare experiences of patients with self-reported mental

health conditions against experiences of other patients who did not report these conditions.

In all areas of the analysis, the experience of patients who have mental health conditions was poorer than for patients with no mental health conditions. For example, they were more likely to say that they:

- were not as involved in decisions around care and treatment as they wanted to be

- did not receive enough information about their care and treatment

- did not get enough emotional support from staff during their stay

- did not get enough support from health or social care professionals to help them recover and manage their conditions.

These results support the varied experiences for patients with mental health conditions found in the 2014 A&E survey and the 2014 children and young people's survey.

The analysis also showed some distinct differences for gay and lesbian respondents, who reported poorer experience for emotional support, coordination and integration of care and respect and dignity.

Introduction

Acute Hospitals

NHS trusts have faced serious challenges in the last few years. These challenges are set to continue as hospitals have to manage a steadily increasing demand for their services, at a time when they are also required to make large efficiency savings.

CQC's State of care in NHS acute hospitals: 2014 to 2016 report found that hospitals faced an unprecedented demand for urgent and emergency services in the winter of 2016/17, with a third of trusts issuing alerts in December 2016 warning that they needed urgent action to cope with the pressure of patient numbers.

Despite these challenges, CQC have built up a picture from comprehensive inspections that shows that the majority of hospital services are providing good care and looking after patients well. However, there remains a great deal of variation in the quality of care both between hospitals and between services of the same hospital. [1]

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.

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 increasingly recognised within the NHS. The NHS Constitution published in 2012 (updated in 2015) 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 and is intended to help NHS trusts improve.[2]

The Department of Health's NHS Mandate 2016 to 2017, published in 2014 (updated in 2015), focuses on those areas identified as being of greatest importance to people – one of which is ensuring that people have a positive experience of care.[3] Domain 4 of the NHS outcomes framework also highlights the importance for hospitals to improve responsiveness to patients' personal needs.[4]

Research, including that carried out in the development work for the NHS Patient Survey Programme, has identified many aspects of care that are important to people using services. These include: being informed and offered options; staff listening to and spending enough time with them; and being involved in their own care.[5]

Evidence from academic research suggests that when people are involved in their own care, decisions are made more effectively and health outcomes improve.[6]

Academic research further suggests that patient experience is positively associated with patient safety and clinical effectiveness.[7] This is supported by research conducted by the National Institute for Health and Care Excellence (NICE), which provides guidance for healthcare professionals to improve patient experience.[8] These themes are reflected in all the questionnaires used in the NHS Patient Survey Programme.[9]

In November 2015, we published Trends in the adult inpatient survey 2005-2014, which suggested that people's experiences of inpatient care have remained largely consistent over the past decade. Experiences were generally good and have mostly remained steady. The areas that show sustained improvement, such as cleanliness, mixed sex accommodation and patient feedback, have been the focus of national campaigns, using mechanisms such as targets, incentives and penalties to change behaviour.[10]

This survey

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

The adult inpatient survey has been running annually since 2004. Wherever possible, questions remain the same over time to measure change. However, it is important to reflect changes in policy and best practice, and to reflect feedback from stakeholders each year to ensure that questions remain relevant.

The questionnaire for the 2016 inpatient survey is broadly similar to the 2015 questionnaire, with the addition of three new questions:

20. Did you get enough help from staff to wash or keep yourself clean?

21. If you brought your own medication with you to hospital, were you able to take it when you needed to?

32. Did you know which nurse was in charge of looking after you? (This would have been a different person after each shift change)

And removal of one question:

20. Were hand wash gels available for patients and visitors to use?

Find more details about the changes to this year's questionnaire in our Development report for the NHS Adult Inpatient Survey 2016 on the NHS Surveys website, http://nhssurveys.org/survey/1793.

This report presents the key results from the most recent (2016) inpatient survey and highlights statistically significant differences between the survey results dating back to 2006 (ten years earlier), 2011 (five years earlier) and 2015 (one year earlier). It also identifies long-term trends where appropriate. Results for all questions are published on our website, www.cqc.org.uk/inpatientsurvey.

Background to the adult inpatient survey

Who participated in the survey?

The 2016 inpatient survey involved 149 NHS acute and NHS foundation trusts in England who sent questionnaires to a total of 185,007 patients. Responses were received from 77,850 people, which is an adjusted response rate of 44%. Trusts selected a sample of patients who received care in hospital during July 2016 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 2016 and January 2017.

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 2016.
- Women using obstetrics or maternity services, including those who had a spontaneous miscarriage.
- Patients admitted for planned termination of pregnancy.
- Psychiatry patients.
- 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.

The survey also collected basic demographic information for all patients who took part, which is available in the 'About the respondents' section in the Quality and Methodology (Q&M) report (see link in Appendix D). The tables in the Q&M report show that basic demographics for respondents remain similar to the 2015 survey, although there have been small but statistically significant changes in the age of respondents.

Age range of respondents

	Age of respondents from 2006 to 2015				
	16-35	**36-50**	**51-65**	**66-80**	**>80**
	%	%	%	%	%
2006	10	16	26	34	14
2007	9	15	27	34	14
2008	9	15	27	34	15
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

Overall, a higher proportion of respondents aged 66 or older responded in 2016 compared to the 2015 survey. A lower proportion of respondents aged 16 to 65 responded in 2016 compared to 2015.

The year-to-year change in age profile is small, but the accumulative change has increased considerably since 2006. To account for this year-to-year change, the results were standardised to ensure that changes in the age profile are accounted for and fairer comparisons between years are made. All data points since 2006 were weighted and adjusted to the age, gender and route of admission of respondents in 2016.

Additional analysis also indicated there was a general trend that as patients become older, they report more positive experiences (see Subgroup analysis summary and Appendix F: Subgroup analysis charts sections). The 16-35 category had below average scores across the majority of questions in the analysis.

There were no significant changes in the ethnic profile or gender of respondents compared with those in the 2015 survey.

The Q&M report also contains relevant background information to help readers to understand the survey data, including response rates, sampling errors and data limitations (see links in Appendix D).

Policy context

Increased demand

The NHS deals with over 1 million patients every 36 hours.[11] According to the NHS Confederation's Key facts and trends in acute care, activity has increased substantially in the acute sector in recent years.[12] This is supported by Hospital Episode Statistics (HES) data from December 2011 to November 2016 for admitted patient care. Finished consultant episodes (FCE) rose from 17.7 million to 19.6 million, FCE which included at least one procedure/episode rose from 10.6 million to 11.7 million, Finished admissions episodes (FAE) rose from 15.2 million to 16.4 million and FAE that were emergency admissions rose from 5.3 to 5.9 million.[13]
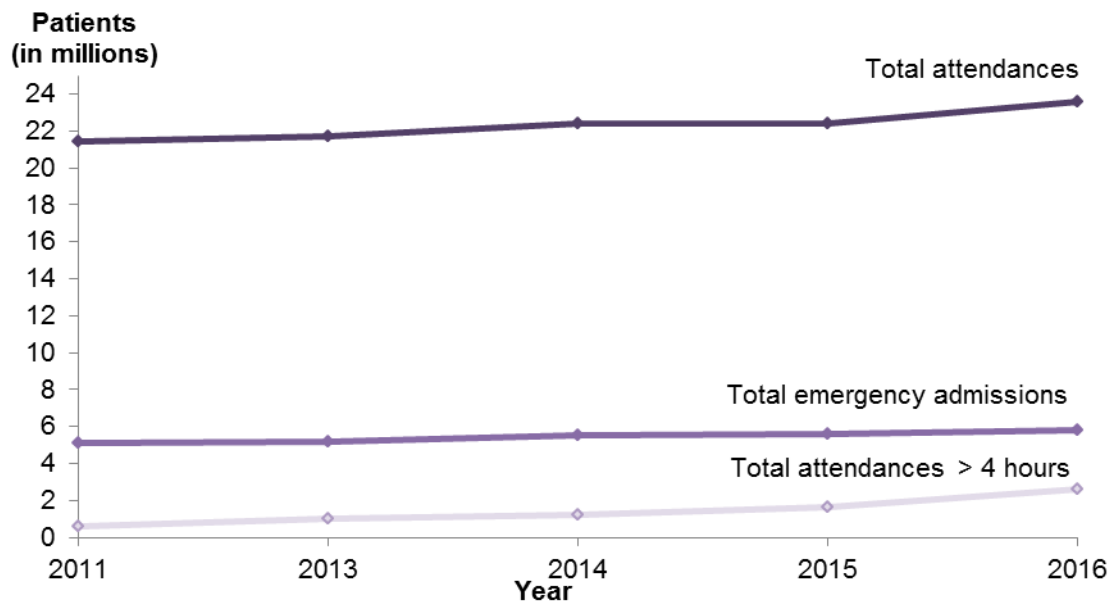
Hospital Episode Statistics data for admitted patient care: 12/2011 to 11/2016
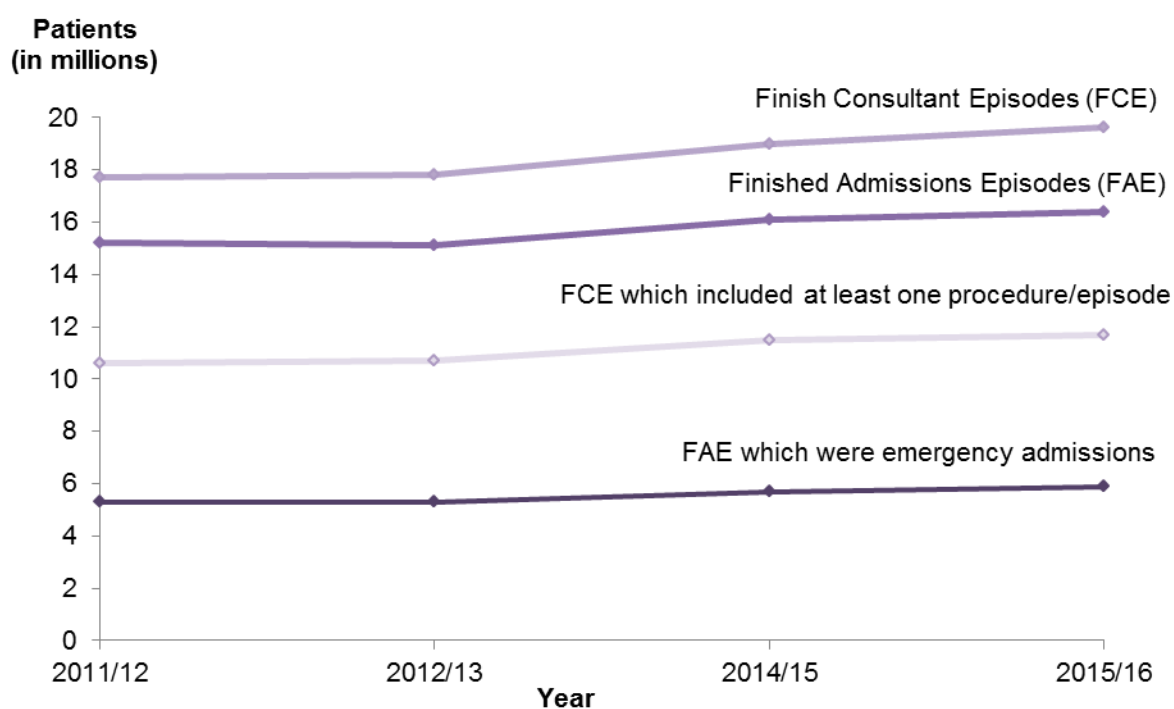
Note: Hospital episode statistics (HES) are produced and published on a monthly basis. This data is provisional and should therefore be treated as an estimate until the final National Statistics annual publications.

According to NHS England's A&E Attendances and Emergency Admissions data, total attendances rose from 21.4 million in 2011 to 23.6 million in 2016, the total number of patients waiting more than four hours rose from 600,000 in 2011 to 2.6 million in 2016 and total emergency admissions rose from 5.1 million in 2011 to 5.8 million in 2016.[14]

A&E attendances and emergency admissions: 2011 to 2016

Note: Hospital episode statistics (HES) are produced and published on a monthly basis. This data is provisional and should therefore be treated as an estimate until the final National Statistics annual publications.

Waiting times

The NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment. This means that patients have the legal right to start their non-emergency, NHS consultant-led treatment within a maximum of 18 weeks from referral, unless they choose to wait longer or it is clinically appropriate to do so. Patients with urgent conditions such as cancer and heart disease will be able to see a specialist more quickly.

The constitution sets a standard that 92% of all patients waiting to start treatment should have been waiting for less than 18 weeks. Therefore no more than 8% of patients should be waiting more than 18 weeks. The proportion of patients who are on the waiting list for more than 18 weeks and still waiting to be treated increased from 8.2% in December 2015 to 10.3% in December 2016. In total, there were more than 268,900 patients waiting to begin their treatment at the end of December 2015. The figure has risen to more than 376,800 at the end of the same time in 2016.[15,16, 17, 18]

Delayed transfers of care

Delayed transfers of care (DToC) occur when patients are well enough to leave hospital, but are still occupying a bed. They delay the flow of patients through the hospital, so that patients in other wards, including A&E, are not able to progress through the system as efficiently as they should. Between January 2016 and December 2016, there were 1.44 million 'delayed days' in the acute sector in comparison to 1.14 million days in the same time period in 2015 due to DToC. Over

this 2016 period, 49,747 patients were affected by these delays in comparison to 39,938 patients in 2015. Between January 2016 and December 2016, the NHS lost more than 1.02 million bed days due to patients waiting for social care-related support.[19,20]

Integrated care

Another challenge is to achieve much closer integration of health and social care. Current policy is aimed at cutting the number of emergency admissions by providing increased and better services outside hospital that can either prevent the need for hospital admission or offer the same care but in different settings. This is a common theme in initiatives for integrated services, including the Government's Better Care Fund.[21]

According to the Parliamentary and Health Service Ombudsman's (PHSO) report of investigations into unsafe discharge from hospital (2016), poor coordination of the discharge process has led to delayed transfers of care, poor or absent care and emergency re-admissions. Their casework exhibits a lack of joint working at various points across the discharge process: within hospital teams, between acute and non-acute NHS services and between health and social care services.[22]

Staffing levels

Ensuring NHS hospitals are staffed with the appropriate number and mix of clinical professionals is vital to the delivery of quality care and in keeping patients safe from avoidable harm.[23]

NICE's Safe staffing for nursing in adult inpatient wards in acute hospitals provides recommendations for hospitals on their responsibilities to support safe staffing for nursing in individual acute adult inpatient wards. The guideline states that there is no single nursing staff-to-patient ratio that can be applied across the whole range of wards to safely meet patients' nursing needs. Each ward has to determine its nursing staff requirements to ensure safe patient care. The emphasis should be on safe patient care not the number of available staff. This includes recommendations to review the nursing staff establishment for the ward and adjust it if needed.

Bed occupancy

High levels of bed occupancy are disruptive for both patients and hospital staff, and have a knock-on effect for the rest of the health system.

As bed occupancy increases, it becomes harder for staff to accommodate emergency patients who need to be admitted from A&E. One of the key causes of the high number of patients stuck between the A&E department and a bed on a ward is the lack of available beds elsewhere in the hospital.

High levels of bed use has a direct impact on patients, who tend to get moved around to accommodate others and there is a greater risk of infection, as it becomes increasingly difficult to isolate patients in the case of an outbreak. The link between high bed occupancy and increased rates of infection is supported by academic

research.[24] NHS England's Bed availability and occupancy-overnight data tells us that acute and general bed occupancy has been on the rise since Quarter 1 of 2010/11.[25]

Bed availability and occupancy-overnight data: Quarter 1 2010/11 to Quarter 3 2016/17
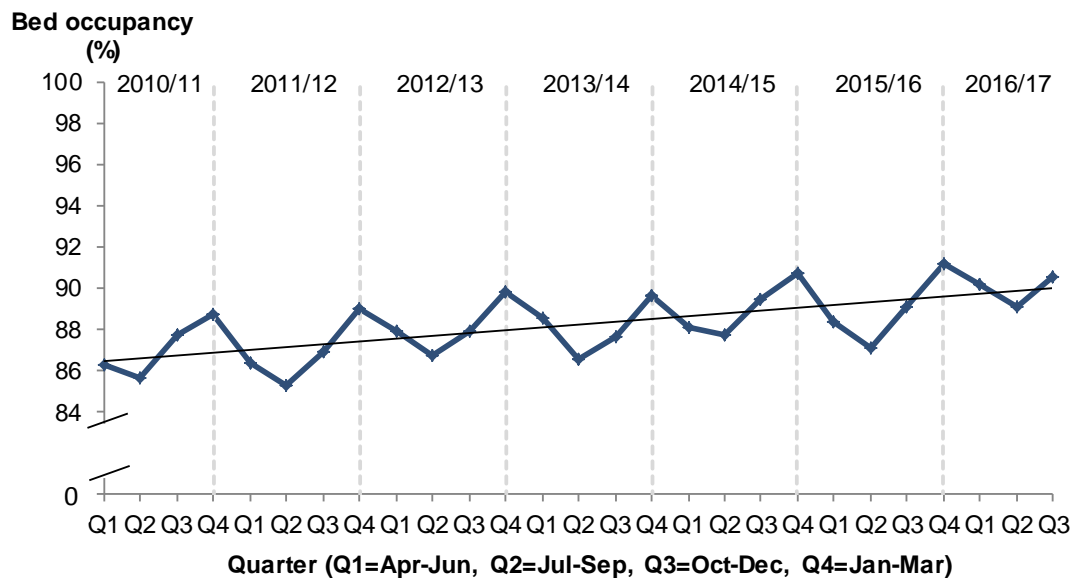
Note: Quarterly collection from all NHS organisations that operate beds, open overnight or day only. It collects the total number of available bed days and the total number of occupied bed days by consultant main specialty. Prior to 2010-11 the data was an annual return collecting beds by ward classification.

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.

People with mental health problems have worse outcomes for their physical healthcare, and those with physical conditions often have mental health needs that go unrecognised. NHS England's objective is to put mental health on a par with physical health, and close the health gap between people with mental health problems and the population as a whole.[26]

The mandate also sets out methods for the NHS to achieve the Government's aim of achieving 'parity of esteem' between mental and physical health. In *The NHS belongs to the people: a call to action* (published in 2013), the NHS defines parity of esteem as, "making sure that we are just as focused on improving mental health as physical health and that patients with mental health problems don't suffer inequalities, either because of the mental health problem itself or because they then don't get the best care for their physical health problems."[27]

Results from the survey

This section presents the results for the 2016 adult inpatient survey. It highlights statistically significant* differences between the results from the most recent survey (2016) and the results from previous inpatient surveys in 2006, 2011 and 2015**. This report presents the results that have changed substantially over time and identifies long-term trends where appropriate.

We have also included additional analysis to compare 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 and sexual orientation. The Act provides an important legal framework which 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 conditions and diagnosis (ICD-10 chapter codes) - for a set of composites based on the NHS Patient Experience Framework.

1. Information sharing (Q32, 37, 61, 66 and 69)
2. Respect for patient-centred values (Q25, 28, 35, 40 and 53)
3. Emotional support (Q38 and 39)
4. Confidence and trust (Q26, 29 and 36)
5. Coordination and integration of care (Q33, 59, 60, 67 and 71)
6. Food choice (Q23)
7. Respect and dignity (Q72)
8. Overall question (Q74)

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

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* Statistical tests were carried out to determine whether there had been statistically significant changes in the results. All of the 11 most recent inpatient surveys (2006 to 2016) have contributed to the data used in this report, but year-on-year significance testing has not been carried out for all the data points. Significance testing was done for 2016 compared to 2006, 2011 and 2015.

** During the sample-checking investigations for the 2016 survey, it was found that eight trusts had made sample drawing errors during previous iterations of the Adult Inpatient Survey. These had not been detected at the time due to the errors only being observable by way of historical comparison. As a result of these errors, three of the eight trusts were excluded from any historical comparisons produced for the 2016 survey, and their 2015 trust level results were removed from the NHS Surveys website. Their 2016 results were unaffected.

***A full methodology is provided in the survey methodology section.

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 beginning of their journey as an inpatient, and compliment a more comprehensive coverage of the experience of accident and emergency (A&E) patients published in our Accident and Emergency survey.

The 2016 inpatient survey results indicate that most respondents were admitted to hospital as an emergency or urgent case (61%). This is an increase from 2006 (53%), 2011 (57%) and 2015 (60%). Of the respondents admitted as an emergency or urgent case, the majority (87%, 86% in 2015) said that when they arrived at hospital they went to the A&E department.

Q1. Was your most recent hospital stay planned in advance or an emergency?
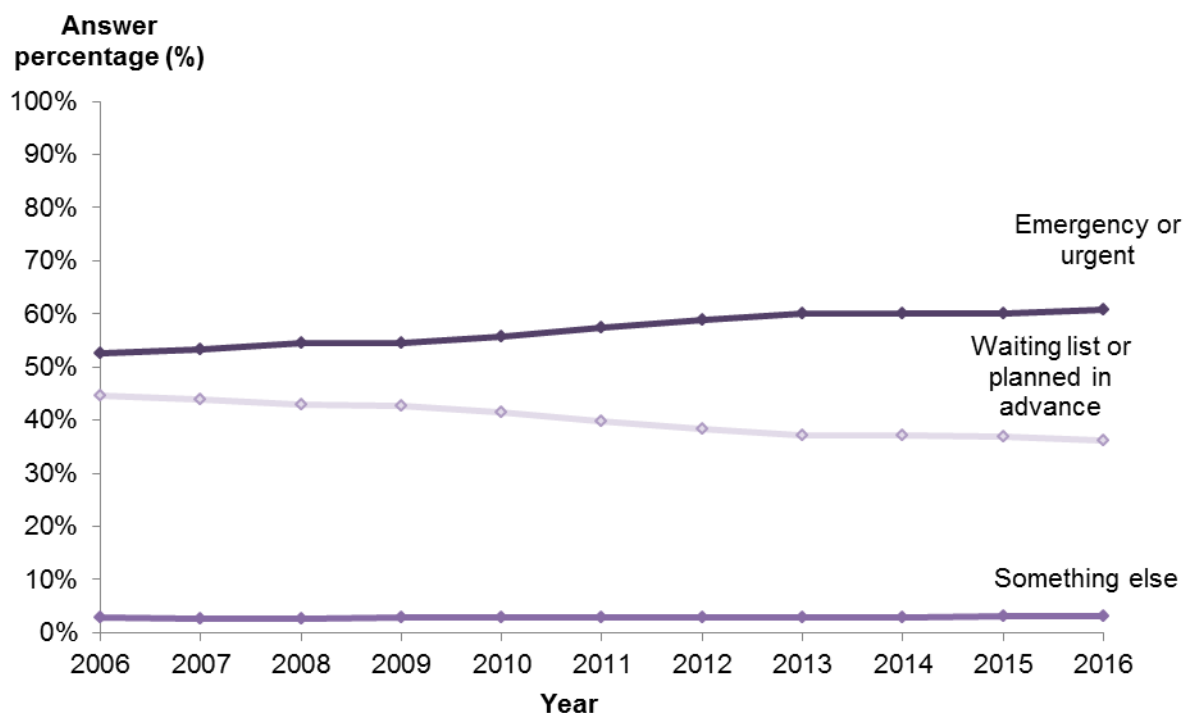
Number of respondents: 2006 (77,665) to 2016 (74,158)

This aligns with Hospital Episode Statistics (HES) data, which indicates that more people are being admitted to hospital from A&E.[28]

2. Accident and emergency (A&E) department

According to NHS data, A&E attendances are on the rise and figures suggest that people arriving at A&E have more serious health issues than ever before, which require them to be admitted into hospital.[29]

Of the respondents in this survey admitted to hospital through A&E, 76% said that while they were there, they were given the right amount of information about their condition or treatment, a decrease of one percentage point since 2015. Nine per cent said they were not given any information.

When patients were asked if they were given enough privacy in A&E, 79% of respondents answered 'yes, definitely', one percentage point down from last year. Comparing results further back to 2006 shows little has changed over the long term.

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

3. Planned admissions

According to the NHS mandate 2016 to 2017, timely access to services is a critical part of patient experience of care over the past 10 to 15 years. The NHS has made improvements in bringing down waiting times for services and has set strict waiting times targets for trusts, applying to both emergency care and planned admissions. NHS England's objective is to comply with these rights and fulfil the commitments set out in the NHS Constitution in this area and, where possible, to further improve the levels of performance in waiting times.[30]

Nearly three quarters of respondents (73%) who had a planned admission to hospital, or who were admitted from a waiting list, said they felt they were admitted to hospital as soon as they thought was necessary and 79% of patients said that their admission date was not changed by their hospital. Both these sets of figures had only very slight changes and have remained mostly consistent over the last 10 years.

4. All types of admissions

Overall, there has been a marked increase in how long patients have to wait to get a bed on a ward. In 2016, sixty-five per cent of patients said they did not have to wait a long time to get to a bed on a ward, in comparison to 69% in 2015, 68% in 2011 and 70% in 2006.

When looking at the difference in waiting times between emergency and planned admissions, the data indicates that emergency patients have been waiting longer to get a bed on a ward. Eighty-two per cent of respondents (2016) who said they definitely had to wait a long time were emergency admissions, compared to 78% in 2015, 75% in 2011 and 73% in 2006.

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?
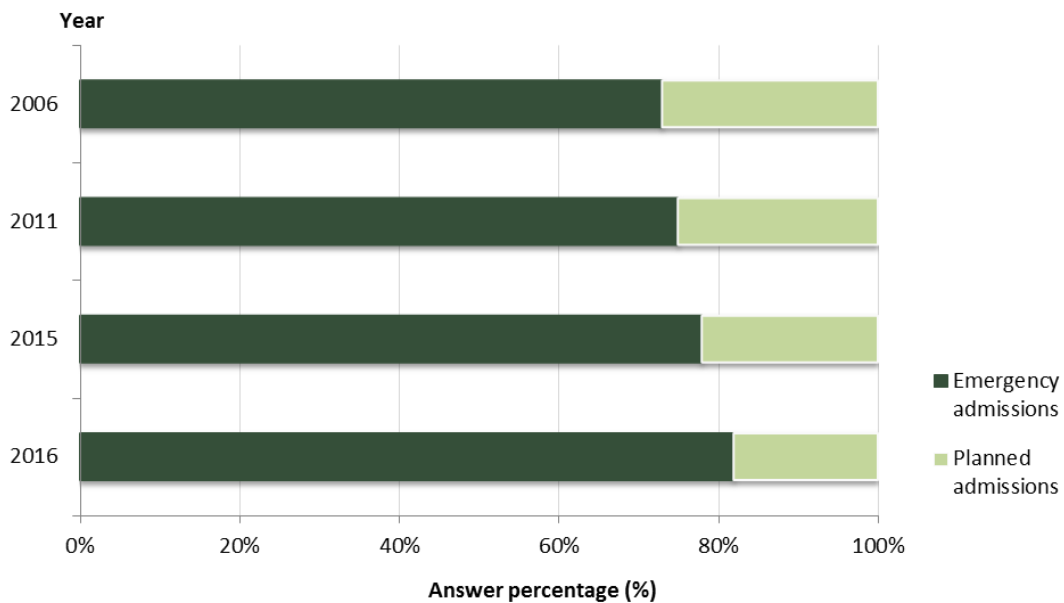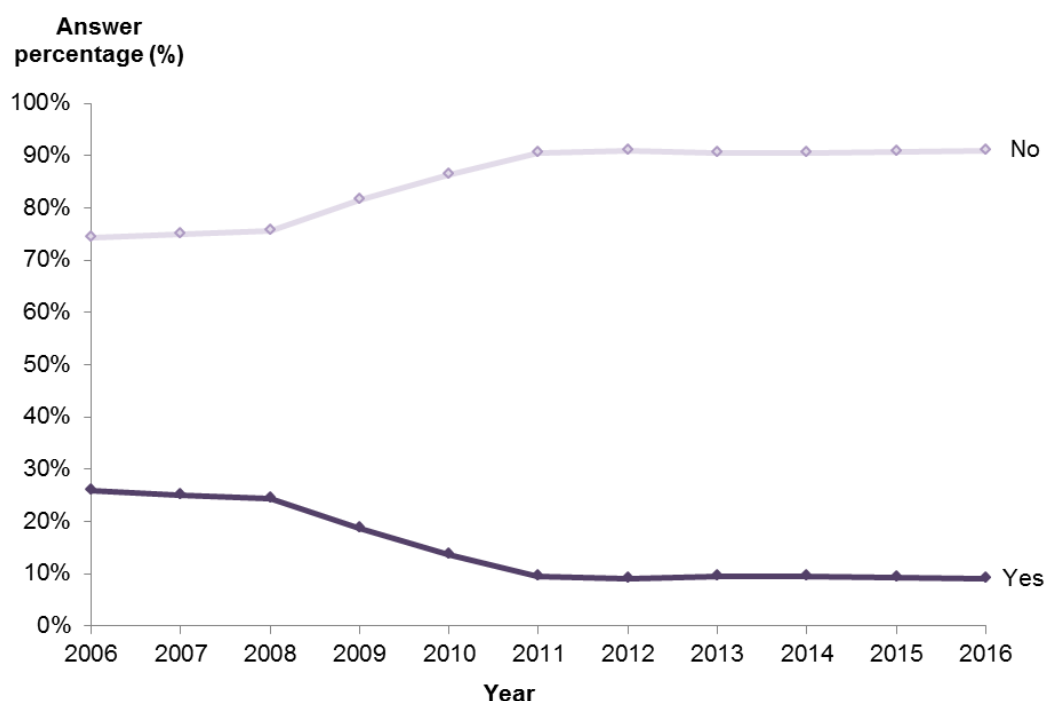

Number of respondents: 2006 (76,016) to 2016 (74,870) - All response options
Note: The chart displays data for the 'Yes, definitely' response option only

5. Hospital and ward

Mixed sex accommodation

Over the past decade, there has been a substantial increase in the proportion of patients only sharing a sleeping area with patients of the same sex. Between 2006 and 2016, the percentage of patients sleeping in single sex accommodation rose from 74% to 91%. Since 2006, the number of patients sharing a bathroom or shower area with only patients of the same sex has increased from 68% to 86% in 2016.

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?

Number of respondents: 2006 (76,379) to 2016 (74,998)
Note: Birmingham Women's NHS Foundation Trust and Liverpool Women's NHS Foundation Trust have been excluded from this question because they provide services for female patients only.

The improvement seen in all these figures was most pronounced since 2008. During this period, the Department of Health launched a Dignity in Care campaign, advocating a zero-tolerance approach to lack of dignity and respect in health and social care services.
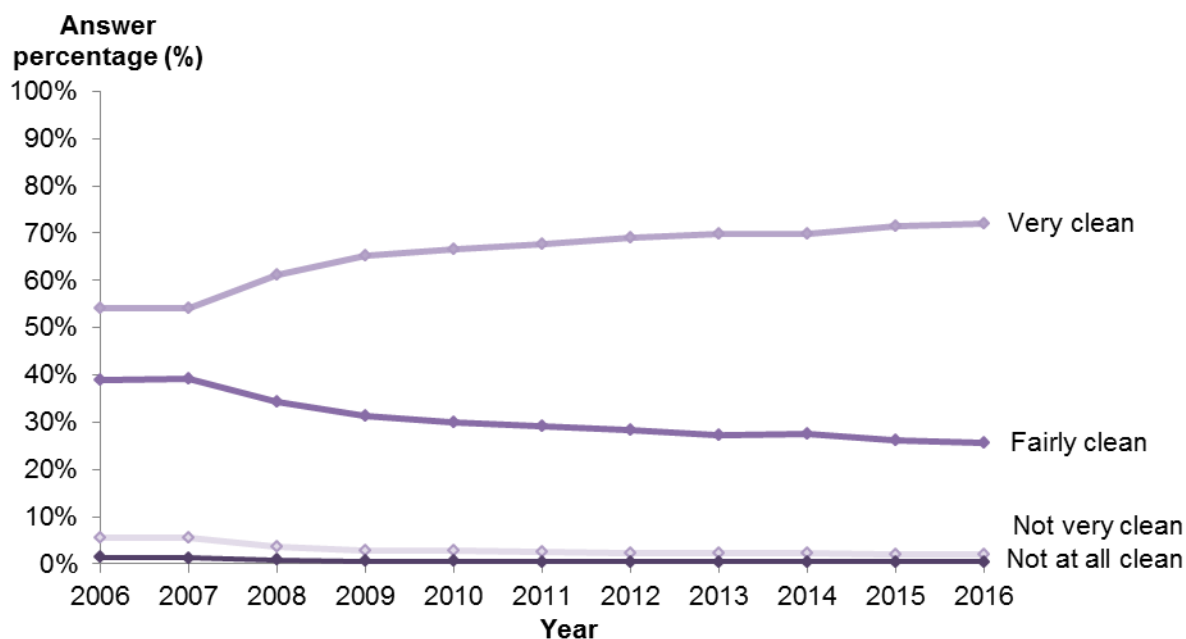
Cleanliness

The cleanliness of toilets, bathrooms, rooms and wards has improved significantly since 2007 as a result of raised standards and specifications on cleanliness following the Clostridium difficile outbreak at Maidstone and Tunbridge Wells NHS Trust in 2005/06 and the Healthcare Commission's response to it.[31] From 2007, the results of Patient Environment Action Team (PEAT) assessments were calculated against the national specifications of cleanliness.[32] Patient-Led Assessments of the Care Environment (PLACE) replaced PEAT assessments 2013. The PLACE assessments are a benchmarking tool to ensure that improvements are made in non-clinical aspects of patient care (for example, environment, food, privacy and dignity). The assessment results help to highlight areas for improvement and share best practice across healthcare organisations in England. The Code of Practice on the prevention and control of infections, under the Health and Social Care Act 2008, states that good

infection prevention (including cleanliness) is essential to ensure people who use health and social care services receive safe and effective care.[33]

There has been a steady increase since 2006 (54%) in the proportion of patients who consider hospital rooms and wards to be 'very clean'. The proportion of respondents giving a response of 'very clean' for hospital rooms or wards was 72% in both 2015 and 2016, and has stayed stable since 2011.

Q17. In your opinion, how clean was the hospital room or ward that you were in?

Number of respondents: 2006 (77,604) to 2016 (75,115)

Cleanliness of toilets and bathrooms data followed the same trend and sixty-four per cent of respondents said hospital toilets and bathrooms had been 'very clean', and 31% considered them 'fairly clean' in 2016.

Hygiene

According to Downey and Lloyd (2008), it is important to ensure that essential hygiene needs are met, including washing and cleaning, and that nursing procedures are correct to prevent the spread of infection and promote dignity and respect for all patients. Assisting 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. The nurses should demonstrate sensitivity and competency to be able to deal with the bodies and bodily functions of individual patients and differences in cultural practices to ensure that hygiene needs are met.[34]

When respondents were asked if they received enough help from staff to wash or keep themselves clean, 72% answered 'Yes, always', 20% answered 'Yes,

sometimes' and 8% answered 'No'. This question appears in the inpatient questionnaire for the first time this year.

Q20. Did you get enough help from staff to wash or keep yourself clean?
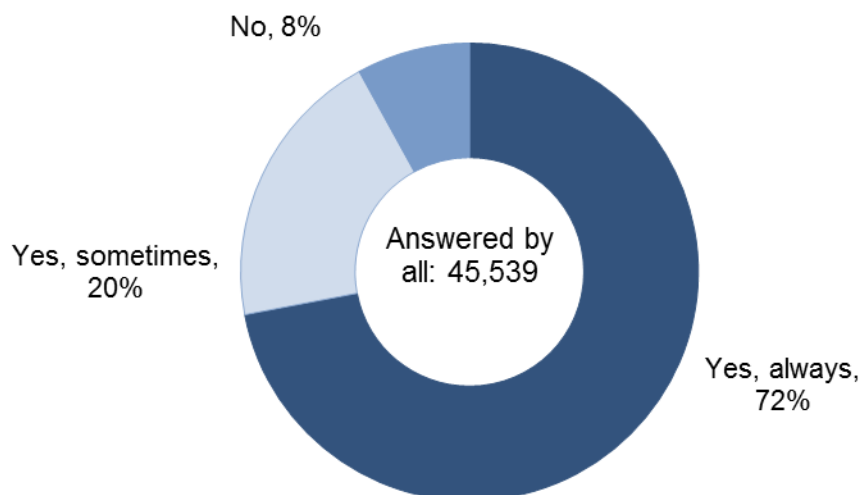
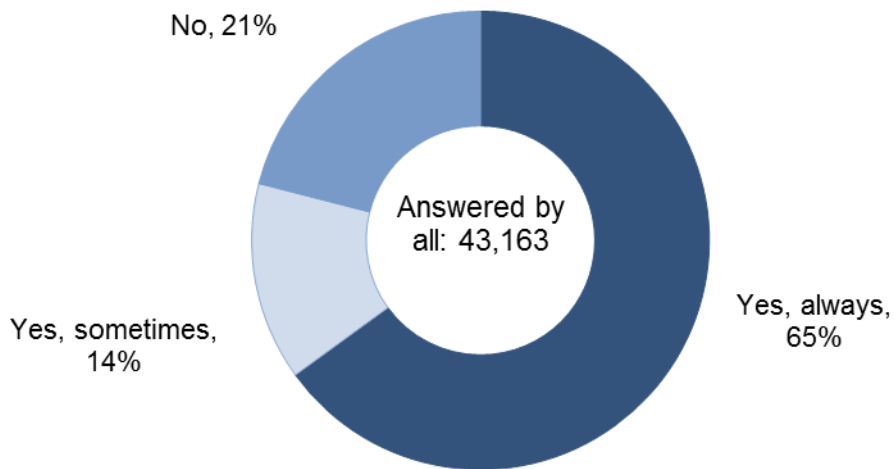Note: respondents who stated that they did not need help with this have been excluded.

Taking medication

According to the NICE guideline on Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes, organisations should ensure that robust and transparent processes are in place, so that when a person is transferred from one care setting to another (for example, when a person is admitted to hospital) the current care provider shares complete and accurate information about the person's medicines with the new care provider and the new care provider receives and documents this information, and acts on it. The guideline also states that in an acute setting, organisations should accurately list all of the person's medicines (including prescribed, over-the-counter and complementary medicines) and carry out medicines reconciliation within 24 hours or sooner if clinically necessary, when the person moves from one care setting to another.

For the first time this year, we asked respondents if they brought their own medication with them to hospital, were they able to take it when they needed it. Twenty-one per cent of respondents answered 'No', 65% answered 'Yes, always' and 14% answered 'Yes, sometimes'.

Q21. If you brought your own medication with you to hospital, were you able to take it when you needed to?

No, 21%

Yes, sometimes, 14%

Answered by all: 43,163

Yes, always, 65%

Note: respondents who stated that they did not have medication with them, or had to stop taking it as part of their treatment for medical reasons, have been excluded.

Food, and help with eating

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. It provides examples of good practice identified through case studies, which include having dedicated staff at mealtimes and improving the quality of food by preparing all meals 'from scratch' on site using fresh produce from local suppliers and seasonal vegetables whenever possible.

Since 2006, there has been a small, very gradual increase in the proportion of patients who consider hospital food to be 'very good'. In 2016, 24% (23% in 2015) rated their food in this way, compared with 20% in 2006. Fewer respondents in 2016 (27%) reported their food was fair as compared to 2006 (30%). Those reporting their food as poor remain the same as last year at 12%.

Q22. How would you rate the hospital food?
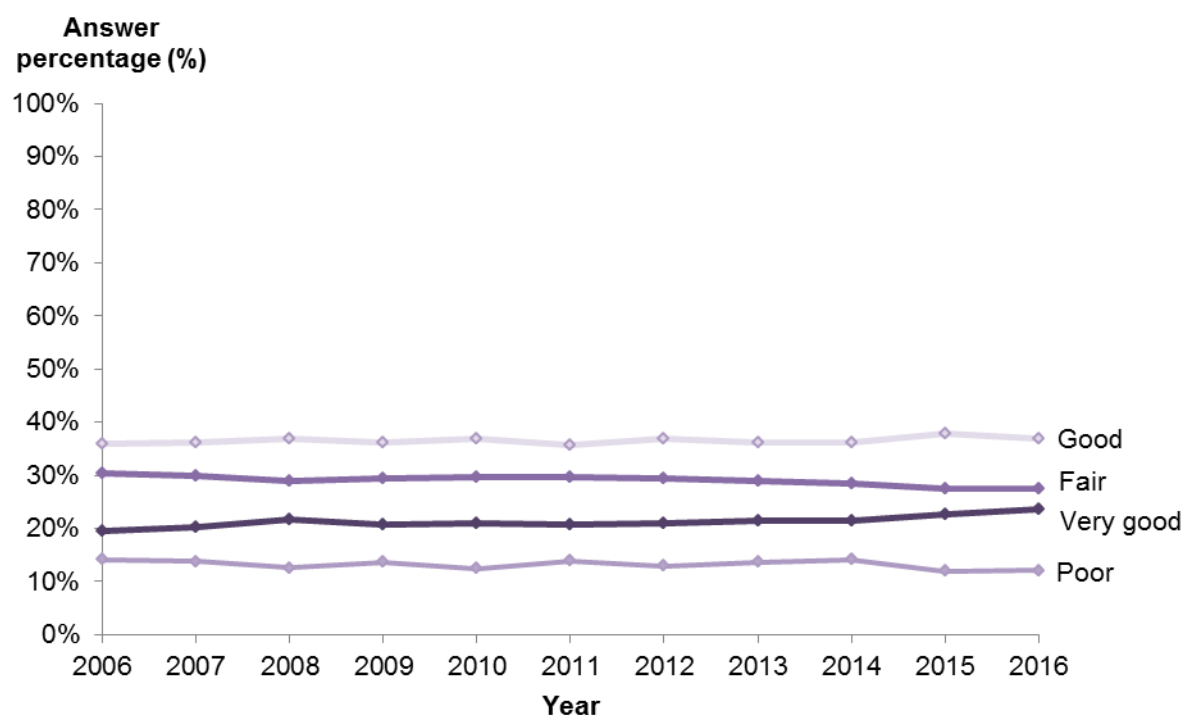
Number of respondents: 2006 (74,569) to 2016 (71,726)
Note: respondents who stated that they did not have hospital food have been excluded.

When comparing the experience of particular groups, results showed that respondents with diseases of the digestive system (XI ICD10 Chapter code) and respondents from the 'Arab and other ethnic group' had a poorer than average experience when it came to food choice during their hospital stay.

NICE quality statement 10 from 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.

Since 2006, there has been an overall increase in the proportions of respondents stating that they 'always' got enough help from staff to eat their meals. There was an increase in this measure from 57% in 2006 to 65% in 2015. However, there was slight decrease to 64% in 2016.

6. Doctors and nurses

Doctors

The survey asks patients about their interactions with doctors. The NHS Patient Experience Framework outlines those elements 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."[35]

Patients were asked if they received an answer that they could understand when asking a doctor an important question; 70% of respondents replied 'yes, always' in both the 2015 and 2016 surveys, an increase of three percentage points from 2011.

Since 2006, there has been a gradual and significant reduction in the proportion of patients who said that doctors talked in front of them as if they were not there. In 2016, 78% (77% in 2015) of respondents felt that doctors did **not** talk in front of them as if they were not there, compared with 71% in 2006.

Q27. Did doctors talk in front of you as if you weren't there?
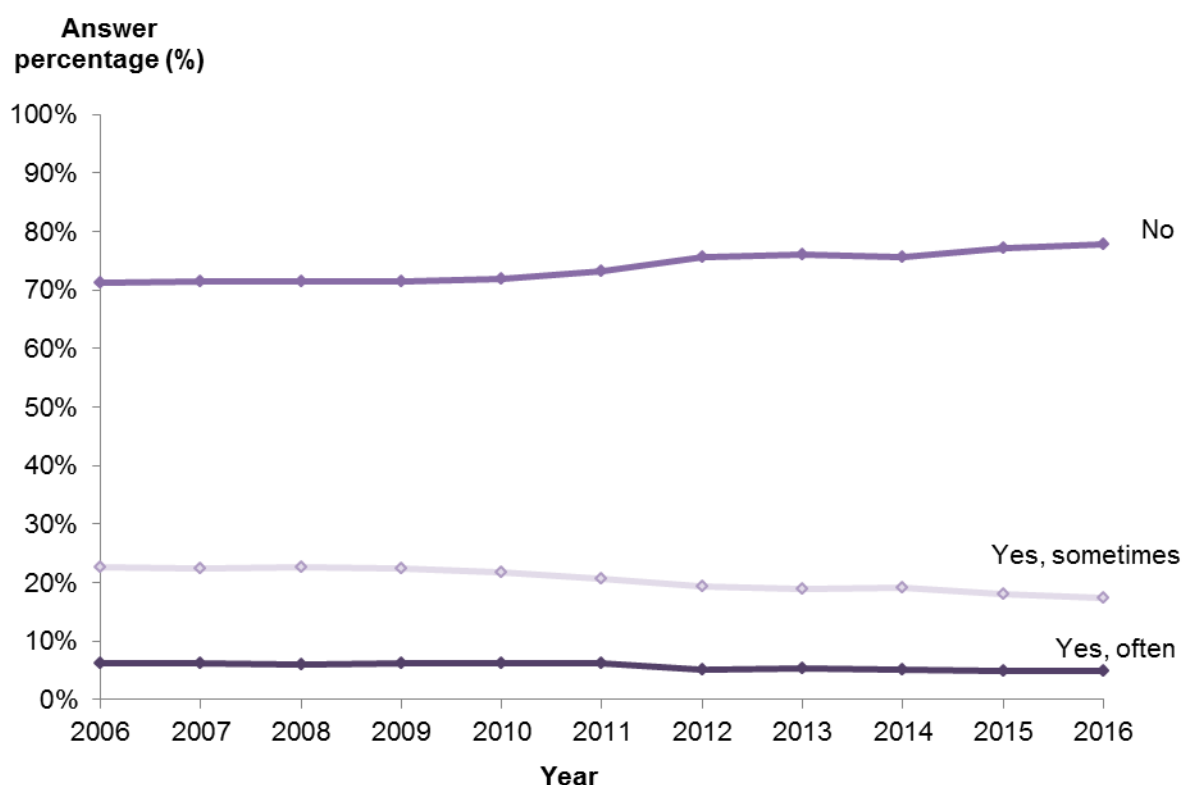
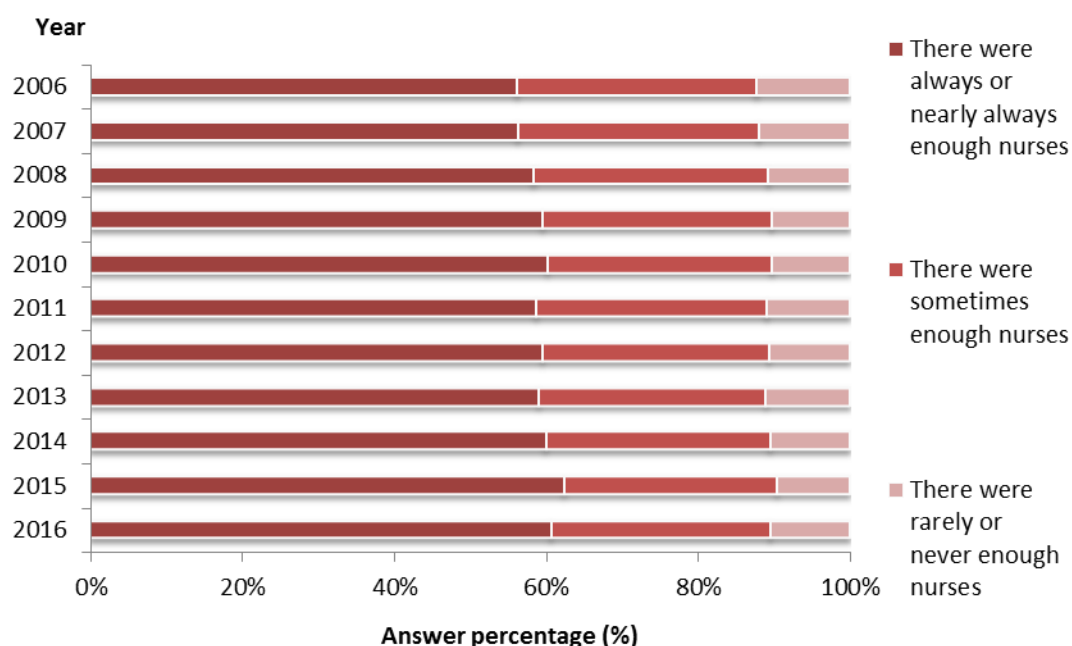Number of respondents: 2006 (77,215) to 2016 (74,523)

Nurses

Interactions with nurses have an important influence on patients' overall experience.[36] The impact of the capacity and capability of nursing, midwifery and care staff on the quality of care and on patient outcomes has been well documented. For example, the National Quality Board cites multiple studies that link low staffing levels to poorer patient outcomes and increased mortality rates, and states that staffing capacity and capability can have a profound impact on patient safety.[37]

In their Leading change, adding value framework for nursing, midwifery and care staff, NHS England makes the commitment (commitment 9) that they'll have the right staff in the right places and at the right time. A key message under this commitment

is to ensure sufficient capacity and capability in order to provide safe, compassionate and effective care, making the best use of resources at all times.[38]

The number of respondents who felt there were 'always or nearly always' enough nurses on duty to care for them has increased from 56% in 2006 to 61% in 2016 (62% in 2015). This left one in 10 respondents in 2016 who felt there were 'rarely or never enough' nurses.

Q31. In your opinion, were there enough nurses on duty to care for you in hospital?

Number of respondents: 2006 (77,235) to 2016 (74,731)

Results from this survey show positive gains in patients' confidence and trust in the nurses treating them. Eight out of ten respondents in 2016 always felt confident (79% in 2015), compared with 75% in 2011.

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.

When patients were asked in 2016 if they received an answer that they could understand when asking a nurse an important question, 70% of respondents replied 'yes, always', an increase of four percentage points since 2006 and 2011, but a decrease of one percentage point from 2015.

Since 2006, there has been a reduction in the proportion of patients who said that nurses talked in front of them as if they were not there. In 2006, 78% of respondents felt that nurses did **not** talk in front of them as if they were not there, compared with 82% in 2015 and 83% in 2016.

For the first time, we asked the question 'Did you know which nurse was in charge of looking after you? 19% of respondents answered 'No', 49% answered 'Yes, always' and 31% answered 'Yes, sometimes'.

Q32. Did you know which nurse was in charge of looking after you? (this would have been a different person after each shift change)
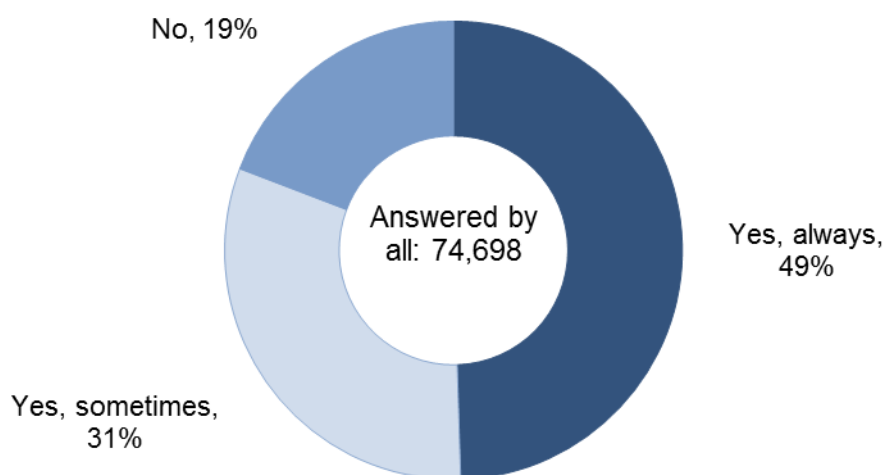
We compared subgroup experience for 'confidence and trust' in nurses and doctors, and confidence in the decisions made about treatment. Results show people with a mental health condition, a long-term physical condition, diseases of the nervous system (ICD-10 VI), diseases of the skin and subcutaneous tissue (ICD-10 XII) and patients with infectious and parasitic diseases (ICD-10 I) all reported poorer experience than other groups. Younger patients also reported having less confidence and trust in hospital staff. Patients who had the most confidence and trust tended to be older (66-80 and 80+), Christian, and without long-term physical or mental health conditions.

7. Care and treatment

Working together

Good team working among health professionals is essential for high quality and efficient care.[39] Its most obvious impact is on the effective sharing of information and it leads to benefits not only for patients but for staff members themselves.[40] NICE quality statement 12 states that patients should experience co-ordinated care with a clear and accurate exchange of information between relevant health and social care professionals.

In the 2016 survey, 77% of respondents were of the opinion that the staff caring for them always worked well together, two percentage points lower than 2015. This

question was asked for the first time last year. In response to the question, 'Sometimes in hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?', a greater proportion of respondents (70%) said this did not happen in 2016 and 2015 compared with 67% in 2011 and 2006.

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. Our report about patients' involvement in care, *Better care in my hands* (2016), found that people using acute hospital services report mixed experiences of being involved in decisions about their care.

Furthermore, in their Leading change, adding value framework for nursing, midwifery and care staff NHS England makes the commitment that they will ensure that individuals are always supported to influence and direct their own health care decisions, so that they are confident that 'no decision is taken about me without me'. Care planning should involve the development of a personalised plan for each individual who is entering, leaving or transitioning care environments whether within a hospital, in their own home, care home or rehabilitation unit.[41,42]

Fifty-six per cent of respondents said that they were definitely involved as much as they wanted to be in decisions about their care and treatment in 2016 (59% in 2015). Despite the decrease from 2015 to 2016, this is an increase of four percentage points since 2006.

Q35. Were you involved as much as you wanted to be in decisions about your care and treatment?
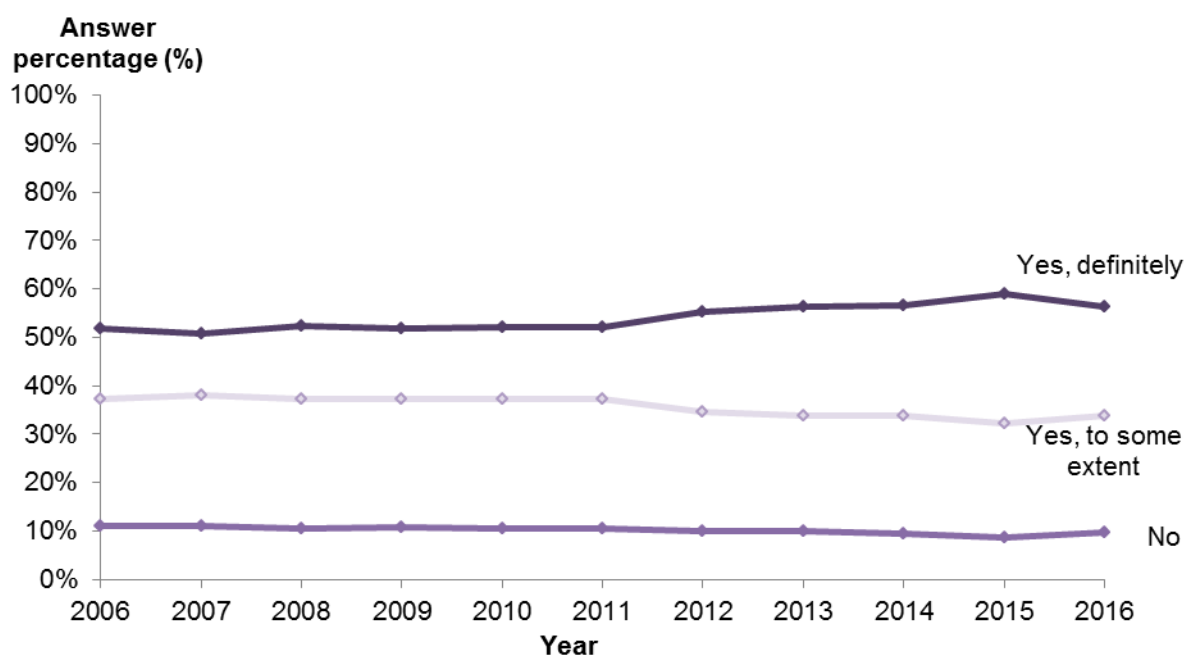
Number of respondents: 2006 (76,770) to 2016 (74,555)

Emotional support

In its report The psychological and social needs of patients, the British Medical Association 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. Hospitals should have a liaison psychiatry service, also known as a psychological medicine service, to bridge the gap between physical and mental health care.[43] NICE quality statements also echo this sentiment; statement 4 states that patients should have opportunities to discuss their health beliefs, concerns and preferences to inform their individual care. Statement 10 states that patients should have their physical and psychological needs regularly assessed and addressed.

Fifty-eight per cent of respondents in 2016 (59% in 2015) felt that they 'always' received enough emotional support from hospital staff during their stay and 38% of respondents (41% in 2015) who had worries or fears could 'definitely' find someone in hospital to talk about them.

Furthermore, there was variation in experience between patient groups for emotional support. In particular, respondents in the 16-35 age group, respondents with a mental health condition (self-reported and by ICD-10 chapter code V) and gay or lesbian respondents reported less favourably on the emotional support provided by hospital staff than other respondents.

Emotional support: adjusted mean score by subgroup with 95% confidence interval
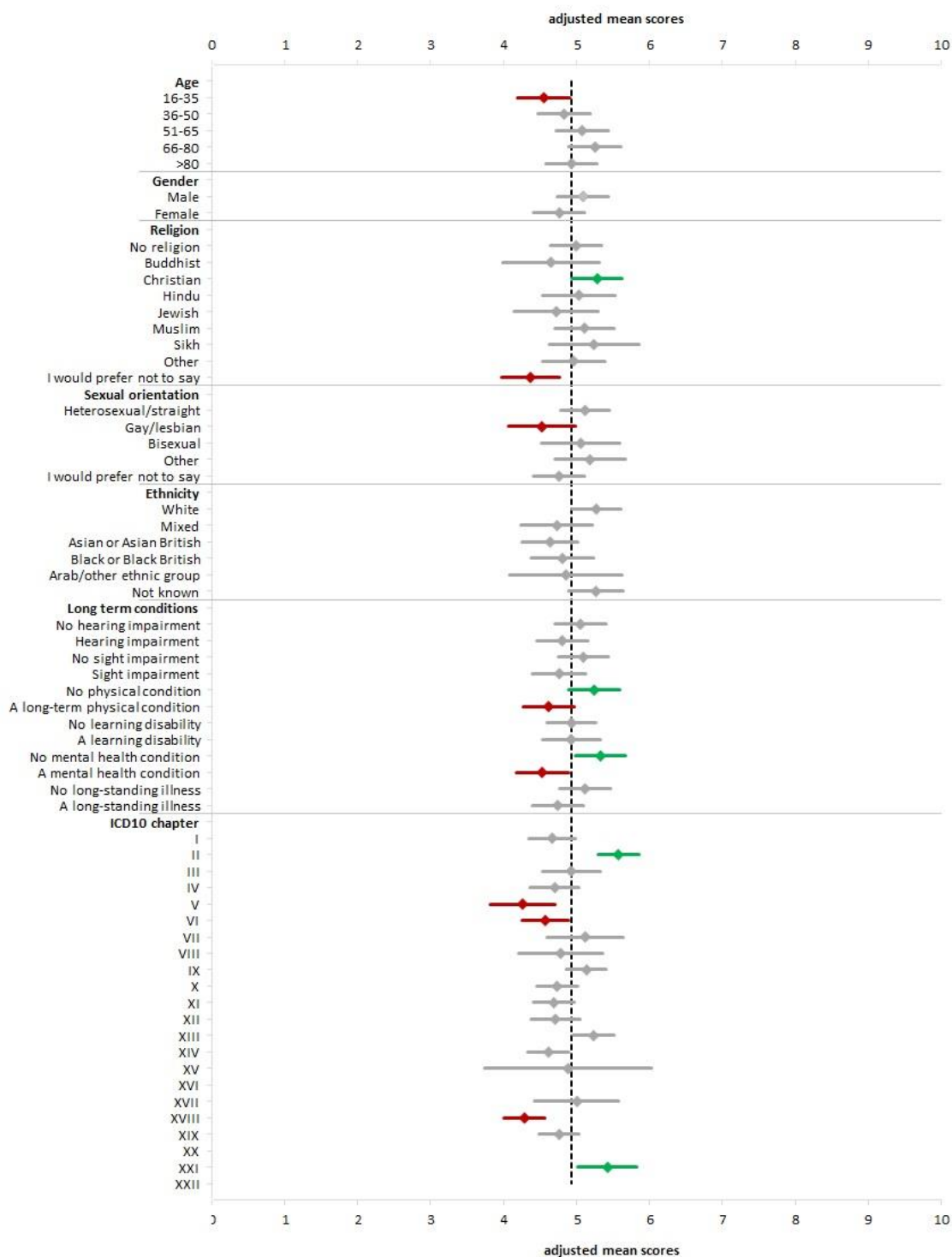
In this chart, the dotted line shows the national average score for the composite, and those highlighted in red or green are more than 0.1 standard deviations away from the mean.

Privacy

Patients' rights to dignity, kindness, compassion, courtesy, respect, understanding and honesty are set out in NICE quality statement 1, and the NHS Constitution

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

There has been an increase in the proportion of respondents who said they were 'always' given enough privacy when discussing their condition or treatment; 77% in 2015 and 2016 compared with 73% in 2011 and 71% in 2006. Six per cent reported this was not the case in both 2015 and 2016.

Call bell responsiveness

An article published in the Nursing Standard journal found a strong correlation between quick response times to call bells and high patient satisfaction. Patients who are dissatisfied with the time it takes for a member of staff to respond to a call bell tend to rate a hospital poorly all other aspects of care.[44] Our report, Time to listen in NHS hospitals: Dignity and nutrition inspection programme 2012 found that in many hospitals, patients are not always able to reach call bells, or staff are not responding to them in a reasonable time.[45]

In this survey, nearly half (49%) of all the respondents had to wait more than two minutes before they received the help that they needed, more than in 2006 (43%), 2011(48%) and 2015 (47%). In 2016, seventeen per cent of all the respondents had to wait more than 5 minutes. This is more than in 2006 (14%), 2011 (16%) and 2015 (16%).

Q44. How many minutes after you used the call button did it usually take before you got the help you needed?
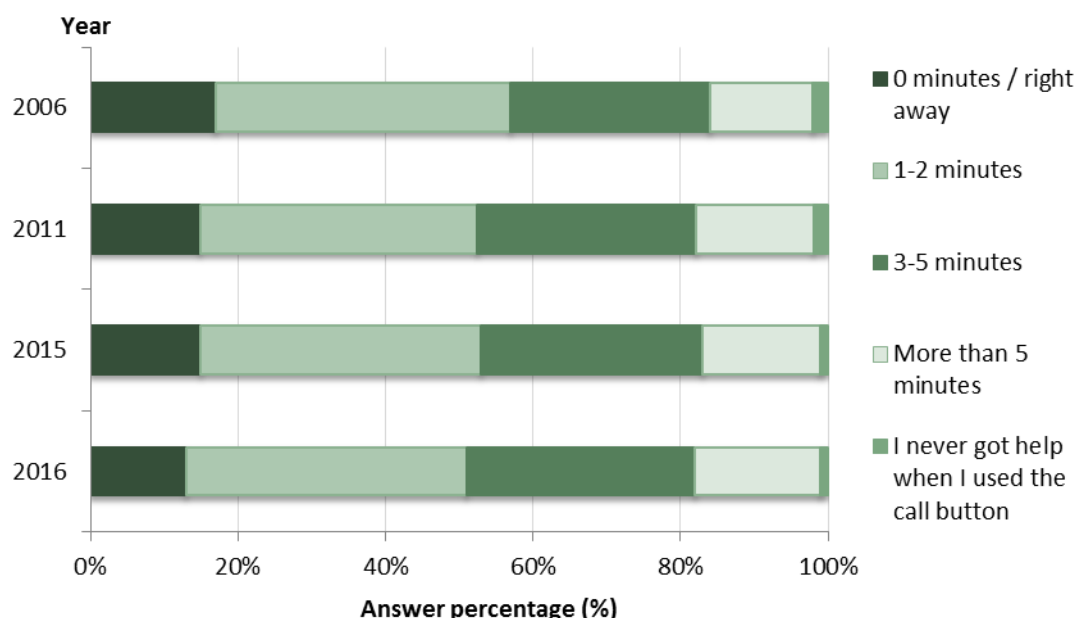
Number of respondents: 2006 (43,949) to 2016 (45,019)
Note: respondents who stated that they never used the call button have been excluded.

8. Operations and procedures

The importance of having clear and comprehensive information before undergoing an operation or procedure is well documented. The Good surgical practice guidance compiled by 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. In its Guidelines for the provision of anaesthetic services, the Royal College of Anaesthetists advised 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.[46,47]

There has been little change since 2015 around information sharing about operations and procedures. Sixty-two per cent of survey respondents had an operation or procedure while in hospital in 2016. Of these, 83% (83% in 2015) received a complete explanation about the risks and benefits of the operation or procedure in a way they could understand, an increase of three percentage points since 2011.

Seventy-six per cent of respondents in 2016 (76% in 2015) said they received a complete explanation of what would be done during the operation, compared to 74% in 2011. Four per cent of respondents did not feel they received an explanation. There was also an increase in the proportion of respondents saying staff answered their questions about the operation or procedure in a way they could understand (76% in 2011 and 79% in 2015 and 2016).

From 2011 to 2016, there has been an increase of three percentage points in the proportion of respondents 'completely' being told how they could expect to feel after an operation or procedure (56% in 2011 to 59% in 2016); 14% of respondents in 2016 (14% in 2015) were not told at all.

An increasing percentage of respondents (64% in 2006 to 69% in 2016) reported that a member of staff 'completely' explained how the operation or procedure had gone in a way they could understand. Nine per cent of respondents in 2016 did not get any explanation at all (13% in 2006, 11% in 2011 and 10% in 2015).

9. 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. In No decision about me, without me, the Department of Health proposed a model of shared decision-making at every stage of the patient pathway giving patients greater involvement in their own care. Shared decision making is fundamental throughout the entire healthcare pathway irrespective of setting.[48]

According to NHS England, shared decision making can only be achieved when patients, carers and clinicians work together, in equal partnership, to make decisions and agree a care plan.[49]

In the 2016 survey, 55% of respondents felt that they were definitely involved in decision about their discharge from hospital (54% in 2011 and 56% in 2015).

Q53 Did you feel you were involved in decisions about your discharge from hospital?

No, 15%

Yes, definitely, 55%

Yes, to some extent, 30%

Answered by all: 72,288
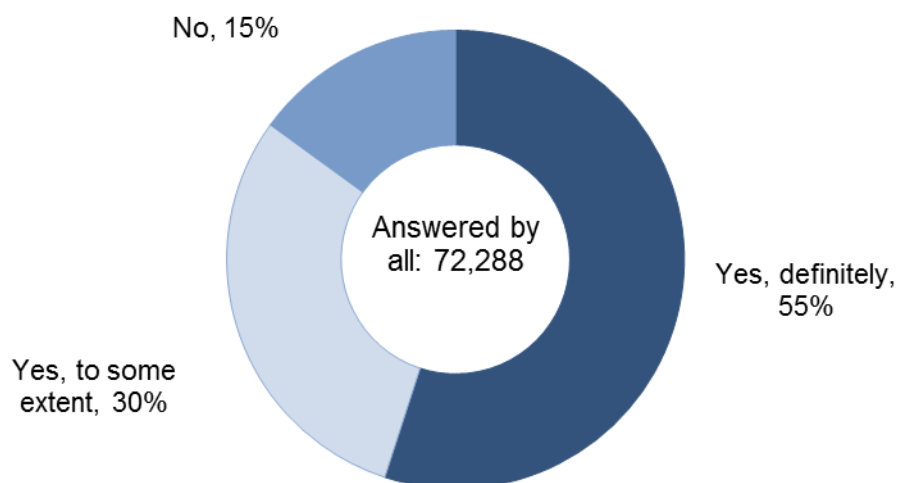
Note: respondents who stated that they did not want to be involved have been excluded.

Discharge Delays

Delayed discharges remain an important concern within NHS hospitals and there are both financial and clinical costs when discharges are delayed. Hospital care is more expensive than care in other settings, so a patient who can be appropriately cared for in another setting, such as a residential home or nursing home, or with support in their own home will be less costly to treat if discharged from hospital. There are also clinical risks for the patient if remaining in hospital when medically ready to be discharged, such as hospital acquired infection and pressure sores. Patient outcomes may be worsened by a prolonged stay in hospital, compared to discharge home or residential/nursing home.[50]

Forty-one per cent of respondents reported that their discharge has been delayed in 2016. This is 3% higher than in 2006, but has stayed consistent since 2011. The main reason for the delay in the last decade is patients waiting for medicine (61% in 2016, 62% in 2015, 60% in 2011 and 61% in 2006) and 57% of delays are for longer than two hours in 2016 (56% in 2015).

Q56. What was the MAIN reason for the delay?
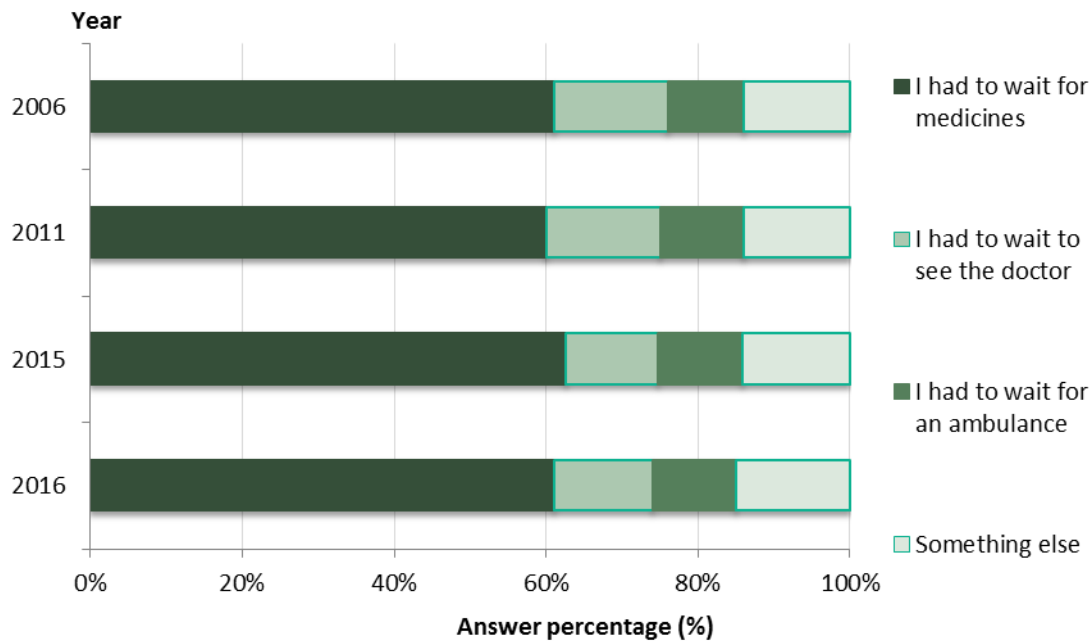
Number of respondents: 2006 (27,523) to 2016 (28,757)
Note: Answered by all who experienced a delayed discharge.

According to academic research conducted by Green, Hunter, Jones and Morris (2015) the majority of discharge medication processing time does not take place in the hospital pharmacy. The research found that discharge delays relating to availability of medicines at discharge result from a combination of events, not solely and not primarily within Pharmacy. Most of the significant opportunities to reduce the delays in delivering discharge medication to patients lie between the point at which the patient is told they can go home, and their discharge prescription either being ready on the ward for the pharmacy team to process or in being delivered to the pharmacy dispensary.[51] Marvin, Kuo and Linnard (2013) suggested that the perception of dispensing individually labelled medicines to take home (TTOs) is responsible for significant delays in patient discharge is unfounded. There is a lag time between TTOs being ready and the patient going home. The clustering of TTO writing infers that very few are written until the morning ward rounds are finished. It is recommended that options to encourage earlier writing times – such as including TTO transcribing pharmacists on consultants' rounds – are considered. [52]

Information

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. Guidance from NICE, published in 2012, recommends that patients are given information (verbally 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.[53] The NHS Constitution also makes a commitment to offer patients easily accessible, reliable and relevant information in a form they can understand, and support them to use it.

From 2011 to 2016, the proportion of respondents who received written or printed information about what they should or should not do after leaving hospital stayed relatively stable (65% in 2011, 66% in 2015 and 64% in 2016). This meant that more than a third (36%) of respondents did not receive any written or printed information in 2016. This question was not included in the 2006 survey.

Information to family and friends

NICE quality statement 13 states that patients' preferences for sharing information with their partner, family members and/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 impact on their recovery and wellbeing. According to Parliamentary and Health Service Ombudsman's (PHSO) Report of investigations into unsafe discharge from hospital (2016), carers and relatives are not being treated as partners in discharge planning. The report found that failures by hospitals to notify family members that relatives are being discharged are common features of the cases they reviewed.[54]

In 2016, 48% of respondents 'definitely' felt doctors or nurses gave their family or someone close to them all the information they needed to help care for them, compared with 44% in 2006 (47% in 2011 and 49% in 2015). A large proportion of respondents' family or someone close to them did not receive all the information they needed to help care for them (28% in 2016). In this survey, only 62% of respondents felt that hospital staff completely took their family or home situation into account when planning their discharge. This was the same in 2015.

Q67. Did hospital staff take your family or home situation into account when planning your discharge?

No, 17%

Yes, to some extent, 21%

Answered by all: 48,556

Yes, completely, 62%
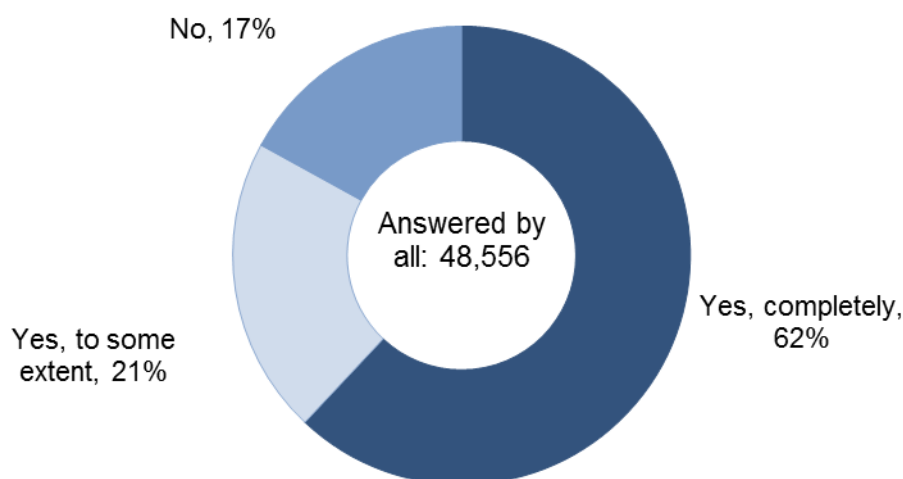
Note: respondents who stated that it was not necessary, or that they did not know / could not remember, have been excluded.

[Subgroup analysis](#) results show that patients above 80 years old reported poorer experiences around this, which is contrary to the findings for other themes, where we see an upward trend with a positive experience and age. Patients in the 51-65 category had the most positive experience. Jewish patients reported poorer experience than other religious categories. There were also some noteworthy differences between ICD-10 chapter codes; those with a mental/behavioural disorder (ICD-10 V), diseases of the nervous system (ICD-10 VI) respiratory system (ICD-10 X) and skin and subcutaneous tissue (ICD-10 XII) all reported poorer experience around information sharing. Those with neoplasms (ICD-10 II), diseases of the eye (ICD-10 VII), diseases of the musculoskeletal system (ICD-10 XIII), conditions related to pregnancy and childbirth (ICD-10 XV) and any external injuries (ICD-10 XII) reported a better than average experience.

Integrated care

Integrated care is a long-standing concern in the NHS. A lack of coordination between services is reported to result in patients experiencing discontinuity of care when they are transferred from hospital to home, or vice versa.[55] Care and support can then be fragmented, delayed or duplicated, which can result in missed opportunities to prevent people's needs from escalating and missing benefits of intervening early. This can lead to poorer outcomes and experiences for the people who use services.[56] The PHSO's [Report of investigations into unsafe discharge from hospital](#) (2016) found that a lack of integration and poor joint working between different aspects of healthcare, such as hospital and community health services can result in people being discharged without the support they need to cope at home. Equally, lack of coordination between health and social care services can lead to lengthy delays in finding suitable care packages for elderly people with complex needs.[57]

Research shows that a structured discharge plan tailored to the individual patient reduces lengths of stay and readmission rates and increases patient satisfaction.[58]

In this survey, 21% of the respondents that went home or went to stay with friends or family after discharge did not get enough support from health or social care professionals to help them recover and manage their condition (this is an increase of 3 percentage points since 2015).

Q59. After leaving hospital, did you get enough support from health or social care professionals to help you recover and manage your condition?
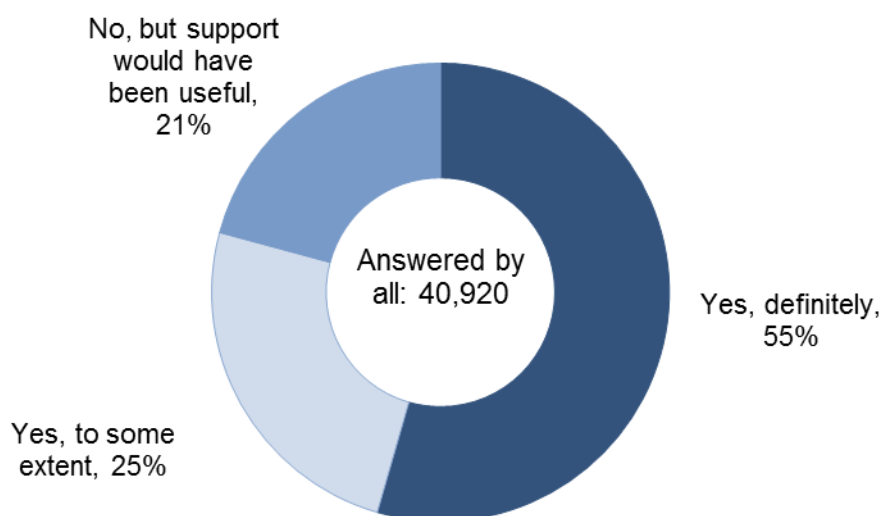
Note: respondents who stated they did not need any support have been excluded.

For respondents who were transferred to another hospital or who went to a nursing home, 53% 'definitely' knew what would happen next with their care.

When asked if hospital staff discussed whether the patient may need any further health or social care services after leaving hospital, 18% of respondents answered 'No, but I would like them to', an increase of two percentage points from 2015.

Patients with a mental health condition, diseases of the nervous system (ICD-10 VI), diseases of the digestive system (ICD-10 XI) and diseases of the genitourinary system (ICD-10 XIV) all reported lower than average experience when it came to coordination and integration of their care. There was also a trend that younger patients (16-35, 36-50) had a worse experience than older age groups. Gay and lesbian respondents also reported poorer experiences for this category.

10. Overall

Respect and Dignity

The NHS Constitution states that patients have the right to be treated with respect and dignity, and that the NHS should actively encourage feedback. NICE Quality Standard 1 states that patients should be treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty.

The proportion of respondents who said they were 'always' treated with dignity and respect has been rising slowly but steadily from 80% in 2006 to 84% in 2016. The subgroup analysis indicated the following groups of respondents felt that they were treated with less dignity and respect than other respondents:

- 16-35 age group
- People with a mental health condition
- People with a long standing physical condition
- Gay or Lesbian respondents
- Buddhist

Whilst respondents in the age groups; 66-80 and over 80 scored higher than average in terms of being treated with dignity and respect.

Respondents who said they were 'always' well looked after by hospital staff has decreased from 81% in 2015 to 80% in 2016.

Patient feedback

In [Equity and Excellence: Liberating the NHS](#), the Department of Health committed to enabling patients to rate hospitals and clinical departments according to the quality of care they receive. To support this, the Friends and Family Test (FFT) was introduced in May 2012, with all trusts using it by May 2013. The test asks patients if they would recommend the services they have used.[59]

Since 2006, the proportion of patients who say they have been asked to give their views on the quality of their care has increased substantially, rising from 6% in 2006 to 20% in 2015, but with a one percentage point decrease to 19% in 2016. Despite this increase, 81% of respondents said they were not asked to give their views in 2016 (80% in 2015).

Q75. During your hospital stay, were you ever asked to give your views on the quality of your care?
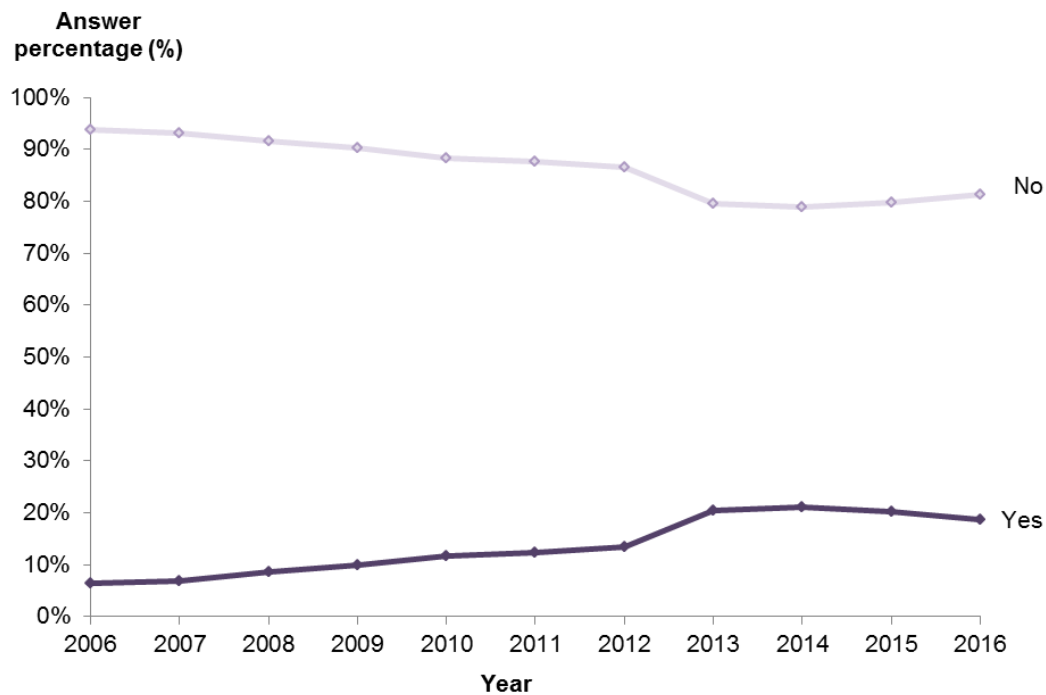

Number of respondents: 2006 (71,311) to 2016 (64,424)
Note: respondents who stated that they did not know / could not remember have been excluded.

Overall experience

Respondents were asked to rate their overall hospital experience on a scale of 0-10. Seventy-five per cent rated their overall experience with a score of eight or above out of 10 in 2016, where 0 indicated a 'very poor' experience and 10 a 'very good' experience. The results are similar to those reported in the 2015 inpatient survey.

Q74. Overall...
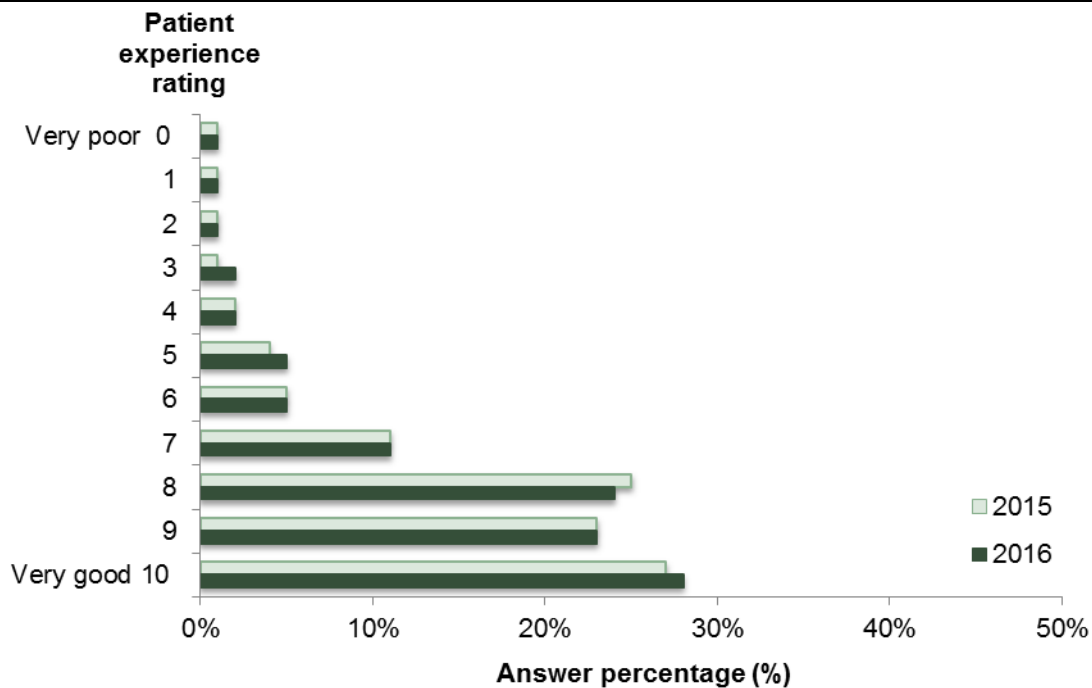
Number of respondents: 2015 (74,827) and 2016 (71,861)

The subgroup analysis indicated the overall experience of the following groups of respondents were below the average of all the respondents:

- 16-35 age group
- Those with a mental health condition
- Those with a long standing physical condition

It was better than average for respondents in the 66-80 age group.

Complaints

According to Healthwatch England's <u>Suffering in silence</u> report, an effective complaints system is crucial to allow consumers to speak up and be heard when things go wrong. As well as providing resolution for individuals, complaints:

- Provide health and social care services with invaluable learning opportunities.
- Provide services with vital information about whether they are performing for the people they serve.
- Hold the potential to act as an early warning system that can prevent further deterioration and crisis.
- Are vital to improving standards and services, but yet it was found that fewer than half of those who experience poor care actually report it.[60]

In 2016, more than three quarters of respondents did not see, or were given, any information explaining how to complain to the hospital about the care they received. This is a one per cent increase from 2015.

11. How experience varies for different patient groups – Subgroup analysis summary

Background

We have included additional analysis to compare how different subgroups of patients rated their inpatient experience by means of a multilevel model analysis.
The subgroup analysis compares the mean scores for a subset of questions by different groups.

In previous surveys, additional analyses (usually at the national level) were broken down by subgroups of respondents using cross tabulations. These cross tabulations were two-dimensional, breaking down a single target (dependent) variable by patient subgroups. This is a very simplified way of showing variation between groups as it does not take account of interdependencies between patient variables. This year, with a multilevel model, we could more effectively explore the relationships between patient characteristics and their experiences.

The analysis modelled the mean scores of different subgroups - age, gender, religion, sexual orientation, ethnicity, long term conditions and diagnosis (ICD-10 chapter codes) - for a set of composites based on the NHS Patient Experience Framework.

1. Information sharing (Q32, 37, 61, 66 and 69)
2. Respect for patient-centred values (Q25, 28, 35, 40 and 53)
3. Emotional support (Q38 and 39)
4. Confidence and trust (Q26, 29 and 36)
5. Coordination and integration of care (Q33, 59, 60, 67 and 71)
6. Food choice (Q23)
7. Respect and dignity (Q72)
8. Overall question (Q74)

See Appendix F: Subgroup analysis charts for detailed charts and Appendix G: ICD-10 Chapter codes

For more information about how the analysis was completed or about the methodology of the subgroup analysis, see the Survey methodology section.

Age

The analysis showed a general trend that as patients become older, they report more positive experiences. The 16-35 subgroup had below average scores for 7 out of 8 composites, with **Information sharing** the only exception. The 66-80 subgroup reported above average scores for five out of 8 of the composites, with the exceptions of **Information sharing, Emotional support** and **Food choice.**

Gender

There was an overall trend that male patients report a more positive experience than female, but there were no significant deviations from the average.

Religion

There were few notable differences when comparing religion categories. Patients who identified themselves as Christian had above average scores for **Emotional support, Confidence and trust** and **Food choice.** Those who identified themselves as Buddhist scored below average for **Confidence and trust**, **Food choice** and **Respect and dignity**. Respondents who answered 'prefer not to say' for religion scored below average for all composites.

Sexual orientation

The analysis discovered some distinct differences for gay or lesbian respondents, who reported poorer experience for **Emotional support, Coordination and integration of care** and **Respect and dignity.**

Ethnicity

There were few differences between ethnic subgroups, though it should be noted that 'Arab and other ethnic group' scored below average for food choice.

Long term Conditions

Patients in the self-reported mental health condition subgroup had below average scores for seven out of 8 of the composites, with **Food choice** the only exception.

This is consistent with results found as part of the 2015 Adult Inpatient survey where we conducted analysis to compare experiences of patients with self-reported mental health conditions against experiences of other patients who did not report these conditions.

Patients in the self-reported long standing physical condition subgroup had below average scores for **Respect for patient-centred values, Confidence and trust, Respect and dignity** and **Overall question.**

ICD-10 Chapter codes

Respondents that were treated for diseases of the digestive system (XI) had a poorer than average experience when it came to **Food choice** during their hospital stay. Patients with diseases of the eye (VII) and Neoplasms (II) reported a better than average experience for five out of eight composites.

There were some large differences when comparing ICD-10 chapter codes. Patients with mental and behavioural disorders (ICD-10 V) reported poorer than average experience across **all** composites and individual questions included in this analysis. Patients with a V ICD-10 chapter code had the lowest scores than any other category for Information sharing (-0.43), Respect for patient-centred values (-0.38), Confidence and trust (-0.38), Coordination of care (-0.35), Respect and dignity (-0.32) and the Overall question (-0.29).

Patients with an ICD-10 VI chapter code, diseases of the nervous system, also reported below average experience for six of the eight composites (Respect and dignity and the Overall question were in line with the average).

Survey methodology

As with almost all surveys in the NHS Patient Survey Programme, the inpatient survey used a postal methodology. Up to two reminders were sent to people who did not respond.

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 during the sampling period. The sample size was sufficient 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 E).

All trusts providing inpatient services were eligible to take part in the survey and no exclusions were applied during the running of the survey. However, one trust was excluded from the national results because of errors made when drawing its sample.

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

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.

'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. This is acceptable when comparing year-on-year results because of the relatively limited annual change in the demographic profile of the overall set of respondents. However, over longer periods, the small annual changes accumulate and need to be taken into account, and further standardisation needs to be applied.

Results for each data point presented in this statistical release are standardised to the demographic profile of 2016 in terms of age/sex/route of admission. These are applied at trust level rather than nationally. There are 16 unique weights per trust per year – one for each of the age/sex/route of admission groups.

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, although only trust weights were used for the mental health and learning disability analysis. 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 2016 compared with 2006, 2011 and 2015.

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 show to be statistically significant. Such small changes do not necessarily indicate a longer term trend.

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. Conversely, the fewer people that answer a question, the greater the difference has to be in order 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 linear mixed effects 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 impact 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 within 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 relating to NHS patient experience framework. See Appendix F for the charts.

Design and interpretation of the questionnaire

New questions for 2016:

20. Did you get enough help from staff to wash or keep yourself clean?

21. If you brought your own medication with you to hospital, were you able to take it when you needed to?

32. Did you know which nurse was in charge of looking after you? (this would have been a different person after each shift change)

Questions removed from 2015 for 2016:

21. Were hand-wash gels available for patients and visitors to use?

Questions amended from 2015 for 2016:

58. When you transferred to another hospital or went to a nursing or residential home, was there a plan in place for continuing your care? (2015)

60. When you left hospital, did you know what would happen next with your care? (2016)

Appendix A: 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://www.gov.uk/government/publications/nhs-outcomes-framework-2015-to-2016

http://www.hscic.gov.uk/indicatorportal.

Waiting times

For further information on waiting times within 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 Health and Social Care 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 ensure that it covers as much about people's experiences of their care and treatment as is reasonable within 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 B: Comparisons with other data

Scotland and Northern Ireland also conduct inpatient surveys. A similar survey is not currently undertaken in Wales.

The surveys in Scotland and Northern Ireland reflect people's experiences of different healthcare systems. Therefore, direct comparisons to this survey are not recommended because of the differences in methodology, the questions, and the time periods over which the surveys were administered. Also, the questions are phrased differently, use different scale lengths, and different report and rating type scales. Each of these factors is associated with differences in responses. Although the measures are not directly comparable to the equivalent question in the inpatient survey questionnaire, placing the overall question next to each other might provide useful context in this one area.

Scotland

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

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, most people responded positively.

Rating	Scotland	England
0 (Negative)	1%	1%
1	1%	1%
2	1%	1%
3	1%	2%
4	2%	2%
5	6%	5%
6	4%	5%
7	10%	11%
8	23%	24%
9	21%	23%
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 first Inpatient Patient Experience Survey was carried out in Northern Ireland in 2014. Examples from the 2014 Northern Ireland survey compared to this survey (England, 2015) include:

When asked to rate their overall hospital experience, respondents answered in the following way:

Very satisfied	55%
Satisfied	35%
Neither satisfied or dissatisfied	5%
Dissatisfied	3%
Very dissatisfied	2%

More information on the Northern Ireland Inpatient Patient Experience survey is available at:
https://www.dhsspsni.gov.uk/publications/inpatient-patient-experience-survey-2014.

Appendix C: Main uses of the survey data

This appendix lists known users of data from the inpatient survey and how they use the data. We have been reviewing the use of all survey data to identify who uses it. We would like to hear from anyone interested in, or already using the data to contact us with feedback or recommendations at: patient.survey@cqc.org.uk.

NHS trusts and commissioners

Trusts, and those who commission services, use the results to identify and make the improvements they need to improve the experience of people who use their services.

Patients, their supporters and representative groups

CQC publishes the survey data online for each participating NHS trust, which appears on the trust's profile page on our website. You can find this by searching for the name of the trust. The data is presented in an accessible format to enable the public to examine how services are performing, alongside their inspection results. The search tool is available on the CQC home page: www.cqc.org.uk.

Care Quality Commission (CQC)

CQC will use the results from the survey in the regulation, monitoring and inspection of NHS acute trusts in England. Survey data will be used in CQC's Insight system, which provides inspectors with an assessment of risk in areas of care within an NHS trust that need to be followed up. The survey data will also be included in the data packs produced for inspections. Results will also form a key source of evidence to support the judgements and ratings published for trusts.

NHS England

NHS England use questions from the NHS Patient Survey Programme (specifically the inpatient, outpatient, community mental health and A&E surveys) to produce a separate index measure called the Overall Patient Experience Score. The score forms part of a regular statistical series that is updated alongside the publication of each respective survey. More information is available at: http://www.england.nhs.uk/statistics/statistical-work-areas/pat-exp/.

The scores are calculated in the same way each year, so that the experience of people who use NHS services can be compared over time. As part of the supporting documentation, NHS England also produce and publish a diagnostic tool to help NHS managers and the public to understand what feeds in to the overall scores and to see how scores vary across individual NHS provider organisations. The tool is available at: http://www.england.nhs.uk/statistics/statistical-work-areas/pat-exp/sup-info/.

Department of Health

The Government's strategy sets out a commitment to measure progress on improving people's experiences through Domain 4 of the NHS Outcomes Framework "ensuring people have a positive experience of care", which includes results from the maternity survey, among other data sources.

The framework sets out the outcomes and corresponding indicators that the Department of Health uses to hold NHS England to account for improvements in health outcomes, as part of the Government's mandate to NHS England. The Outcomes Framework survey indicators are based on the standardised, scored trust level data from the survey (similar to that included in CQC benchmark reports), rather than the England level percentage of respondents data that is contained within this report. For more information see: https://www.gov.uk/government/publications/nhs-outcomes-framework-2015-to-2016.

NHS Improvement

On 1 April 2016, the NHS Trust Development Authority became part of NHS Improvement. NHS Improvement oversees NHS trusts and independent providers that provide NHS-funded care. It supports providers to give patients consistently safe, high-quality, compassionate care within local health systems. NHS Improvement will use the results of the adult inpatient survey to inform quality and governance activities as part of its Oversight Model for NHS Trusts.

For more Information about the NHS Trust Development Authority and NHS Improvement see https://improvement.nhs.uk/ and http://www.ntda.nhs.uk/.

Appendix D: Quality and methodology

Quality and methodology document

All detail on data limitations can be found in the Quality and methodology document, available: at http://www.cqc.org.uk/content/inpatientsurvey.

Revisions and corrections

CQC publishes a Revisions and Corrections Policy relating to these statistics. The National Patient Experience programme data is not subject to any scheduled revision as they capture the views of patients about their experiences of care at a specific point in time. All new survey results are therefore published on CQC's website and NHS Surveys, as appropriate, and previously published results for the same survey are not revised.

This policy sets out how CQC will respond if an error is identified within this and it becomes necessary to correct published data and/or reports.

Appendix E: 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 the survey development and methodology: www.cqc.org.uk/content/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: http://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: http://www.cqc.org.uk/content/surveys.

Further questions

This summary has been produced by CQC's Survey Team and reflects the findings of the inpatient survey 2016. 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.
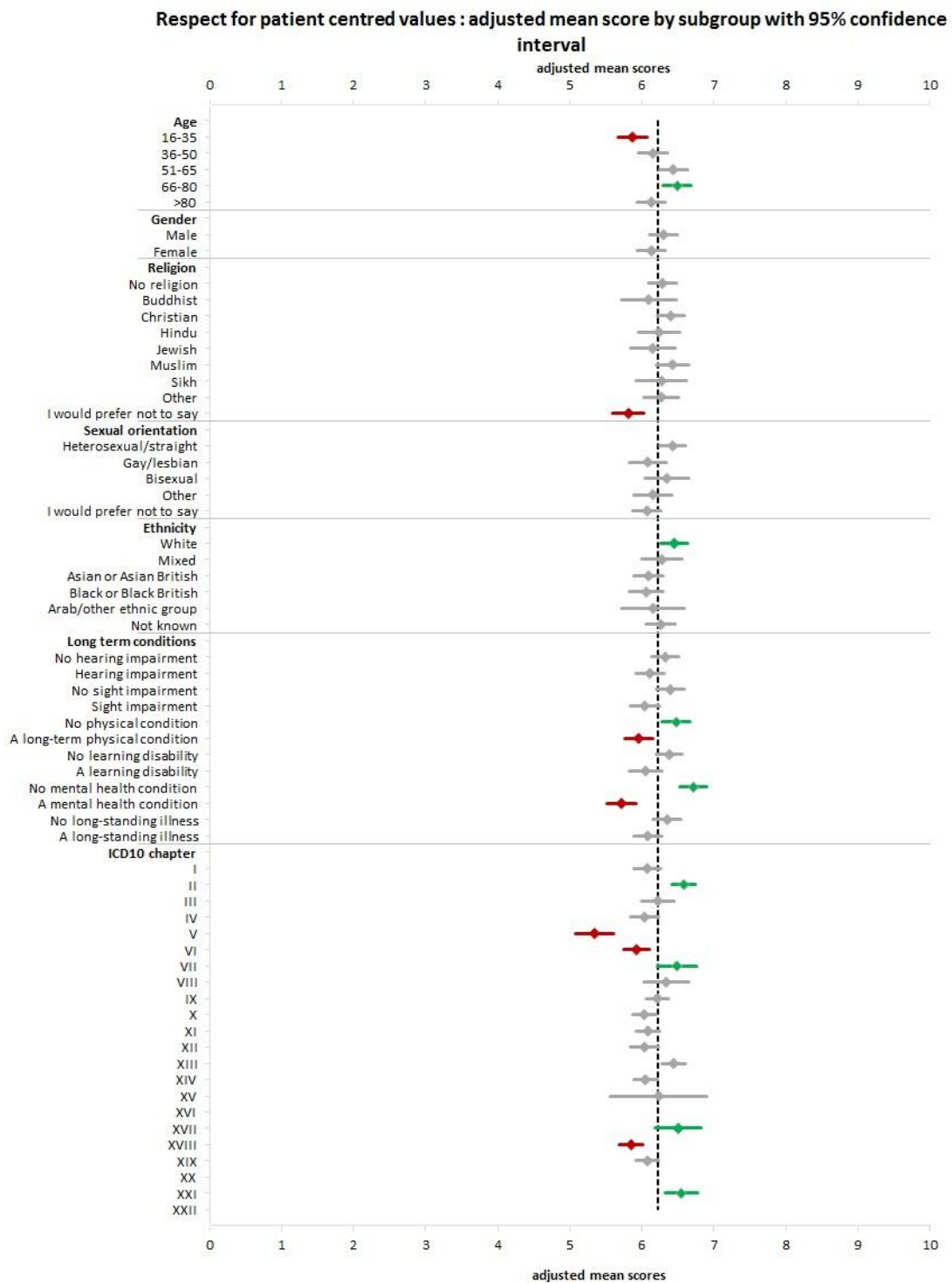
Information sharing

Information sharing: adjusted mean score by subgroup with 95% confidence interval

Respect for patient centred values

Respect for patient centred values : adjusted mean score by subgroup with 95% confidence interval
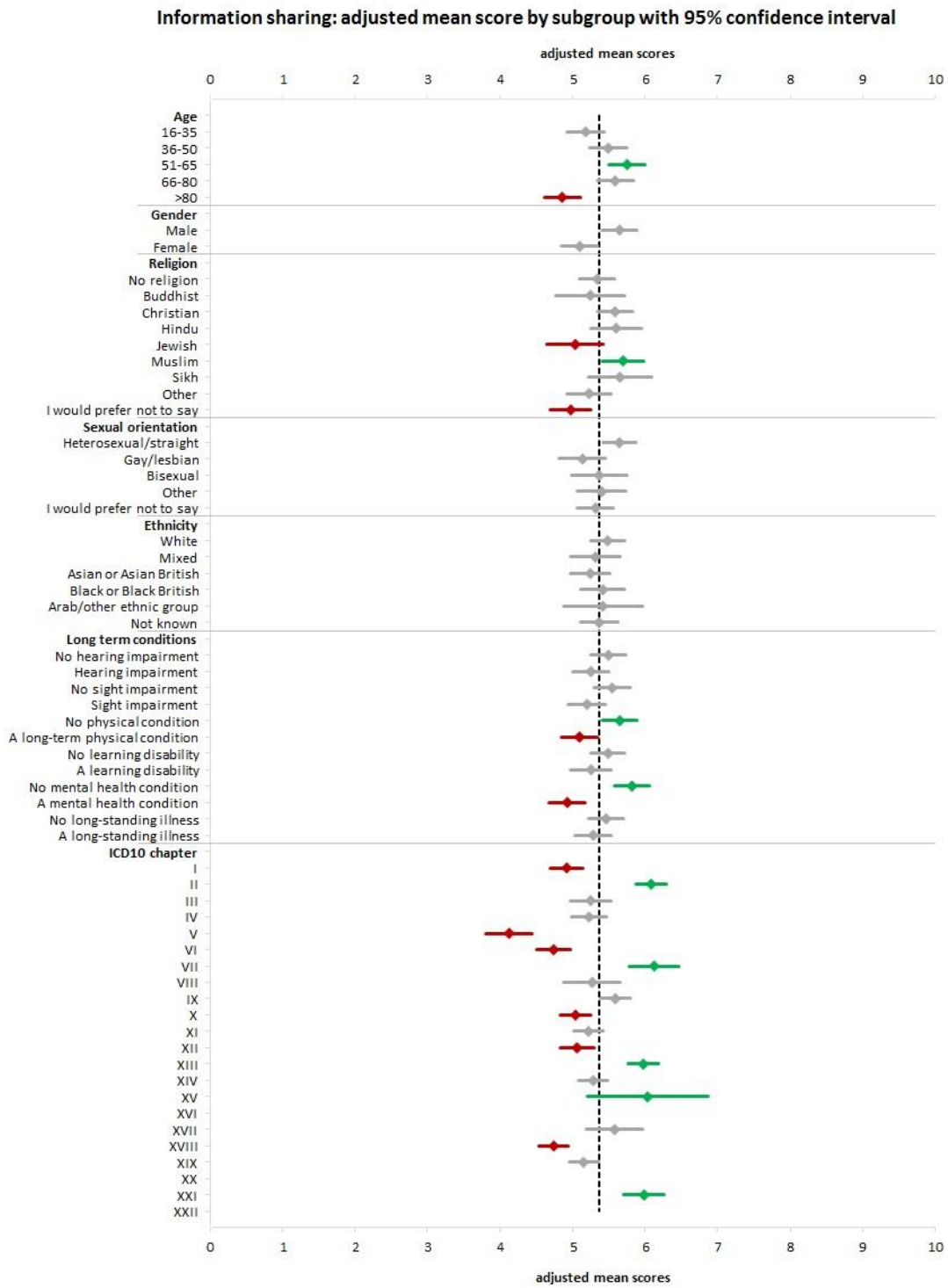
Emotional support

Emotional support: adjusted mean score by subgroup with 95% confidence interval
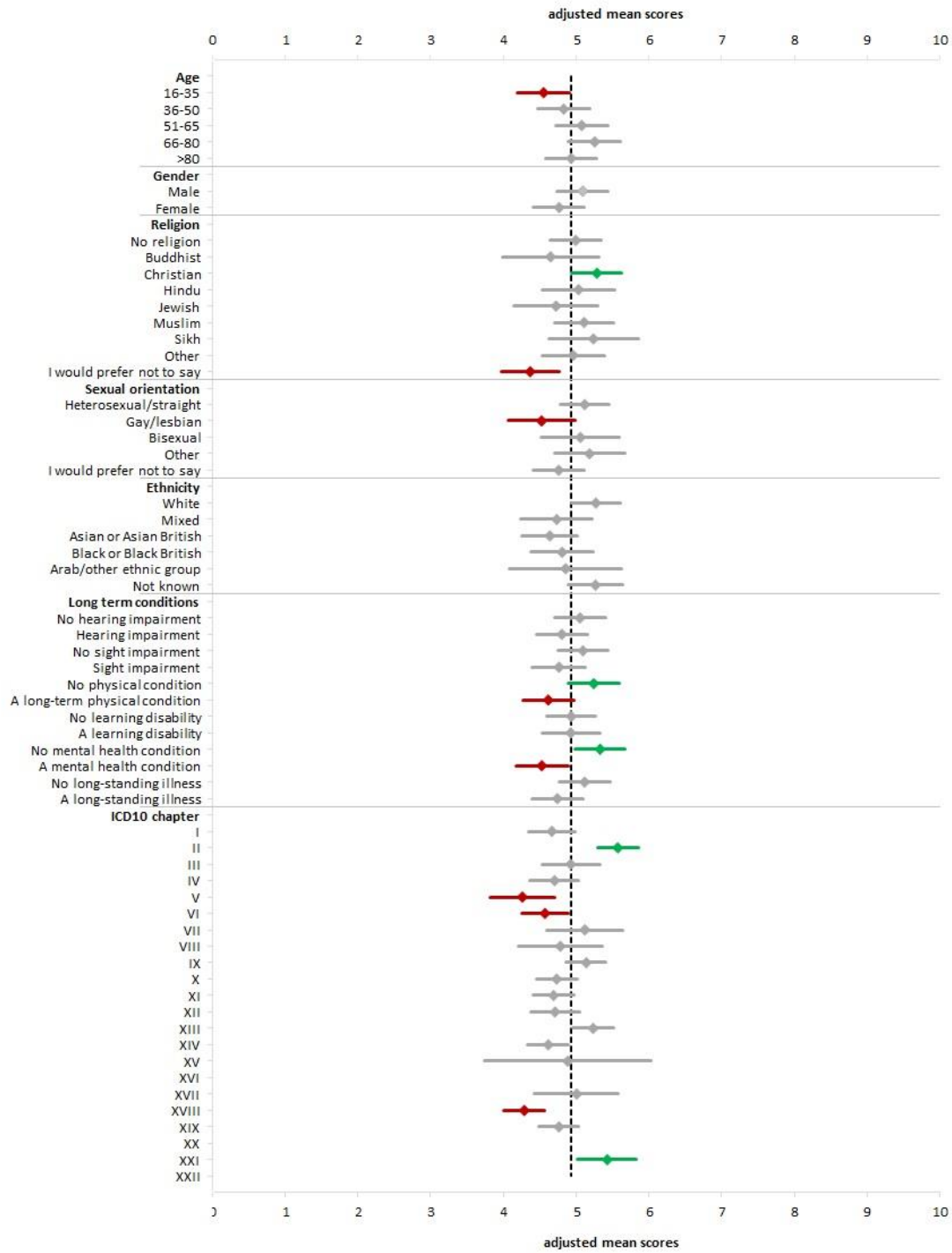
Confidence and trust

Confidence and Trust: adjusted mean score by subgroup with 95% confidence interval

Coordination and integration

Co-ordination and Integration of care : adjusted mean score by subgroup with 95% confidence interval
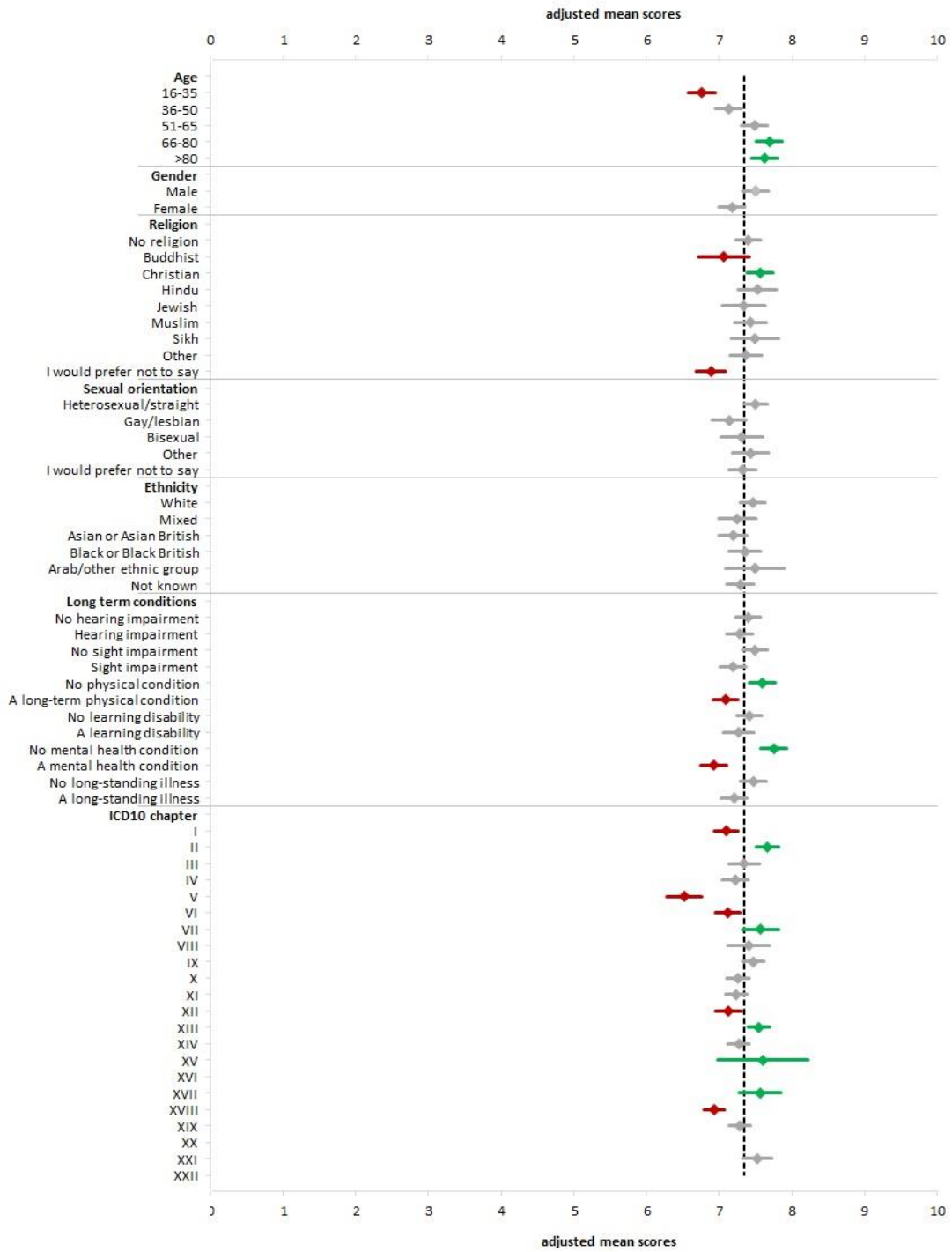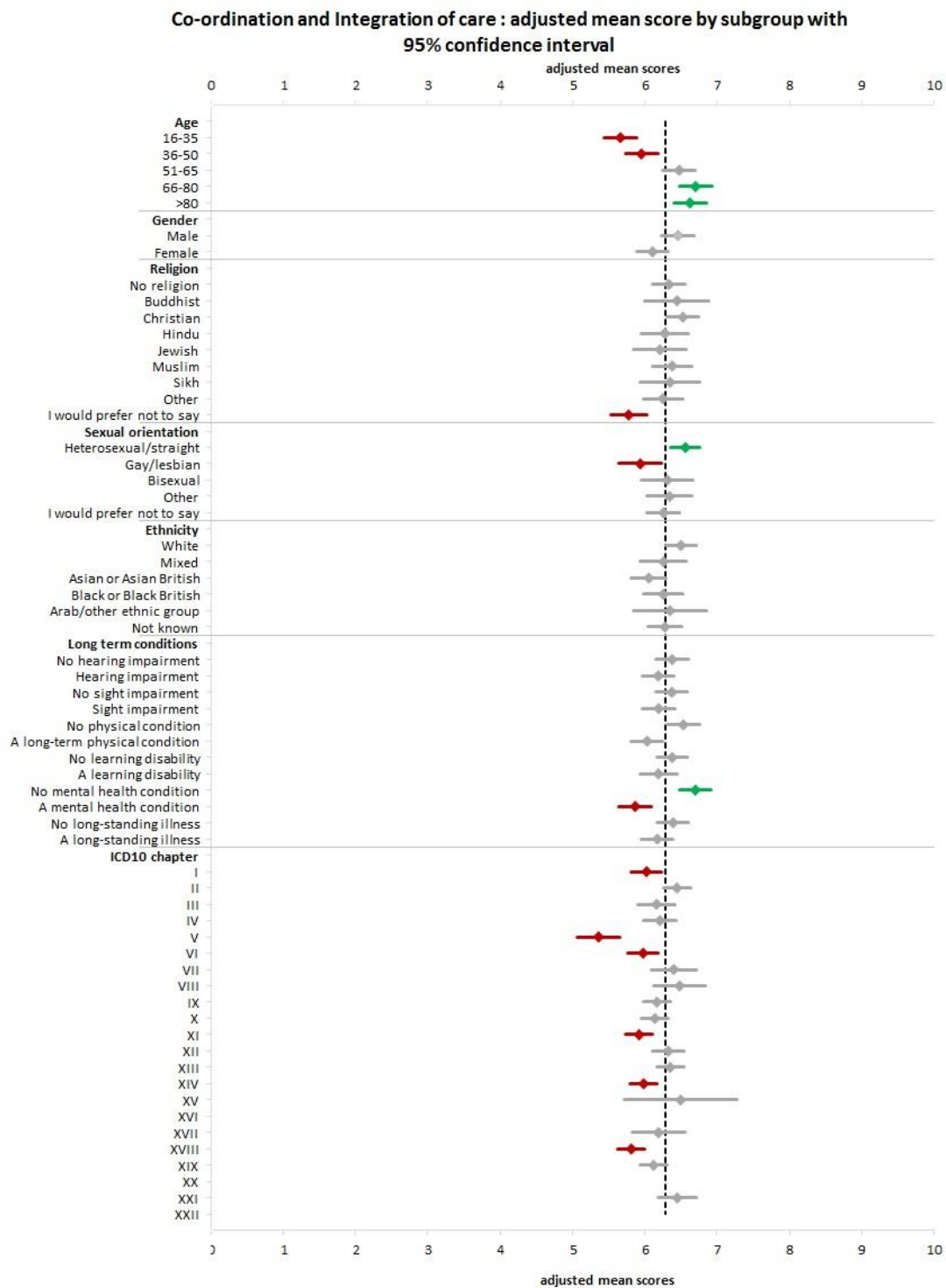
Food choice

Food choice: adjusted mean score by subgroup with 95% confidence interval
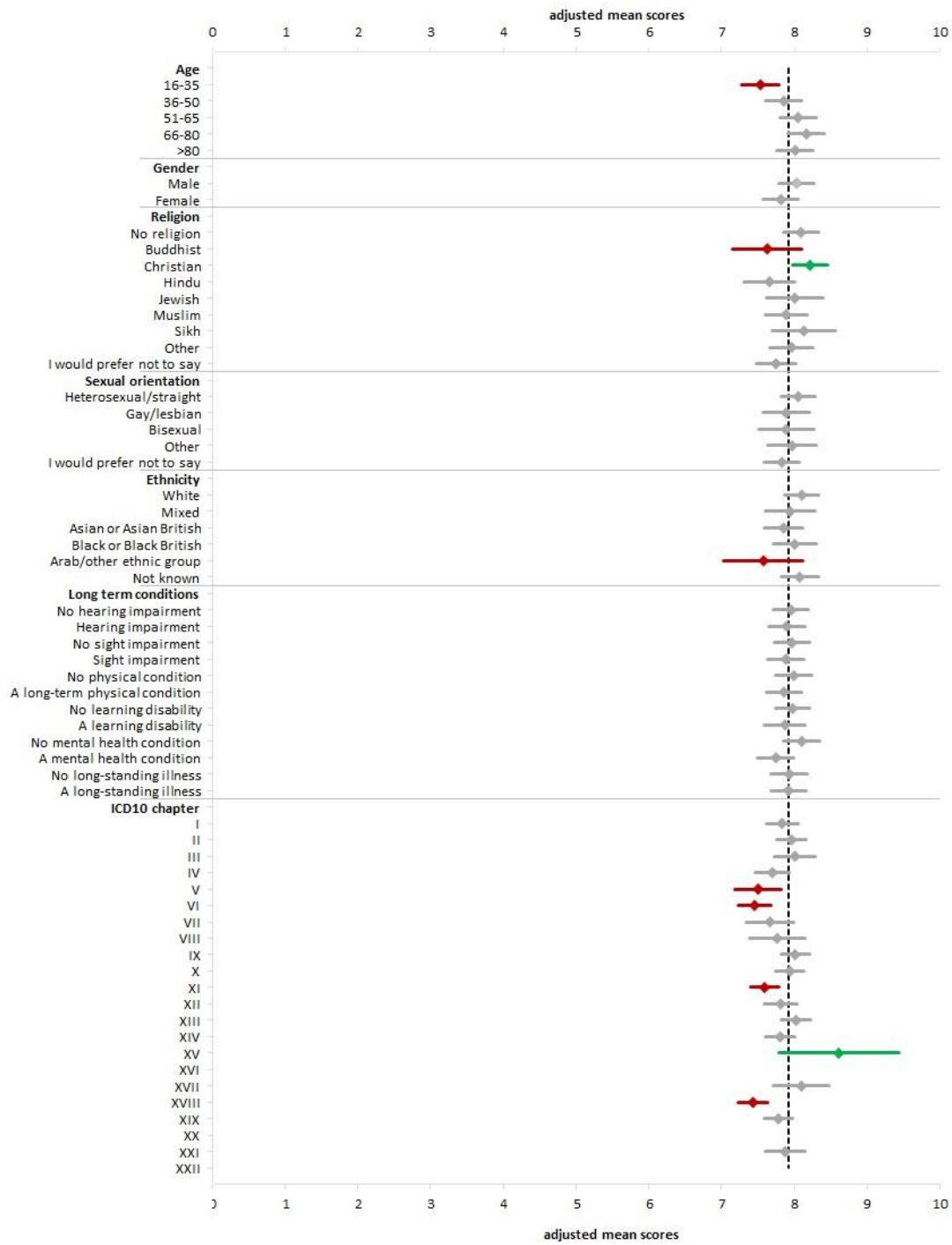
Respect and dignity

Q72. Respect and Dignity : adjusted mean score by subgroup with 95% confidence interval
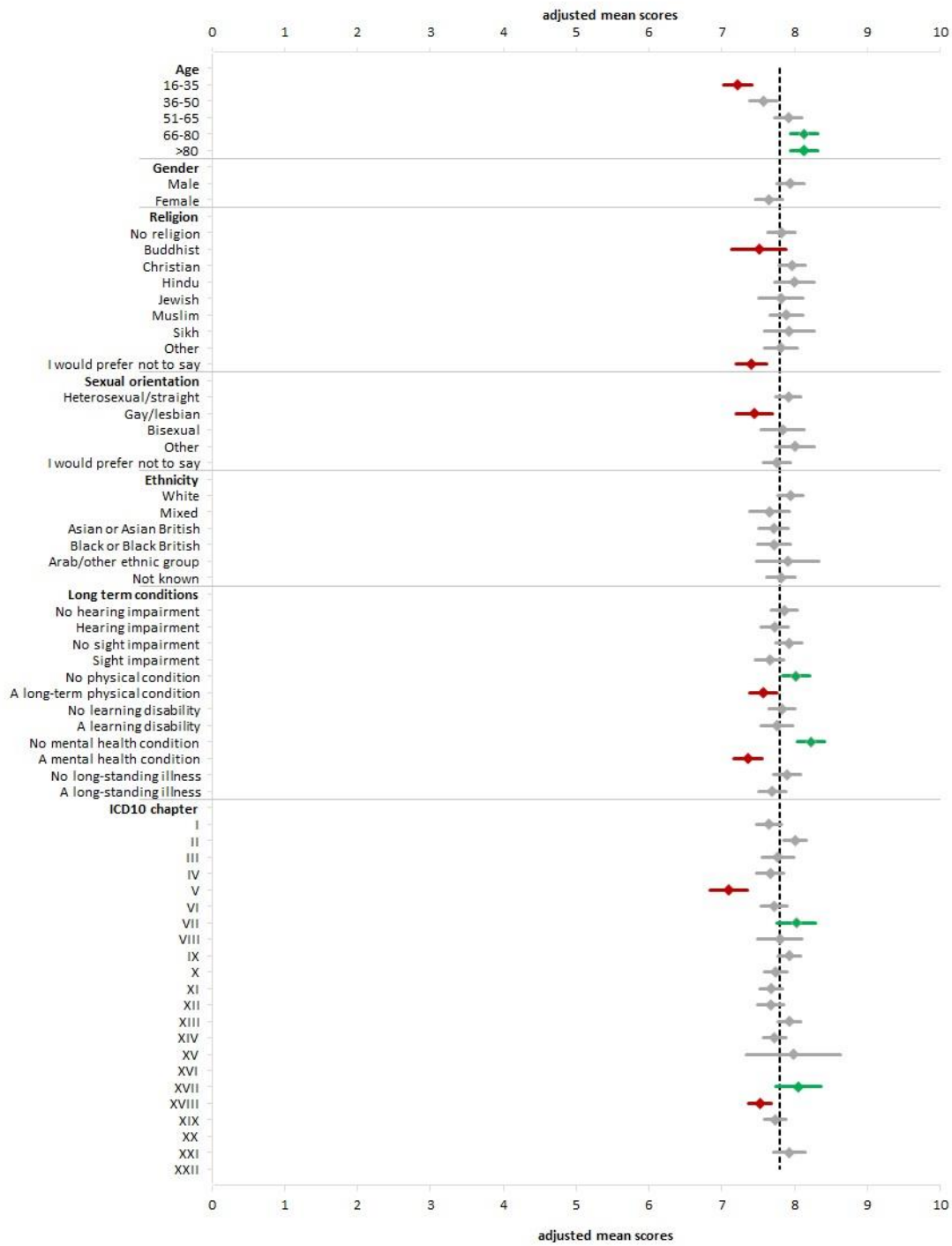
Overall

Q74. Overall question : adjusted mean score by subgroup with 95% confidence interval
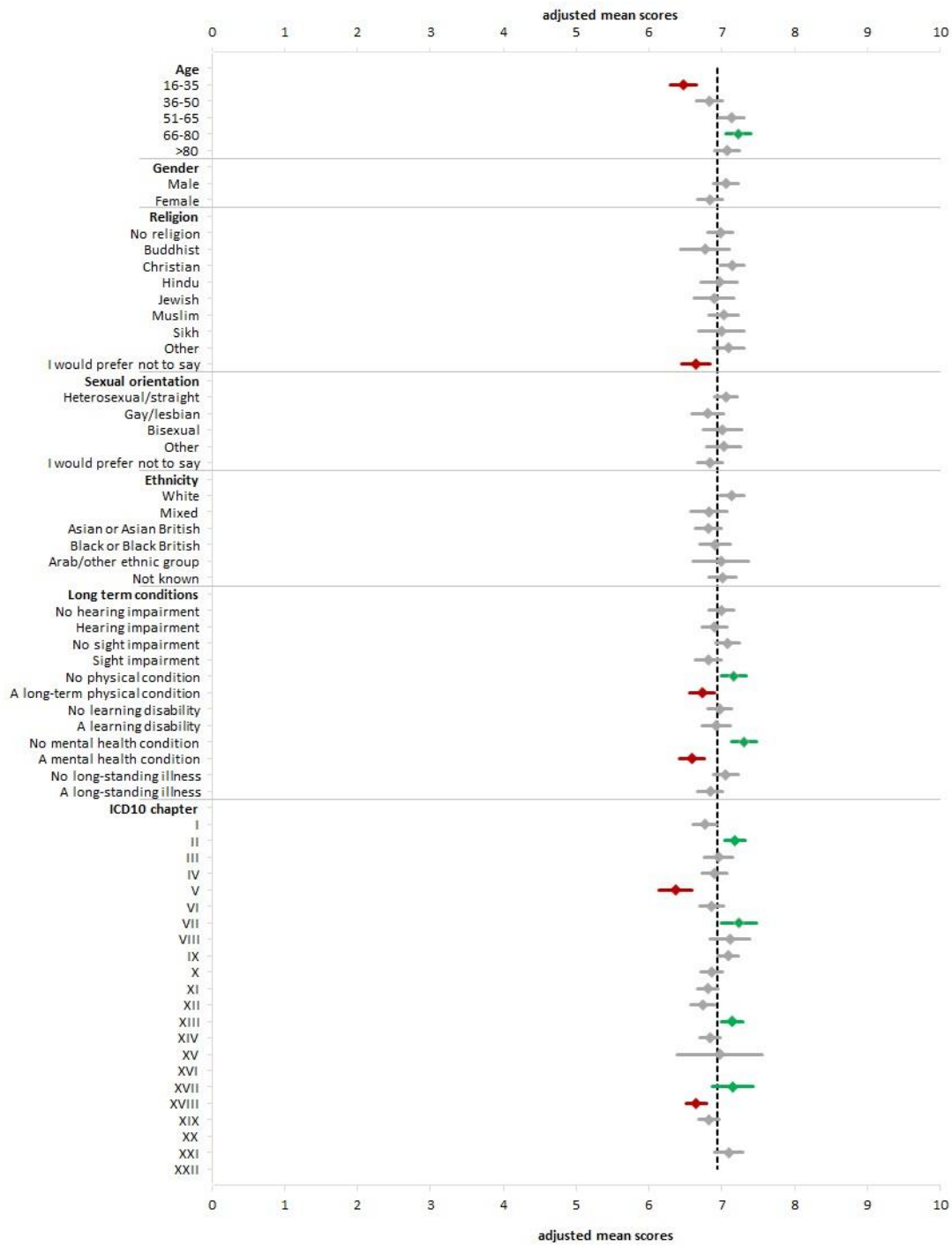
Appendix G: ICD-10 chapter codes

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 Organisation's website, or the ICD-10 User guide.

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Look at our website: www.cqc.org.uk

Write to us at: Care Quality Commission
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