

NHS Patient Survey Programme

2019 Adult Inpatient Survey

Statistical release

Published July 2020

Independent data analysis

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Summary of findings

The number of people being admitted to hospital is increasing year-on-year.¹ Research has shown that this increase, along with financial pressures, staff shortages and outside influences, such as issues with the provision of social care, have put strain on NHS adult inpatient services.² However, the UK Government has introduced measures in the form of policy changes, guidance and new initiatives to address these pressures, especially those brought about by an increasingly ageing population. The adult inpatient survey is a reliable barometer for the quality of patient experience within this complex environment.

The 2019 adult inpatient survey received feedback from 76,915 people who received inpatient care in an NHS hospital in July 2019. The response rate was 45% which is the same as the response rate in 2018. All data was collected between August 2019 and January 2020, before the COVID-19 pandemic spread to the UK. Therefore, patient experience as discussed within this report, does not reflect the impact of the coronavirus on NHS adult inpatient services.

The report shows that, generally, people's experiences of inpatient care are good, and show signs of improvement or sustained good performance across many themes, such as communication around operations and meeting fundamental needs, including cleanliness and hydration. Overall, people were most positive about being treated with dignity and respect while in hospital.

Notably, however, there has been a decline in people's experiences of accessing services and also being discharged from hospital when they are ready to return home. Those who are frail, in particular, reported worse experiences of discharge from hospital. There has also been sustained decline with regard to information and communication around medications, with many people not being given clear written or printed information about medicines; or being told what side effects of their medicines to look out for after leaving hospital. The survey also found that a large proportion of people (four in 10) were not always able to get help within a reasonable amount of time when in hospital, with a similar amount of people also reporting that there weren't always enough nurses on duty to care for them.

Experiences of patients in 2019 again showed differences according to certain patient characteristics. Generally, older people (aged 66+) reported a more positive experience, while younger respondents (aged 16 to 35) reported those that were more negative. Those who had an emergency admission reported worse experiences, while those with an elective admission reported more positive experiences.

In line with findings across other surveys, such as the 2018 Urgent and Emergency Care survey and the 2019 Community Mental Health survey, people with dementia or Alzheimer's and those with chapter code V (Mental and behavioural disorders) have also reported poorer experiences of inpatient care.

This year for the first time, additional analysis was undertaken to better understand the experiences of patients who self-reported as being frail, with regard to ensuring they are supported after leaving hospital. Frail respondents reported worse experiences for all four questions analysed.

Positive findings

Dignity and respect

A number of questions focus on whether patients were treated in a respectful and dignified manner while in hospital. Most of these continued a trend of sustained improvement over the last 3-6 years. For instance, when patients were asked if, overall, they felt they had been treated with respect and dignity during their time in hospital, 81% responded 'yes always'. This is an increase of half a percentage point since 2018 and above where we would expect results to be, based on past findings, for a sixth year. All three questions assessing privacy showed patients were having positive experiences. Ninety per cent of people responded 'yes, always' when asked if they were given enough privacy when receiving treatment or being examined. Improvement was also seen when respondents were asked if doctors talked in front of them as if they weren't there. Seventy-seven per cent of people reported that doctors did not talk in front of them as if they were not there. This is a significant increase of one percentage point and continues an upward trend.

Person-centred care

Within this theme, results show communication between staff and patients before and after operations is improving. For instance, 80% of those who had an operation responded 'yes, completely', when asked if a member of staff answered their questions about the operation in a way they could understand. This result adds to consistent improvement throughout the 10-year reporting period. People were also asked if, beforehand, they were told how they could expect to feel after they had the operation or procedure. Sixty-two per cent of people responded 'yes completely' which is an increase of one percentage point since 2018. Similarly, when asked if a member of staff discussed with them how the operation or procedure had gone, 68% answered 'yes, completely' which is a significant increase of one percentage point since 2018.

Confidence in doctors and nurses also remains high this year, with results for both questions being higher than expected, based on past findings, for multiple years. Seventy-nine per cent of people reported they 'always' trusted doctors and 78% 'always' trusted nurses.

Meeting fundamental needs

Respondents continue to report positively when asked about the cleanliness of the hospital environment, the choice of food available to them and hydration. For example, when asked for their opinion about the cleanliness of the hospital room or ward they were in, 97% responded either 'very clean' (69%) or 'fairly clean' (28%). These results have gradually improved since 2010 when they were below the expected limits of variation. However, this year's result is above these limits for the fifth year in a row.

Respondents overwhelmingly reported that they were given enough to drink during their stay in hospital. Results for this question remain unchanged since the question was introduced in 2017, with 93% reporting positively.

Another question which consistently performs well within this theme is 'were you offered a choice of food?', with 79% of people responding 'yes, always'. The results

for 2019 remain unchanged for five years and have been above expected limits of variation during this period.

Areas for improvement

Patient discharge from hospital and integrated care

This theme monitors coordination of care at hospital discharge, discharge delays and information about medicines when leaving hospital.

The number of people reporting a delayed discharge remains at 41%, however the length of delays has continued to increase. Of the people reporting a delayed discharge, 89% reported being delayed more than one hour, with over a quarter (26%) being delayed more than four hours.

Communication at the point of discharge is another area for improvement. Forty per cent of people reported not being given any written or printed information about what they should or should not do after leaving hospital. This is a gradual decline since 2013, and has been below the expected limits for the last four years. Other areas for improvement included people being told about danger signals to look out for after being sent home, which has declined one percentage point since 2018, and being given information about who to contact if people were worried about their condition after they left hospital (26%).

Consideration of support post discharge was also less positive. For example, respondents were asked if hospital staff discussed whether they would need any further health and social care services after leaving hospital. Results show 20% of people reported that they did not discuss their health and social care needs after leaving hospital but would have liked staff to ask. Similarly, patients were asked if staff discussed with them whether they would need any additional equipment in their home, or adaptations to their home, after they left hospital. Again, 22% responded 'no, but I would have liked them to'. Both questions show gradual deterioration and are below the expected limits of variation.

All three questions regarding information about medication when leaving hospital, show a decline over time. Ten per cent of people said that a member of staff did not explain the purpose of medication in a way they could understand, which is a significant increase of one percentage point since 2018. When asked if they were given clear written or printed information about their medication, 65% responded 'yes, completely' which is a decrease of six percentage points since 2017. The most negative results were seen for 'Did a member of staff tell you about medication side effects to watch for when you went home?'. Almost half of patients (44%) were not told what side effects of their medication to look out for. This question has seen gradual decline since 2015, with results below the expected limits of variation for two years in a row.

Experience of admission to hospital

All three questions in this theme have shown decline and are below expected limits of variation. Seventy-two per cent of people who were on the waiting list or had a planned admission felt that they were admitted as soon as they thought was necessary, which is a decline of four percentage points since 2013. One in five

people (21%) had experienced changes to their admission date at least once, which is a gradual decline in results since 2013.

Eighteen per cent of people reported definitely waiting a long time to get a bed on a ward once admitted to adult inpatient services. This is a significant increase of two percentage point since 2018. The percentage of people not waiting a long time to get a bed on a ward has decreased by eight percentage points since 2015 and shows the sharpest rate of decline out of all the questions in the survey.

In addition, only a quarter of respondents were offered a choice of hospital for their first appointment. Based on past findings, this is lower than where we would expect results to be, which is the first time this has happened during the 10-year reporting period.

Availability of staff

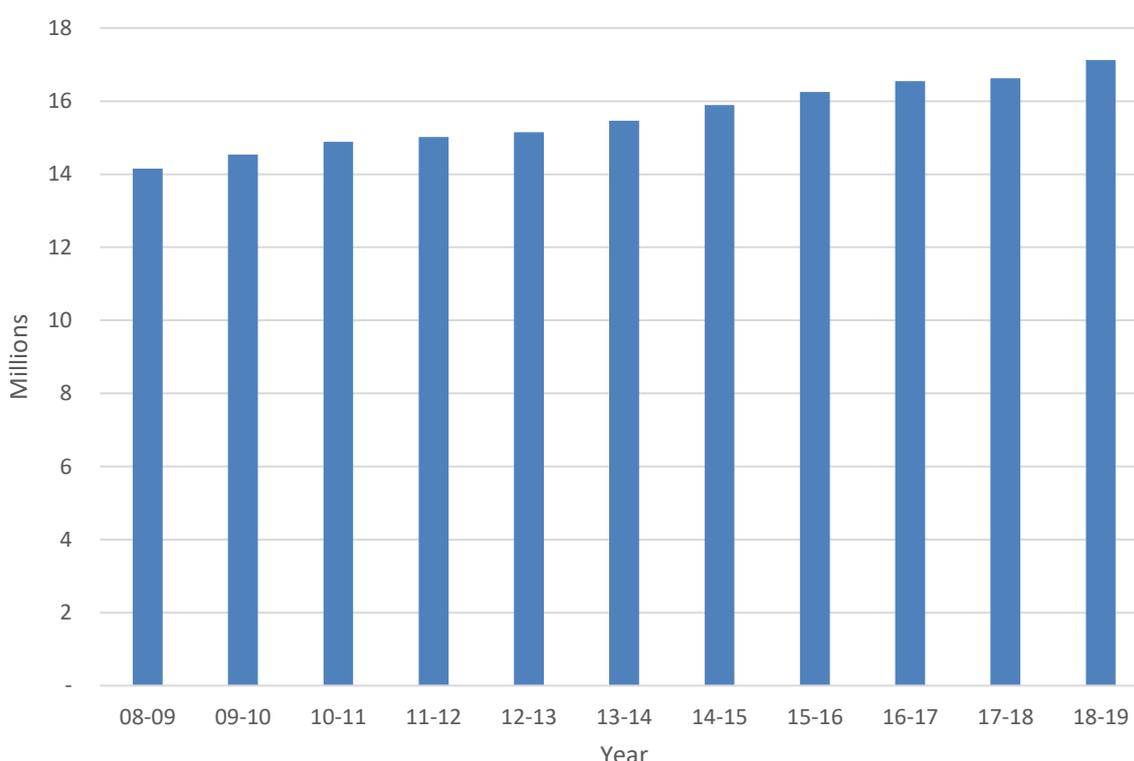
Results show 42% of people reported there were 'sometimes enough' (30%) or 'rarely or never enough' (12%) nurses on duty to care for them. While results are within the expected limits of variation for this question, the percentage of people experiencing shortages in nursing staff remains high. People were also asked if, when they required attention, they were able to get a member of staff to help them in a reasonable amount of time. The survey found that 59% of people were always able to get help in a reasonable amount of time, while the remaining 41% were either sometimes able to get help (33%) or not able to get help (8%).

Introduction

Adult inpatient services provide care to people who stay in hospital for one night or more for tests, medical treatment and surgery. Some patients access inpatient services as the result of an emergency via A&E or an urgent treatment centres, whereas others receive pre-planned elective treatment.

Data from [NHS Digital](#) shows that there were 17.1 million finished admission episodes between April 2018 and March 2019, an increase in admissions of 3% since 2017/18 and 21% since 2008/09.³

Figure 1: The number of finished admission episodes per year from 2008/09 to 2018/19.



Source: Produced from 2018/2019 finished admission episode statistics, NHS Digital. Available at <https://digital.nhs.uk/data-and-information/publications/statistical/hospital-admitted-patient-care-activity/2018-19>

This is set within the context of an ageing population, with people aged between 70 and 74 accounting for the largest number of admissions (1.9 million) in 2018/19.

The [NHS Long Term Plan](#) highlights integrated care as being a vital component in reducing the number of hospital admissions. However, staff shortages in both acute and primary care, as well as increasing numbers of people registering for GP services and funding cuts to social care services, have resulted in challenges for the NHS in trying to create an effective, fully integrated care system.^{4,5,6}

Funding overall is an area of concern with regard to implementing plans for an integrated care system that works well. For instance, between 2009/10 and 2018/19,

the NHS budget increased on average by 1.4% each year, compared to the average of 3.7% each year since the NHS was established. In July 2018, the Prime Minister announced a five-year funding deal, increasing funding by £33.9 billion. However, according to The Kings Fund, this is still lower than the long-term average and excludes areas such as investment in infrastructure, public health and the education and training of NHS staff.⁷

In addition to funding, staffing in the NHS has also become an issue of national interest. The UK Government have set out plans to address the pressures caused by staffing shortages in publications such as the [NHS Long Term Plan](#), the [Interim NHS People Plan](#) and the Green paper '*Prevention is better than cure*'.^{8,9,10}

England-based data collected by [NHS digital](#) shows increases in numbers of doctors and nurses between 01 Nov 2018 and 31 October 2019. However, this is coupled with growing NHS vacancy rates and concerns that one in three nurses are due to retire within the next three years.^{11,12} In addition, the UK's decision to leave the European Union may also have implications with regard to keeping international staff who are not close to retirement age.¹³ Overall, this implies that current staffing levels are not meeting demand, with the situation potentially becoming worse in the near future. However, it should also be noted that there has been an increase in the number of people applying to work, or returning to work, in the NHS, following the COVID-19 outbreak.

One of the key reasons the NHS requires a growth in staff numbers, is the increased demand placed on the NHS by the UK's aging population. We now live longer than previous generations, with one in three of today's babies expected to reach their 100th birthday.¹⁴ However, although people are living longer, they are doing so in poor health. Healthy life expectancy has not kept up with general life expectancy. For example, women born today are expected to live an average of 19.3 years in ill-health and men 16.1 years, with the majority of these years occurring post-retirement.¹⁵ Often, people have multiple health issues which means that the NHS is required to provide intensive support and care for more complex conditions, for a growing number of people.

The government's commitment to tackling NHS pressures caused by an aging population can be seen throughout recent health policies. The [NHS Long Term Plan](#) discusses the creation of a fully integrated and joined up health service which is fit for the 21st century, as well as training medical staff with the generalist skills required to meet the needs of an ageing population.¹⁶ The [Interim NHS People Plan](#) addresses the need to recruit more nurses to cope with the increasing demand for services, while the paper, '*Prevention is better than cure*' takes a more proactive approach and sets out ambitions to reduce the demand for in-hospital care.^{17,18} In adopting a preventative approach to healthcare, an individual's potential health issues will be identified and treated by community and primary care services, before the need for hospital treatment is required.

In addition to policy changes, the government has launched new initiatives, such as the [Aging Society Grand Challenge](#), which comes with an investment of £300 million.¹⁹ This challenge encourages both public and private sector organisations to develop ideas that will 'ensure that people can enjoy at least five extra healthy, independent years of life by 2035, while narrowing the gap between the experience of the richest and poorest'.

About the adult inpatient survey

The adult inpatient survey is part of the NHS Patient Survey Programme, which covers a range of topics including maternity care, children and young people's inpatient and day-case services, urgent and emergency care and community mental health services. To find out more about the survey programme and to see the results from previous surveys, please see the links in the further information section.

The survey of people who use adult inpatient services has been conducted annually since 2004. A total of 143^a NHS trusts in England, who deliver adult inpatient services, participated in the 2019 survey.

All patients aged 16 years or over at the time of their hospital stay were eligible to take part if they were treated in the trust during July 2019. Fieldwork took place between August 2019 and January 2020. In total, we received completed questionnaires from 76,915 people, a response rate of 45.3%.^b

The survey collected basic demographic information from all people who took part, and this anonymised data is available in the 'About you' section of the [Open data](#) published on CQC's website. The basic demographic characteristics of respondents in 2019 remain similar to previous surveys for age, gender and ethnicity.

Where possible, the questions remain the same over time to measure change. However, questions can be amended, added or removed to reflect changes in policy or survey best practice. This is undertaken with guidance from key stakeholders to ensure questions remain relevant. The questionnaire is broadly similar to the 2018 questionnaire however, a full list of changes can be found in [Appendix F](#).

This statistical release presents the key results from the 2019 survey and highlights statistically significant differences compared to 2018. Long-term trends dating back to 2010 are identified where available and appropriate. Results for all questions patients were asked are published on our website, www.cqc.org.uk/inpatientsurvey.

The importance of collecting patient experience data

According to research, positive experiences of using health services has many benefits for both patients and the trust.²⁰ Good experiences for those using health services are linked to better outcomes. At an organisational level, positive experiences can lead to better staff experiences and lower care costs. Research has also highlighted the importance of ensuring that patients and families are given an opportunity to feed into the system which has been set up to protect and care for them.²¹

^a Since the 2018 survey, there have been two trust mergers. These are between South Tyneside NHS Foundation Trust (RE9) and City Hospitals Sunderland NHS Foundation Trust (RLN); and Derby Teaching Hospitals NHS Foundation Trust (RTG) with Burton Hospitals NHS Foundation Trust (RJF).

^b We report the 'adjusted' response rate. The adjusted base is calculated by subtracting the number of questionnaires returned as undeliverable, or if someone had died, from the total number of questionnaires sent out. The adjusted response rate is then calculated by dividing the number of returned useable questionnaires by the adjusted base.

There are a number of elements which contribute to a person's positive experience of NHS care. The [NHS Patient Experience Framework](#) identifies these factors as being:

- respect for patient-centred values, preferences and expressed needs, such as shared decision-making and cultural issues
- welcoming the involvement of friends, family and those close to the patient
- emotional support
- access to care, with attention given to waiting times.

The [NHS Constitution](#) commits the NHS to encourage patients to give feedback on their care and experiences, with the view that this feedback should be used for the continuous improvement of services.²² The experiences of patients can provide key information about the quality of services provided across England. The Constitution highlights the important role of this information in encouraging improvements, both nationally and locally, among providers and commissioners of services.

The [NHS outcomes framework \(Domain 4\)](#) and the Department of Health and Social Care's [NHS Mandate for 2020/21](#) also recognise the importance of patient experience with regard to delivery of a high quality service.^{23,24} Specifically, the mandate notes a main objective of the NHS is to help the government to meet its manifesto promise to improve services for all NHS patients.

In addition, the [Health and Social Care Act 2012](#) states that those who commission services must encourage and enable the involvement of people who use services and carers in decisions about their care and treatment.

Policy context

This section discusses some of the broader policy and contextual issues relevant to the care of adult inpatients by the NHS in England.

In October 2014, NHS England published the [Five Year Forward View](#).²⁵ Addressing key issues within the NHS, such as variable quality of care and rising preventable illness, the plan set out six new models of care to be delivered over a five-year period. The models of care prioritised prevention, community-based care and integrated services, with three of these models being specific to adult inpatient services.^c Although growing financial pressure on the NHS required local leaders to concentrate efforts on managing deficits and addressing staff shortages²⁶, new care models were nonetheless tested across the country and local sustainability and transformation plans (STPs) have since evolved into integrated care systems in many areas.²⁷

In more recent years, the [NHS Long Term Plan](#) set out priorities for the NHS over a period of 10 years. Building on the care models proposed in the [Five Year Forward View](#), the plan reinforces the government's commitment to provide an effective, integrated care system with the aim of a more primary and community-based approach to delivering care. The plan also recognises the importance of prevention and encourages the NHS to influence individual behaviour change. The latter priority has resulted in the publication of the green paper '[Prevention is better than cure](#)'. This paper encourages the NHS to make prevention the core of all activity, proactively addressing the root causes of poor health for the whole population. It is hoped that in adopting a prevention-first approach to care, the ageing population will live a better quality of life for longer, without the requirement for hospital-based care, relieving some of the pressures on the NHS.

Integrated care

Providing a fully integrated health service which allows patients to receive care outside the hospital setting, is a central focus of the majority of recent national government policy.²⁸ [NHS England](#) describes integrated care as being person-centred, coordinated, and tailored to the needs and preferences of the individual, their carer and their family.²⁹ An integrated health system moves away from episodic care and brings together multiple services to put people at the centre of how their care is organised and delivered. NHS England also suggests that those who are frail are less likely to require urgent care within a fully integrated system. Instead, they are given support to live independently and better manage their long-term conditions.

The National Institute for Health and Care Excellence (NICE) emphasises the importance of providing an integrated service in [NICE guideline 94](#), highlighting the increasing number of patients treated for multiple illnesses which cross service boundaries.³⁰ This is reinforced by the [NHS Constitution](#), with cross-organisational partnerships to deliver health improvements being one of the seven guiding principles.

The [NHS Long Term Plan](#) describes integration of the care system as vital in easing pressure on acute services and reducing hospital admissions. However, some

^c The three models of care applicable to adult inpatients services are the primary and acute care systems, viable smaller hospitals and specialised care models.

commentators have noted that declining staff numbers in both primary and acute settings, while the registered patient population is rising, has resulted in increased pressure in primary care services.³¹ For example, longer waiting times for specialist care leads to repeat GP appointments, home visits and GPs having to support more patients with complex needs until they are able to access the acute care they require. They worry that transferring more care to the primary setting will stretch services further. This is reinforced by the Care Quality Commission's (CQC) report 'The state of health care and adult social care in England: 2017/18'.³² The report states that 40% of GPs now provide access outside of their normal hours, resulting in a general practice workforce that is increasingly stretched. Overall, there is a clear link between staffing levels and achieving a sustainable integrated care and support system.

Staffing levels

The NHS is the UK's largest employer and one of the world's largest employers with almost 1.3 million hospital and community staff in England alone.³³ While staffing figures are not available for acute adult inpatient services, [NHS digital workforce statistics](#) for October 2019 show there to be almost 180,000 nurses for adult acute, elderly and general services and 32,000 doctors of all grades assigned to general medicine in England.³⁴

Having the right number of doctors and nurses with the right knowledge, skills and experience is critical to delivering a service that is safe, effective and high-quality.^{35,36} Data from [NHS digital](#) shows growth in the number of adult acute, elderly and general services nurses; and general medicine doctors. This is supported by the Nursing and Midwifery Council (NMC) which reports growth in the number of nurses joining the register.^{37,d}

Although the numbers of staff have grown, at December 2019 there were 99,843 vacancies (whole time equivalent) in trusts across England – a vacancy rate of 8.1%.³⁸ This is supported by a report by [The Health Foundation](#) which highlights that staff numbers are struggling to keep pace with demand.³⁹ In addition, the [Royal College of Nursing \(RCN\)](#) has warned that one in three nurses are due to retire within the next 10 years.⁴⁰ A [survey](#) of 30,865 frontline nurses carried out by the RCN in 2017^e reported that poor staffing levels are negatively impacting their day-to-day working life. The survey also found that:

- 58% of nurses working for an NHS provider reported a shortfall in planned staffing of one or more registered nurses on their last shift
- 65% of all respondents said they worked additional time on their last shift, with very little difference in the results for NHS and non-NHS nurses
- 93% of nurses who worked extra unplanned time in NHS providers were not paid for this time (estimated at £396million annually).

In addition, [The Kings Fund](#) has highlighted a growing demand for NHS services and the need for more staff, driven by the ageing population.⁴¹ Discussing NHS pressures in England, the House of Commons stated that between 2010/11 and

^d Not everyone on the register will currently be working as a nurse, midwife or nursing associate or working in the field in which they are registered.

^e This survey was repeated in 2019 with results expected to be published in June 2020.

2018/19, the population of England rose by 6%, while the population of those aged 65 and over rose by 19%.⁴² They also added that during the same time period:

- hospital admissions rose by 15% with older people accounting for most of the growth
- the number of people receiving their first treatment for cancer has risen from 657 per day to 859 per day, an increase of 27%
- the number of GP referrals for suspected cancer has more than doubled.

In January 2019, the [NHS Long Term Plan](#) set out a vision of a 21st Century NHS. In June that same year, the [Interim NHS People Plan](#) was published, setting out the immediate actions required, with regard to staffing, in order to make the vision a reality. Describing low nursing numbers as the single most urgent of all shortages to address, the plan sets out a number of areas to focus on to encourage a 'domestically grown workforce'. These include:

- increasing the number of nurses recruited through undergraduate nursing degree courses
- providing clear pathways to the profession through the nursing associate qualification
- improving staff retention and encouraging nurses to return to practice.

To increase the number of nurses recruited through an undergraduate degree entry route, the Interim NHS People Plan discusses how NHS England plan to work with higher education institutes to ensure there are enough places available to applicants. They also pledged to increase clinical placement capacity by 5,000 for September 2019 intakes. Poor placement capacity has historically been identified by the Council of Deans of Health as being a significant barrier.⁴³

With regard to retaining existing staff, NHS England intend to expand the [Direct Support Programme](#) which supports trusts in developing interventions which are proven to increase retention rates, such as ensuring staff are well supported and have career development opportunities. NHS England also plan to launch a new 'return to practice' campaign, hoping to build on the success of return to practice courses delivered by Health Education England which has recruited more than 5,400 nurses onto courses since September 2014.

The Interim People Plan also highlights the need to significantly increase the recruitment of international nurses in the short to medium term due to the time required to train new nurses. In September 2019, the NMC reported a decline of 3.21% (1,062) in the number of professionals on their register from the European Economic Area (EEA). However, they also reported an increase of 5.55% (4,065) in the number of professionals from outside the EEA, with the majority of these professionals being trained in India and the Philippines.

In response to the COVID-19 pandemic, [NHS England](#) report that around 25,000 retired doctors, nurses and other staff have volunteered to return to work for the NHS.⁴⁴ In addition, between 9 March 2020 and 8 April 2020, there were 907,000 visits to the NHS jobs website, compared to 620,000 during the same period last year. However, as the pandemic and the response to it is unprecedented, it remains to be seen if this level of interest in working for the NHS will continue when COVID-19 is no longer an influencing factor.

Waiting times and admission to hospital

Short waiting times are considered important to improve patient experience, but in some cases, for conditions where early diagnosis improves chances of the treatment being successful, they are a necessity to provide safe and effective care.⁴⁵

NHS England state that patients currently have the legal right to:

- start non-urgent consultant-led treatment within 18 weeks
- be seen by a specialist for suspected cancer within two weeks
- receive treatment in A&E within four hours
- be transferred from A&E to a ward within 12 hours.

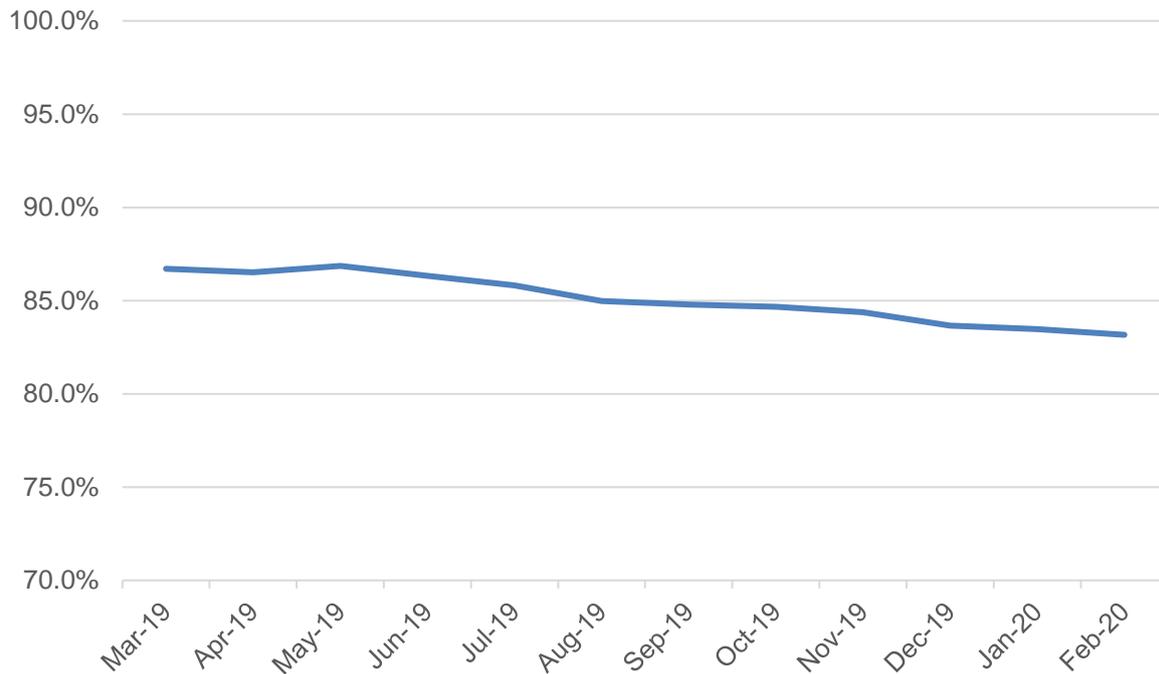
As at November 2019, over 4.4 million people were waiting for consultant-led hospital treatment. Almost 700,000 of these people had waited more than 18 weeks for treatment.^{46,47,f} Following a review of NHS access standards by NHS England in 2019, proposals for testing new ways of measuring waiting times for A&E, RTT and cancer treatments were put forward. The A&E four hour wait and the RTT targets have been tested using an average waiting time measure. A new standard for cancer diagnosis was also proposed, testing the use of a diagnosis target of 28 days (from GP referral to diagnosis), replacing the current 14-days target.

However, amidst this testing, the Royal College of Surgeons of England (RCS) expressed concern in August 2019 that the 18-week RTT target was dropped from NHS England and NHS Improvements accountability framework before a new target was implemented. Similar concerns were raised by the Public Accounts Select Committee who add that during a time of rising demand for NHS services and increasing financial restraint, the Department for Health and Social Care has allowed NHS England to prioritise meeting standards for emergency services and cancer care over elective care.⁴⁸

Referral to treatment target (RTT) for February 2020 show that the target of 92% was not met, with 83.2% of patients seen in less than 18 weeks (figure 2).⁴⁹ While a clear trend of decline can be seen in the following chart, it should also be noted that the COVID-19 pandemic spread to the UK in late January 2020. Therefore, data reported for February 2020 could be impacted by this.

^f Please note, data up to March 2020 is available at this present time. However, data from November 2019 coincides with the sample period of this survey and the data from March appears to have been impacted by COVID-19 and the NHS focusing all resource on managing this pandemic.

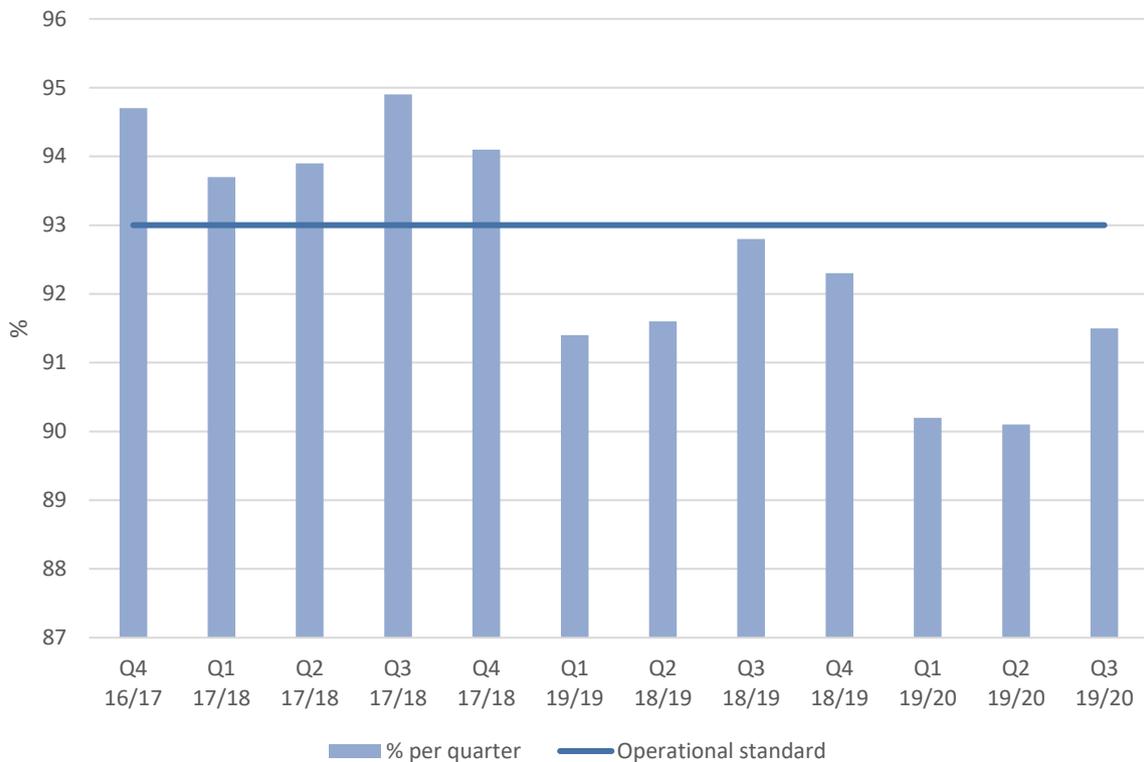
Figure 2: Percentage of patients accessing treatment within 18 weeks of referral – March 2019 to February 2020



Source: Produced from NHS digital consultant-led referral to treatment waiting time data – March 2019 to February 2020. Available online at: <https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-data-2019-20/>

In addition, for October to December 2019 the target for 93% of patients with suspected cancer to be referred to a specialist from their GP within two weeks was not met, with 91.5% seeing a specialist within the target time (figure 3). The chart below shows data up to December 2019, before the new coronavirus (COVID-19) was reported in the UK.

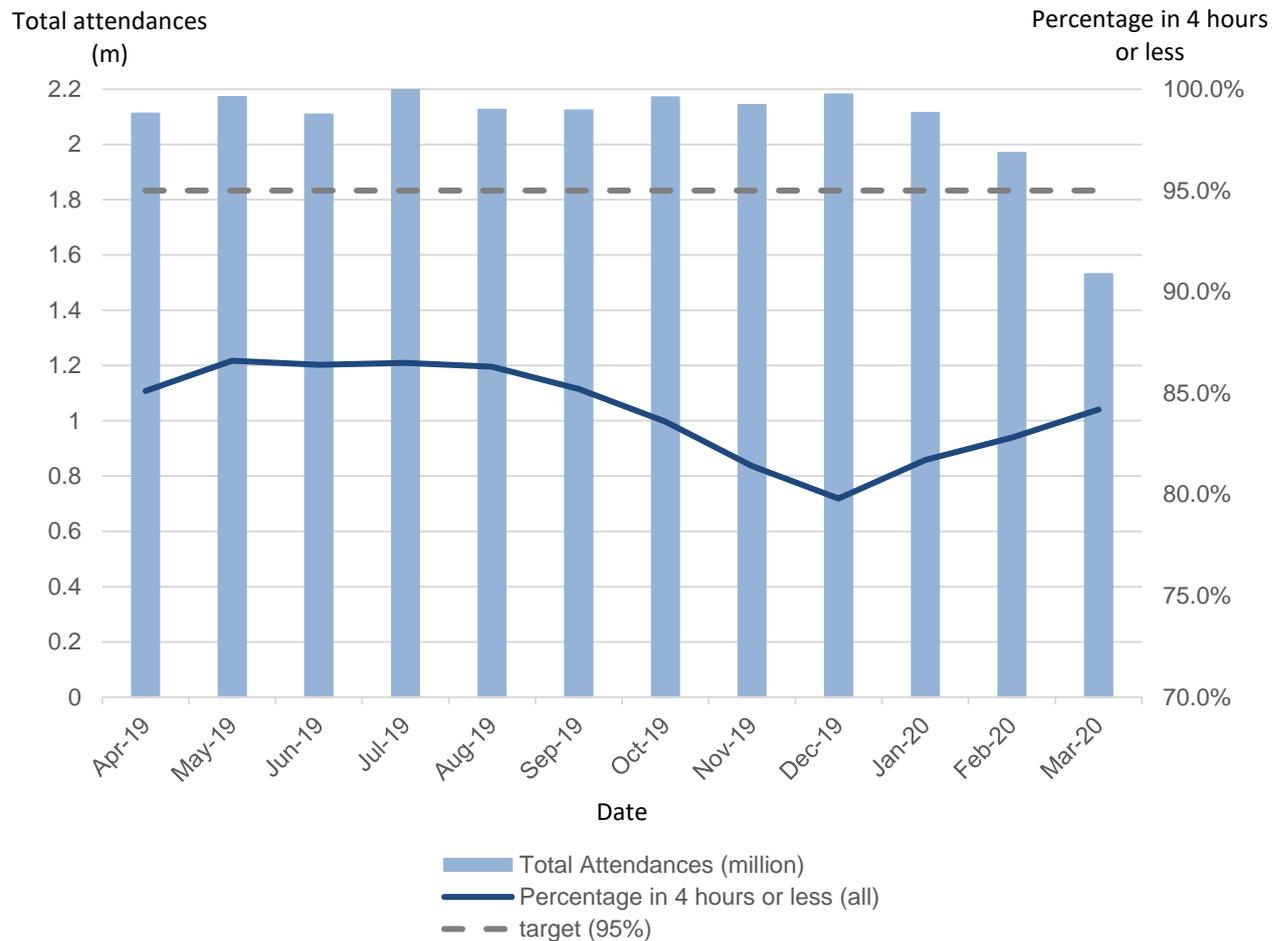
Figure 3: Percentage of people seeing a cancer specialist within two weeks of urgent GP referral – Q4 2016/17 to Q3 2019/20



Source: Produced from Q3 2019/20 cancer waiting time statistics, NHS England. Available at: <https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2020/01/q2-2019-2020-cancer-waiting-times-provider-workbook-final.xlsx>

In March 2020, only 84.2% of people were seen in under four hours at A&E, falling short of the 95% target. Of the 427,921 emergency admissions to hospital (325,787 via A&E), 51,795 waited more than four hours to be admitted and 1,184 waited more than 12 hours (figure 4).

Figure 4: A&E attendances and proportion of A&E patients seen under four hours



Source: Produced from March 2020 A&E attendances & emergency admission statistics, NHS and independent sector organisations in England, NHS England. Available at <https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/ae-attendances-and-emergency-admissions-2019-20/>

Please note, as shown in figure 4, the number of A&E attendances declines sharply in March 2020. The data in this month was collected during beginnings of the new coronavirus (COVID-19) pandemic in the UK. The drop in attendances reflects concerns that the general public were avoiding A&E due to fears of contracting the virus.⁵⁰

Delayed transfer of care

Research shows that hospitals are struggling with capacity levels, with bed occupancy rates being consistently above recommended levels. This is in part due to the declining number of beds available. In 2019 the Nuffield Trust reported changes in bed availability and occupancy over time. They found an overall decrease in the number of NHS hospital beds of 12% between 2010/2011 Q1 (144,455) and 2018/2019 Q3 (127,589).⁵¹ In addition to the reduction in bed numbers, delayed transfers of care (DToc) are increasing. This also reduces the number of beds available to patients who require acute care.

A delayed transfer of care occurs when a patient occupies a bed, but they are deemed fit and ready to leave hospital by clinicians or multidisciplinary teams. The most common reasons for delays in acute settings in December 2019 were:

- 21,694 days - awaiting further non-acute NHS care (including intermediate care and rehabilitation services)
- 10,938 days – awaiting nursing home or residential home placement or availability
- 9,553 days – patient or family choice
- 7,203 days – awaiting care package in own home.⁵²

Pressures in adult social care were highlighted in a [briefing paper](#) published by the House of Commons as a key contributor to DToC.⁵³ As well as the growing ageing population and increasingly complex care needs, the paper also highlights reductions in government funding to local authorities as the cause of this pressure. Commentators point out that a lack of sustainable funding for social care is transferring increased financial pressure to the NHS as it is more expensive to be in a hospital bed than it is to receive care in your own home or a care home.⁵⁴

[NHS Improvement](#) estimates excess bed days as costing £346 per day.⁵⁵ In comparison, research shows that providing support to an elderly person:

- in a local authority care home has a mean cost of £83.43 per day
- in a private care home has a mean cost of £113.29 per day
- providing homecare using a private provider has a mean cost of £17.32 (based on 1.08 hours per day).⁵⁶

In addition to the financial implications, [Age UK](#) highlights the detrimental impact of DToC on individuals as it can seriously delay recovery and rehabilitation or in some cases, put it out of reach altogether.

In response, the government have announced [three dedicated adult social care funding streams](#) to tackle this issue. Firstly, there will be an additional £1 billion grant for adult and children's social care (local authorities will determine how the funds are split between the two services). Secondly, the government have provisionally allowed local authorities to increase council tax by 2% for the years between 2016/17 and 2019/2020. Funds raised will be ring-fenced for social care. This will enable councils to access a further £500 million in funds. Finally, existing social care grants of £2.5 billion will roll over into the 2020/21 financial year.

In response to the COVID-19 pandemic, guidance has been released to advise care homes in England that they can only accept new or returning residents from hospital if they have the capacity to safely isolate. It is too early to know if this action will impact the number of people who experience DToC.

[Recruitment of patients in clinical research](#)

Research conducted by the [National Institute for Health Research \(NIHR\)](#) has shown that research-active hospitals have better health outcomes for patients.⁵⁷ An article published by the [Royal College of Physicians \(RCP\)](#) highlights evidence showing hospitals with high research participation as having a 30% lower mortality rate than those who do not.⁵⁸ A [2017 study](#) of 200,000 people diagnosed with colorectal cancer at 150 trusts found that those receiving treatment at a trust with high levels of

research participation had lower mortality rates overall.⁵⁹ They also had a five-year survival rate of over 44% compared to 41% for those trusts with little to no research activity.

As a result of this evidence, CQC now monitor access to clinical research as part of their assessment of whether a trust is effective and well-led.⁶⁰ In addition, they also note that there is a link between trusts that actively facilitate the delivery of a meaningful programme of clinical research and improved CQC ratings.

The [NHS Long Term Plan](#) highlights the benefits to patients of participating in research, including earlier diagnosis and faster recovery. The plan discusses an aim to increase the number of people registering to participate in health research to one million.

Results from the survey

This section presents key results for the 2019 adult inpatient survey.⁹ It highlights statistically significant differences between the results from the most recent survey (2019) and the results from the 2018 survey.^h

We also present the results that have changed noticeably over time and identify long-term trends where appropriate through 'control-charts'. In the 2019 survey, 49 questions allowed us to monitor long-term trends. Of these, 18 found that results were above where we'd expect them to be, based on past data and assumptions of no underlying change. Results for 14 questions were lower than we would expect, based on past findings. The control-charts in this report plot the percentage of the most positive responses to questions and show the expected limits of variation in survey results. To interpret results, there has been no 'real' or meaningful change unless the results go outside of expected limits.

Using control-charts allows comparisons between data points covering a number of years, as opposed to observing statistical significance between just two time points. Viewing trends in survey results over a number of years allows for greater confidence in interpreting relationships within the data.

Where results do not occur outside of expected limits or it is not possible to compare questions over time, no control-chart results are reported. Figure 5 shows a control-chart that fluctuates from below expected limits in 2010 and 2011, to above expected limits in 2016 and then falls back within expected limits between 2017 to 2019; suggesting an initial improvement in results that was not sustained over time.

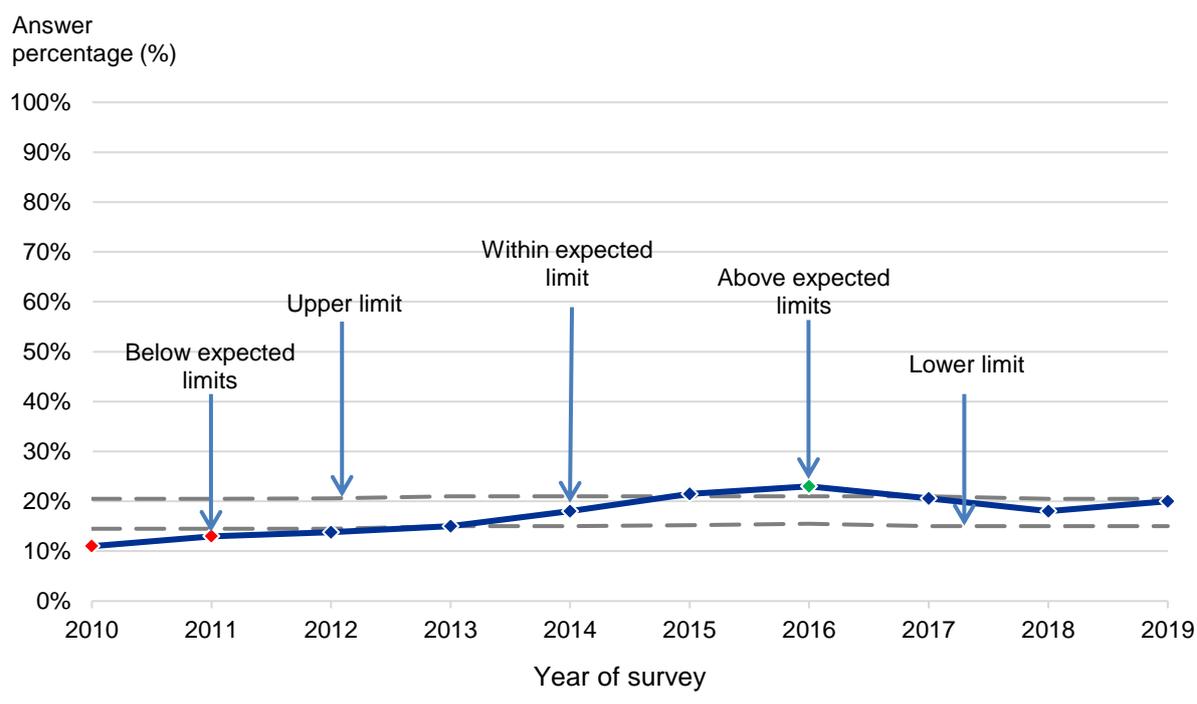
It should be noted that since the last survey in 2018, we have refined statistical processes across the survey programme for the generation of control charts. The limits of variation are now calculated using the results for the first five years of the reporting period as a baseline. Using a baseline prevents data points from changing their status from in-control to out-of-control (or vice-versa) with every new data point that is being added to the chart.

This means, however, that there may be some instances when results reported in previous surveys are now occurring inside or outside of limits.

⁹ Responses to questions such as "don't know/can't 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.

^h With this approach, there is 5% or less probability that the result could have been observed when there has been no underlying change.

Figure 5: Control-chart example



All charts are available in the [open data source files](#) on the CQC website.

We have also included analysis that compares how different subgroups of patients rated their inpatient experience. The Equality Act 2010 requires that public bodies have due regard to eliminate discrimination, and to advance equality of opportunity by fostering good relations between people who share certain protected characteristics and those who do not. The protected characteristics are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. Under the Act, the NHS has a legal duty to promote equality alongside its commitment to address health inequalities as required by the Health and Social Care Act 2012.

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

1. Information, communication, and education (Q30, 36, 56 and 63)
2. Respect for patient-centred values (Q23, 26, 34, 39 and 48)
3. Emotional support (Q37 and 38)
4. Confidence and trust (Q24, 27 and 35)

ⁱ The sum of question scores divided by the number of questions in the composite.

^j A new classification of ICD codes was published in June 2018, including 11 chapters where the former classification included 10 codes. As trusts’ patient records were based on the old classification, ICD-10 codes are used in reporting the results of the adult inpatient survey 2018. The new ICD-11 classification can be found on the [website](#) of the World Health Organization.

5. Coordination and integration of care (Q32, 54, 61, and 65)
6. Food choice (Q20)
7. Hydration (Q22)
8. Respect and dignity (Q67)
9. Overall experience question (Q68)

Findings from subgroup analysis will be presented throughout the report, as well as discussed overall at the end of the results section.

Survey results are discussed under the following key themes:

- 1. Person-centred care**
- 2. Experience of admission to hospital**
- 3. Meeting patients' fundamental needs**
- 4. Dignity and respect**
- 5. Discharge from hospital**
- 6. Availability of staff**
- 7. Recruiting patients to participate in research**
- 8. Overall experience**
- 9. Sub-group analysis**

Responses to questions such as 'don't know / can't remember' are not displayed and are excluded from percentage calculations. 'Don't know / can't remember' and similar responses are provided to accommodate respondents who cannot remember or may not have an opinion on a particular element of their experience.

1. Person-centred care

NICE guidance and recommendations identify person-centred care as being central to good quality health services.⁶¹ The [NHS Long Term Plan](#) renews a commitment from the NHS to deliver a system that ensures patient involvement in decision-making processes, allowing people to feel empowered to take more ownership of their care. A key element in ensuring people are more active in decisions about their care, is to give people greater choice over how they receive their healthcare.

The [NHS Choice Framework](#) sets out some of the choices available to people who use the NHS. These include choosing:

- a GP
- where to have care
- who carries out specialist tests.

The framework also provides details on where to find more information to help people choose, allowing for educated choices and greater confidence in the choices being made.

A number of questions within the adult inpatient survey 2019 measured the experiences of patients with regard to making choices about their care and also the information made available to them to ensure they are making well-informed choices.

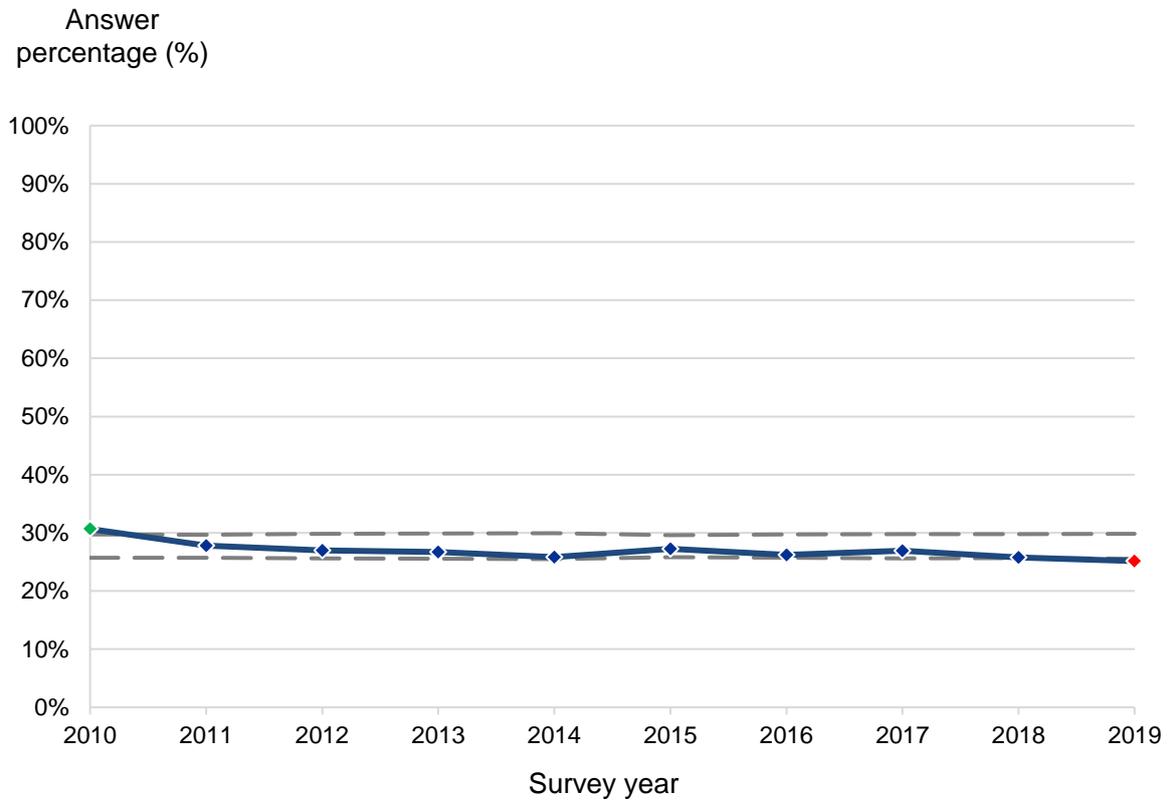
1.1 Patients' involvement in the choices concerning their care

Ensuring patients are offered a choice of when and where they have their first hospital appointment when they are referred to a specialist, is a legal requirement as set out in the [NHS Choice Framework](#).

The [NHS Constitution](#) states that patients have the right to 'transparent, accessible and comparable data on the quality of local healthcare providers, and on outcomes, as compared to others nationally'.⁶² Therefore, helping people to make informed decisions about where to receive care and treatment. The constitution also states that patients have the right to be included in decision-making and planning their care along with their care provider. Research has found that, for patients, equal communication and involvement between themselves and treatment teams is important to give the patient a sense of control and responsibility, which in turn helps rehabilitation.⁶³

Respondents who were on the waiting list or had a planned admission were asked if they were offered a choice of hospital for their first appointment, when they were referred to a specialist. Twenty-five per cent answered 'yes' which, based on past findings, is lower than where we would expect results to be. This is the first and only time this has happened during the analysis period. This is also a decrease of one percentage point from the 2018 survey and a six-percentage point decrease since 2010. As shown in the chart below, results have gradually declined over the 10-year analysis period and have gone from being above limits in 2010 to below limits in 2019.

Q5: When you were referred to see a specialist, were you offered a choice of hospital for your first hospital appointment? (Answer: 'Yes')



Answered by those whose most recent hospital admission was waiting list or planned in advance, and who were referred from an English CCG.

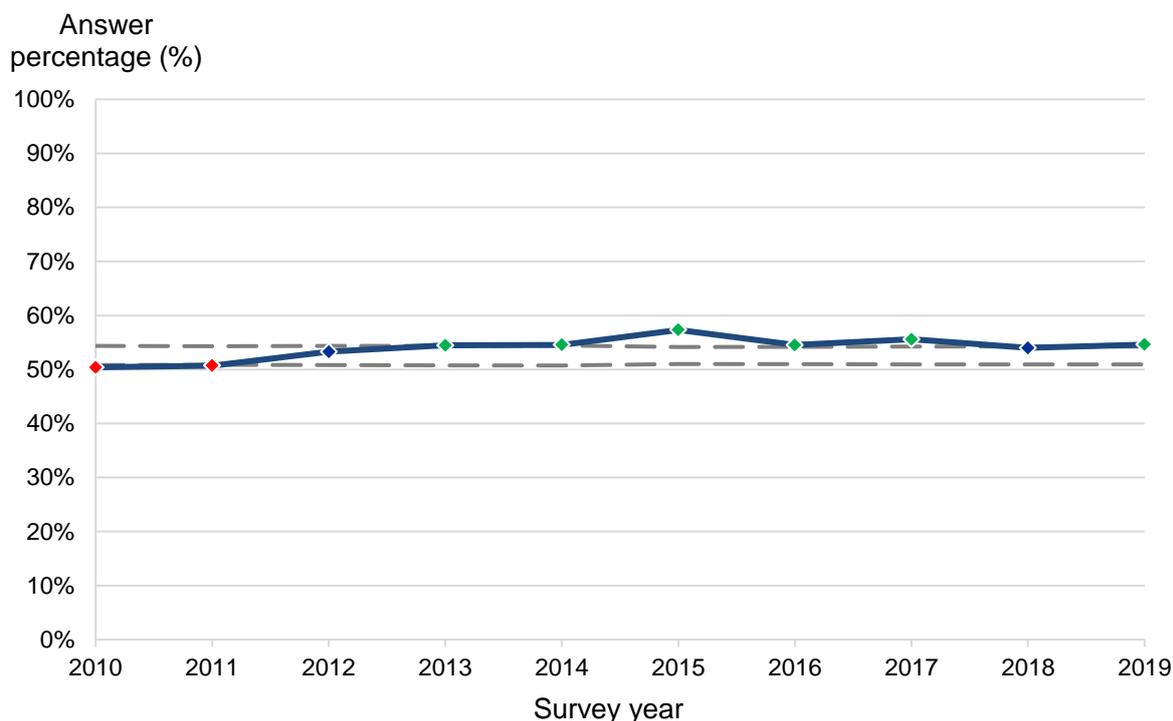
Respondents who stated that they didn't know / couldn't remember have been excluded.

Total number of respondents to question: 2010 (24,683), 2011 (25,473), 2012 (22,070), 2013 (21,459), 2014 (20,004), 2015 (27,843), 2016 (25,122), 2017 (22,845), 2018 (23,277), 2019 (21,889).

Fifty-five per cent of people responded 'yes, definitely' when asked if they were involved in decisions about their care and treatment as much as they wanted to be. This is a significant increase of one percentage point from the 2018 result. With the exception of 2018, the results for this question have been higher than expected, based on past data, since 2013.

A further 35% of people said they had been involved to some extent. However, for the same question, one in 10 people (11%) reported that they had not been involved in decisions about their care and treatment as much as they wanted to be.

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



All respondents were asked this question.

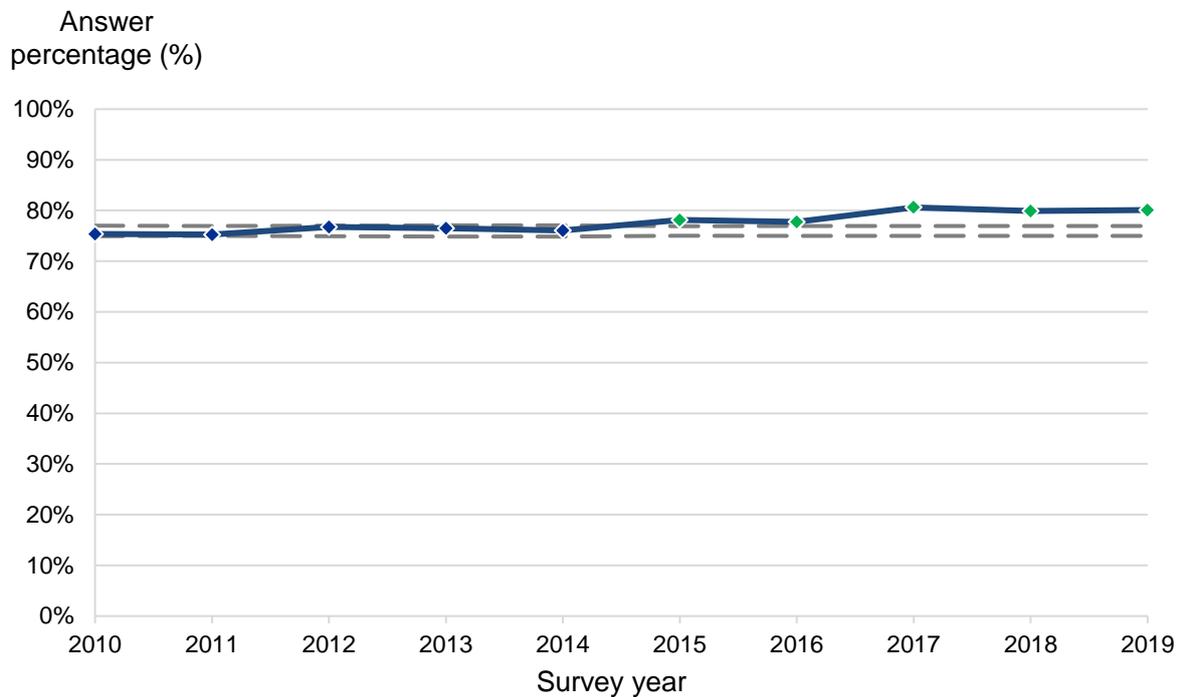
Total number of responses to question: 2010 (64,749), 2011 (69,170), 2012 (63,151), 2013 (60,985), 2014 (57,583), 2015 (80,177), 2016 (75,807), 2017 (70,759), 2018 (74,768), 2019 (74,511).

Similarly, 53% of people responded 'yes, definitely' when asked if they had been involved in decisions about their discharge from hospital. While results are where we would expect them to be, based on past data, almost one in five people (17%) reported they had not been involved in making decisions surrounding their discharge.

NICE recognises the importance of not only including people in making decisions, but also making sure that the information shared is communicated in a way that the patient understands. As a result, NICE has produced [clinical guidelines](#) to improve communication with, and the inclusion of, people using NHS adult services.

Respondents who had an operation during their stay were asked if their questions were answered in a way they could understand. Eighty per cent of people responded 'yes, completely', which is higher than we would expect, based on past results for this question, for a fifth consecutive year. It represents an increase of five percentage points since 2010, showing gradual improvement over time.

Q45: Beforehand, did a member of staff answer your questions about the operation or procedure in a way you could understand? (Answer: ‘Yes, completely’)



Answered by those who had an operation or procedure.

Respondents who stated that they did not have any questions have been excluded.

Total number of responses to question: 2010 (35,242), 2011 (36,610), 2012 (32,135), 2013 (30,896), 2014 (29,430), 2015 (40,862), 2016 (37,686), 2017 (38,608), 2018 (39,194), 2019 (38,279).

The analysis of a subset of questions relating to respect for patient-centred values, preferences and expressed needs^k shows that, as in 2018, younger patients (aged 16 to 35), patients with dementia or Alzheimer’s and patients with ICD-10 chapter codes V (Mental and behavioural disorders) reported poorer than average experiences.

Poorer than average experiences were also reported by respondents who:

- preferred not to state their religious beliefs
- preferred not to state their sexuality
- had an emergency admission
- had completed the questionnaire with the help of a healthcare professional

^k The analysis included the following questions: Q23: When you had important questions to ask a doctor, did you get answers that you could understand?, Q26: When you had important questions to ask a nurse, did you get answers that you could understand?, Q34: Were you involved as much as you wanted to be in decisions about your care and treatment?, Q39: Were you given enough privacy when discussing your condition or treatment?, Q48: Did you feel you were involved in decisions about your discharge from hospital?

- and XVIII (Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified).

Overall, results for patient involvement in decisions about their care are mixed. There are some areas that show improvement, such as communication before operations and involvement in decision-making. However, results also show decline in patient experience of choice and, while people feeling involved in decision-making has improved since 2018, there are still considerable numbers of people not feeling included.

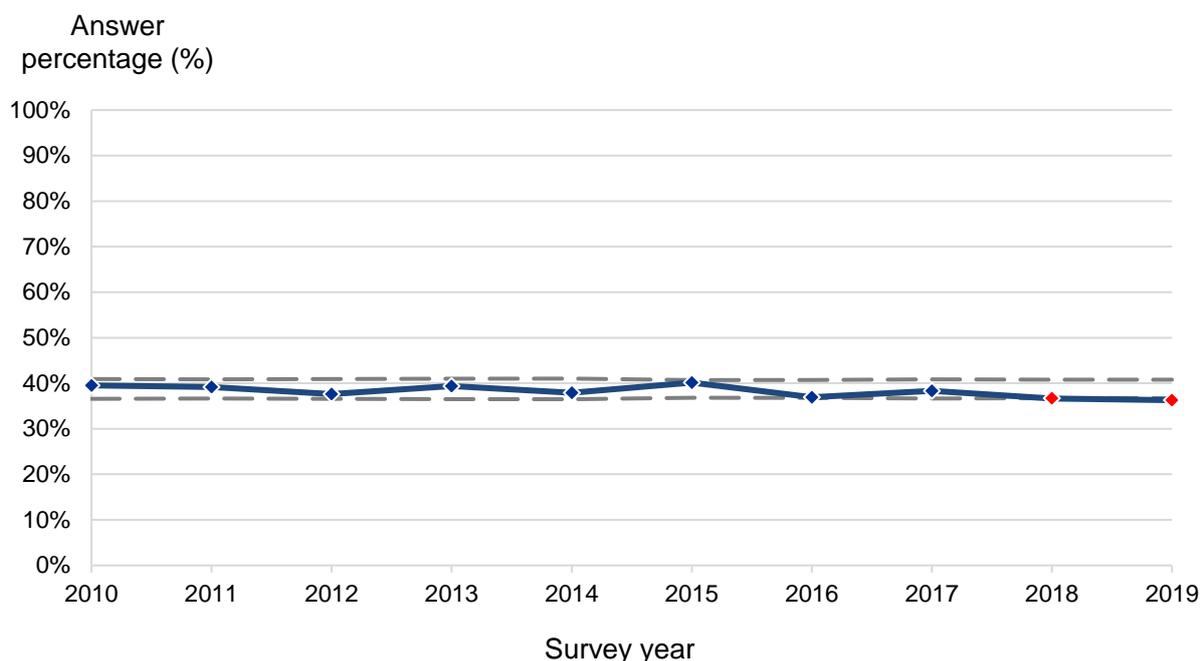
1.2 Emotional support

In addition to being provided with information, patients may also need emotional and psychological support during their time in hospital. Guidance from NICE encourages healthcare professionals to discuss concerns and fears with patients in a way that is sensitive and non-judgemental.⁶⁴ However, a survey conducted by the [Royal College of Nursing](#) found that due to staff shortages nurses were not able to provide this element of care to the standard they would like.

When asked if they felt like they got enough emotional support from hospital staff during their stay, 53% of people responded 'yes, always'. This is the same as the result in 2018. Almost one in five people (17%) reported they did not receive enough emotional support during their stay.

In addition, when people were asked if they found someone on the hospital staff to talk to about their worries and fears, 36% of people responded 'yes, definitely'. This is one percentage point lower than the result for 2018. This result is also lower than we would expect, based on past findings for this question, for a second year in a row. Over a quarter of people (28%) reported that they had not found someone on the hospital staff to talk to about their worries and fears. This continues a trend of gradual decline over the 10-year analysis period.

Q37: Did you find someone on the hospital staff to talk to about your worries and fears? (Answer: 'Yes, definitely')



All respondents were asked this question.

Respondents who stated that they had no worries or fears have been excluded.

Total number of responses to question: 2010 (41,123), 2011 (43,671), 2012 (38,849), 2013 (37,856), 2014 (36,802), 2015 (49,985), 2016 (47,789), 2017 (43,119), 2018 (45,818), 2019 (45,543).

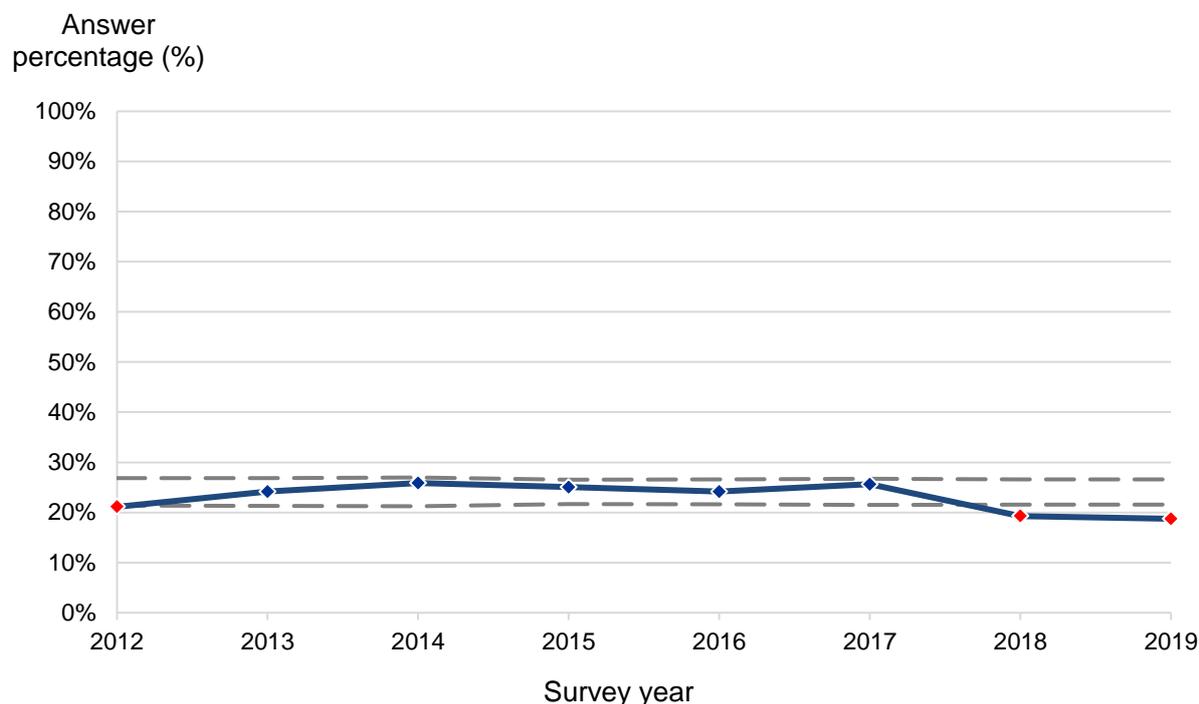
When considering patient experiences of receiving emotional support, results show, overall, people are reporting poorer experiences. Only half of respondents felt like they received enough emotional support, while a quarter of people did not find someone to discuss concerns and fears with, during their hospital stay.

1.3 Collecting patient feedback

The NHS is committed to encouraging and welcoming patient feedback on the quality of their health and care. According to [NHS England](#) in 2018, feedback using the friends and family test (FFT) is regularly used by staff to drive improvement of services and teams. On average, 1.2 million responses are collected using the FFT each month. While there have been criticisms about the methodology used and the representativeness of collected data, NHS England note that the FFT has helped patients influence decisions, as well as lifting staff morale.⁶⁵

Respondents were asked if during their stay in hospital, they had been asked to give their views on the quality of care received. Eighty-five per cent of people responded 'no', which shows no change from 2018. In addition, 81% people had not seen, or been given, any information explaining how to complain to the hospital about the care they received. This shows a small but significant decrease from the result in 2018 and returns results back to 2012 levels. The proportion of positive responses was lower than what would be expected, based on past results, for a second year in a row.

Q71: Did you see, or were you given, any information explaining how to complain to the hospital about the care you receive? (Answer: 'Yes')



All respondents were asked this question.

Total number of responses to question: 2012 (50,232), 2013 (48,593), 2014 (45,373), 2015 (63,038), 2016 (59,597), 2017 (53,887), 2018 (58,863), 2019 (58,842).

1.4 Quality of the information given about care, condition and treatment while in hospital

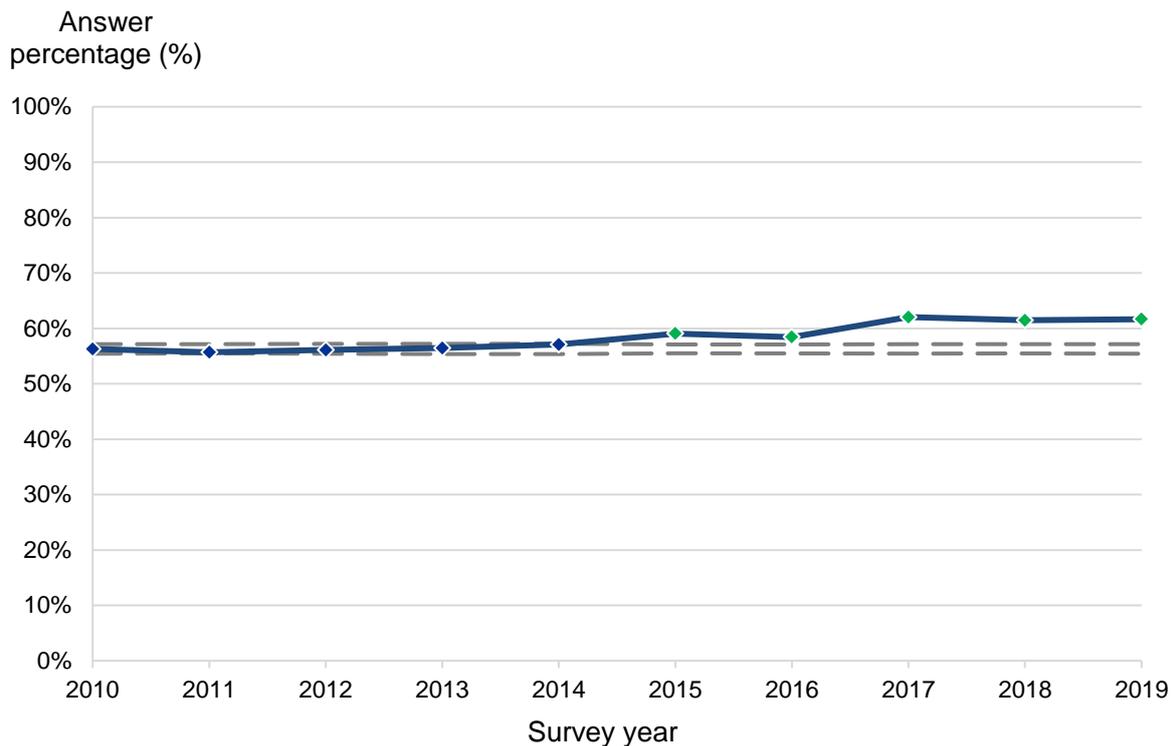
NHS Improvement defines good patient information as that which makes sure that patients are 'prepared and fully aware of the next steps in their pathway so they are able to plan ahead'.⁶⁶ NICE guideline CG138, [Patient experience in adult NHS services: improving the experience of care for people using adult NHS services](#), adds that information should also be communicated in a way that a patient understands and specifically noting that professionals should avoid using jargon and define unfamiliar words and terminology.

To improve the quality of information made available to patients, the Department for Health and Social Care have established [The Information Standard](#) for organisations producing evidence-based health and care information. In response to the question, 'How much information about your condition or treatment was given to you?', 77% of people felt they had received the 'right amount' of information. In contrast, one in five (19%) answered 'not enough'. One per cent reported receiving too much information. Similarly, 73% of those who attended A&E before being admitted to hospital also felt they had received the right amount of information, while almost one in five people (17%) felt they had not. This shows that generally, experiences of information sharing are consistent throughout a person's care and treatment.

People who had an operation or procedure during their hospital stay were asked about the amount of information given to them before the operation took place. In

response to the question, 'Beforehand, were you told how you could expect to feel after you had the operation or procedure?', 62% responded 'yes, completely'. While this result is lower when compared to the amount of information received in A&E and during the patient's stay in hospital, overall there is a gradual trend of improvement. There has been an increase of six percentage points since 2010 and results have been higher than we would expect, based on past results, for five consecutive years. Twelve per cent of people responded 'no' to this question which remains unchanged for three consecutive years.

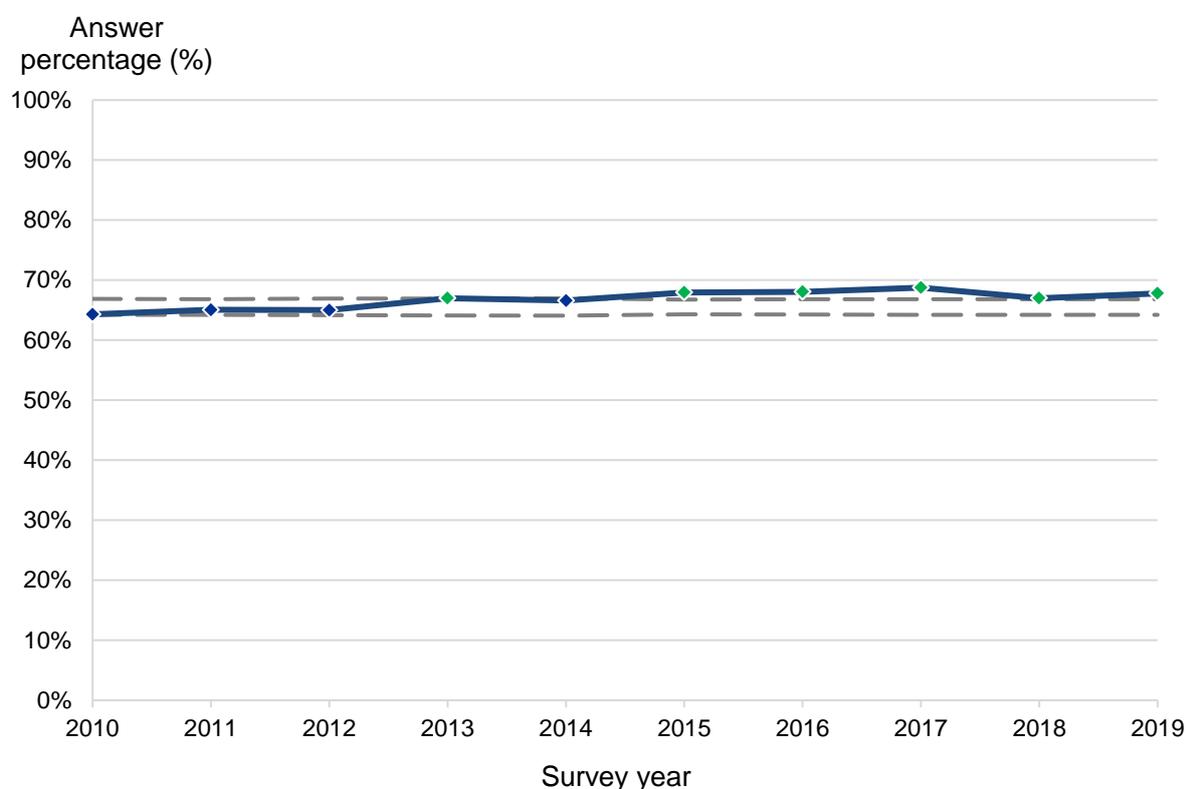
Q46: Beforehand, were you told how you could expect to feel after you had the operation or procedure? (Answer: 'Yes, completely')



Answered by those who had an operation or procedure.
 Total number of responses to question: 2010 (40,052), 2011 (41,781), 2012 (37,098), 2013 (35,260), 2014 (33,724), 2015 (46,835), 2016 (43,542), 2017 (40,716), 2018 (41,386), 2019 (40,227).

Similarly, when asked 'after the operation or procedure, did a member of staff explain how the operation or procedure had gone in a way you could understand?', 68% of people responded 'yes, completely'. This is a significant increase of one percentage point from 2018 and an increase of four percentage points since 2010. When considered alongside the results from the previous question (Q46) and question 45 (Beforehand, did a member of staff answer your questions about the operation or procedure in a way you could understand?), people's experiences of communication and information sharing both before and after operations and procedures has improved over the 10-year analysis period.

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



Answered by those who had an operation or procedure.

Total number of responses to question: 2010 (39,745), 2011 (41,492), 2012 (36,952), 2013 (35,299), 2014 (33,590), 2015 (46,662), 2016 (43,321), 2017 (40,725), 2018 (41,061), 2019 (40,276).

Overall, results show most people are receiving an appropriate amount of good quality information throughout their experience as an adult inpatient. The information given to patients before and after operations has improved across all indicators for the 10-year reporting period.

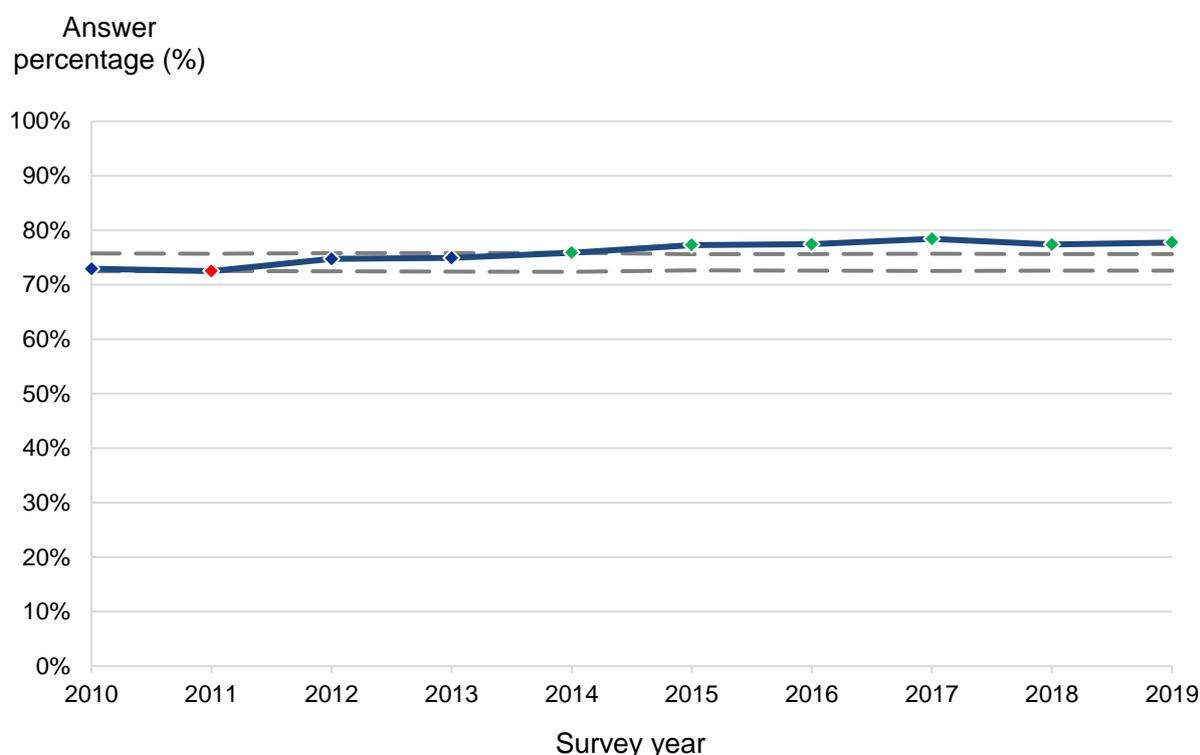
1.5 Confidence and trust in people providing care

Research has found that patients who have confidence and trust in their healthcare professionals report having a higher quality of life, better health outcomes and are more satisfied with their treatment.⁶⁷ Also, making sure that the information given to patients is clear, accurate and balanced is crucial when helping them to make informed choices about their care. However, the information being delivered is more likely to be well-received if the patient has confidence in those delivering it.

Respondents were asked if they had confidence and trust in the staff treating them. Seventy-nine per cent of people indicated that they always had confidence and trust in the doctors treating them, while 4% responded 'no'. This is the same result as the 2018 survey and, based on past results, has been above where we would expect results to be for five years in a row. Similarly, 78% of people always had confidence in the nurses treating them which, based on past results, has been higher than expected for six years in a row. This shows an increase of five percentage points

since 2011 when results were below expectations for this question. Three per cent of people responded 'no', which is also unchanged from 2018.

Q27: Did you have confidence and trust in the nurses treating you? (Answer: 'yes, always')



All respondents were asked this question.

Total number of responses to question: 2010 (65,300), 2011 (69,688), 2012 (63,462), 2013 (61,456), 2014 (57,887), 2015 (80,528), 2016 (76,278), 2017 (71,315), 2018 (75,282), 2019 (75,361).

Respondents were asked if they had confidence and trust in any other clinical staff treating them, such as physiotherapists, speech therapists and psychologists. Seventy-six per cent responded 'yes, always', which is an increase of one percentage point from 2018 and is the same as the 2017 score, when the question was first introduced to the survey. Five per cent of people responded 'no' to this question, which also remains unchanged since 2017.

People are also more likely to have confidence and trust in the medical professionals treating them, and the decisions made about their care, if the medical professional appears informed about the patient's medical history and is able to communicate with them clearly.⁶⁸ Therefore, respondents whose most recent admission was via a waiting list or planned in advance, were asked if, in their opinion, the specialist they saw in the hospital had been given all of the necessary information about their condition or illness from the person who referred them. Most people (81%) responded 'yes, definitely', with a further 16% responding 'yes, to some extent'. These results are the same as those in 2018 and continue a steady trend throughout the 10-year reporting period.

Seventy per cent of people responded 'yes, always' when asked if they had confidence and trust in decisions made about their care. This result is where we would expect results to be, based on past findings, and is the continuation of a stable trend over six years.

The analysis of a subset of questions relating to confidence in staff¹ found poorer experiences for younger patients (aged 16-35 and 36-50).

This was also the case for respondents who:

- preferred not to state their religion,
- had a neurological condition,
- were admitted as an emergency or
- have chapter codes V (Mental and behavioural disorders) and XVIII (Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified).

Overall, most people continue to have confidence and trust in the hospital staff providing them with care and treatment they require. This is a trend we have seen for multiple years.

¹ The analysis included the following questions: Q24: Did you have confidence and trust in the doctors treating you?, Q27: Did you have confidence and trust in the nurses treating you?, Q35: Did you have confidence in the decisions made about your condition or treatment?

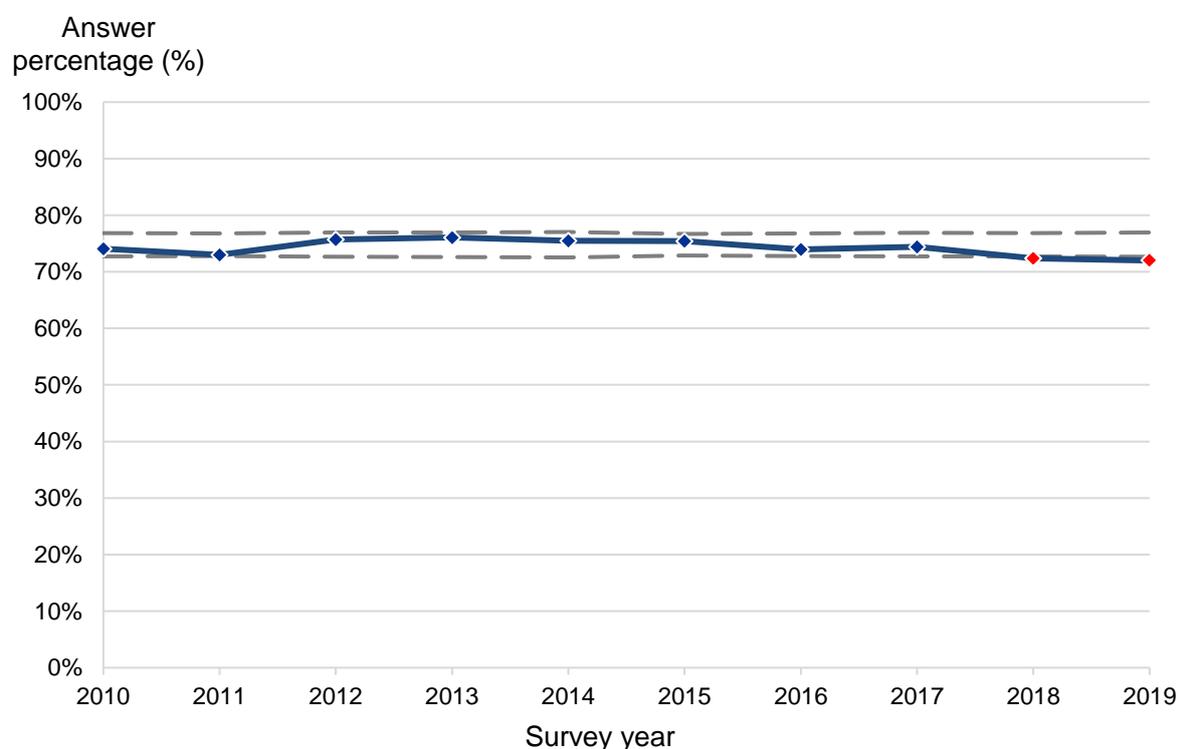
2. Experience of admission to hospital

Admissions to adult inpatient services are categorised as either emergency or planned. Patients admitted through a referral are classed as planned admissions and those accessing services following a visit to the accident and emergency department (A&E) or an urgent treatment centre, are known as emergency admissions. In a small number of cases, admission can be planned, but due to the urgent nature of care required, admission is re-categorised as emergency. Previous Adult Inpatient surveys have found that typically, emergency admission patients are likely to report worse patient experiences than those who have a planned admission.

Seventy-one per cent of respondents to the 2019 adult inpatient survey were categorised as an emergency admission.

Twenty-five per cent of respondents had a planned admission to hospital. Of these people, 72% reported feeling they had been admitted to hospital as soon as they thought was necessary. This result is the same as that reported in the 2018 survey, however positive responses to this question have been lower than we would expect, based on past results, for two consecutive years, continuing the trend of decline which began in 2012. One in 10 people (11%) reported feeling they should have been admitted to hospital a lot sooner.

Q6: How do you feel about the length of time you were on the waiting list before your admission to hospital? (Answer: 'I was admitted as soon as I thought was necessary')

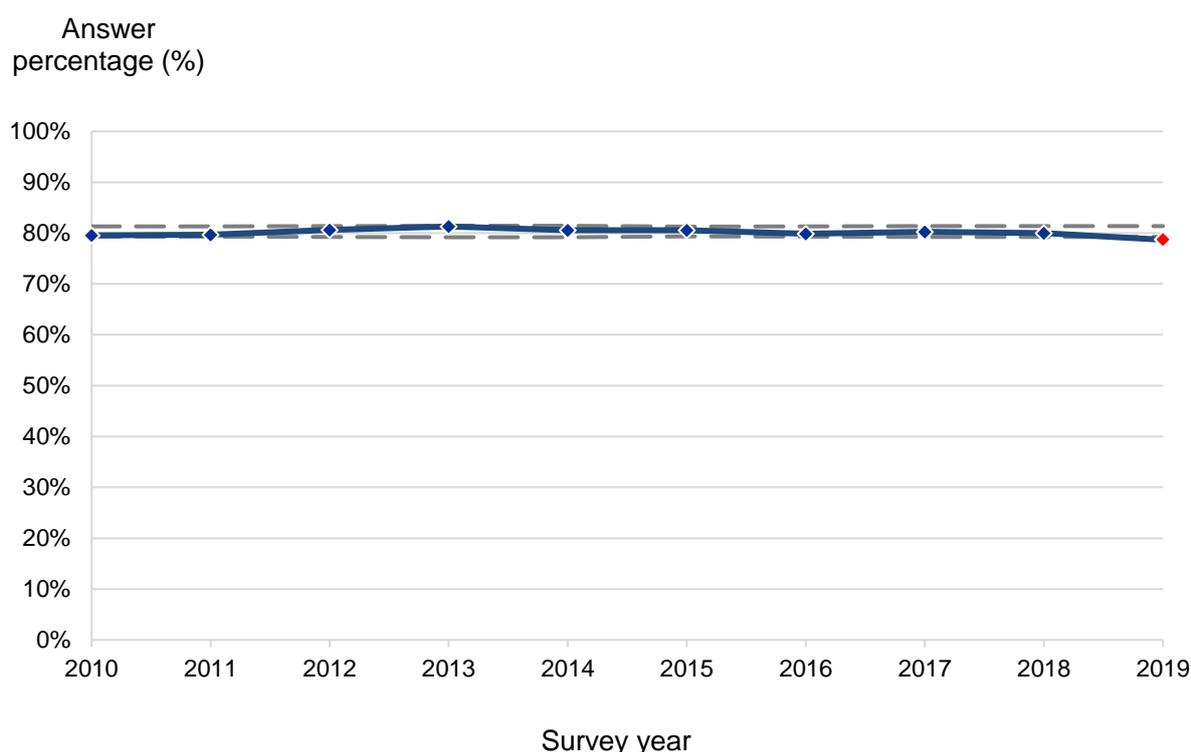


Answered by those whose most recent hospital admission was waiting list or planned in advance. Total number of responses to question: 2010 (25,104), 2011 (25,997), 2012 (22,761), 2013 (23,083), 2014 (20,709), 2015 (28,775), 2016 (26,210), 2017 (23,921), 2018 (24,165), 2019 (22,758).

Furthermore, 79% did not experience changes to their admission date, a decline of one percentage point since 2018 and below where we would expect results to be for this question, based on past findings, for the first time during the analysis period. This result continues a pattern of decline seen since 2013 and it should be remembered, that these results do not reflect the impact of COVID-19.

Of the remaining respondents almost a quarter of people (21%) reported that their admission date had been changed by the hospital at least once, with 5% reporting two or three changes. This is a significant increase of one percentage point since 2018.

Q7: Was your admission date changed by the hospital? (Answer: ‘No’)



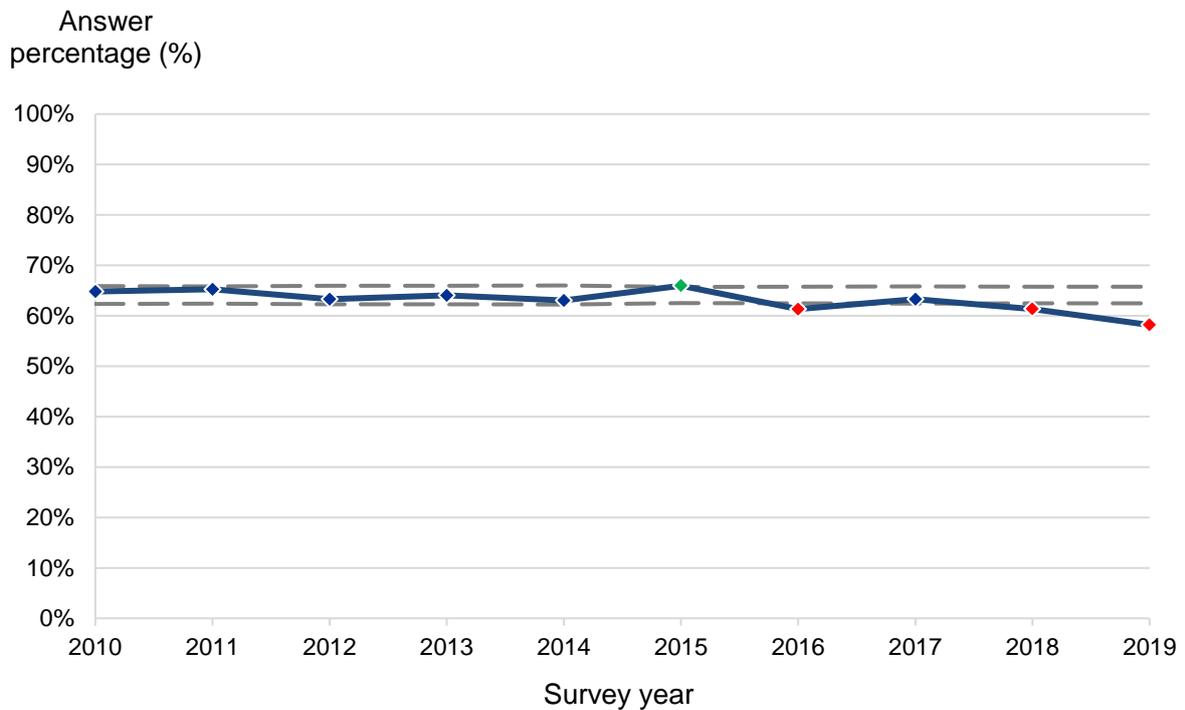
Answered by those whose most recent hospital admission was waiting list or planned in advance. Total number of responses to question: 2010 (25,548), 2011 (26,366), 2012 (23,096), 2013 (22,443), 2014 (21,157), 2015 (29,368), 2016 (26,553), 2017 (24,203), 2018 (24,511), 2019 (23,223).

As discussed in earlier sections, delayed transfers of care at discharge can slow the flow of patients accessing services at admission, by increasing bed occupancy rates. NICE highlights that trusts with bed occupancy rates exceeding 85% can experience regular bed shortages, bed crises and increased numbers of health-care acquired infections.⁶⁹ For the period of time in which our respondents would have accessed adult inpatient services (July 2019), NHS England reported a bed occupancy rate of 90% for general and acute services (88% bed occupancy rate across all services). This is an increase of one per cent from the same period of time in 2018.

Increased bed occupancy seems to be reflected in survey results, with the number of respondents who felt they definitely waited a long time to get a bed on a ward significantly increasing by two percentage points between 2018 (16%) and 2019 (18%). The number of people who felt they did not wait a long time to get a bed on a

ward significantly decreased from 61% to 58% in 2019, placing results for this question below what we would expect, based on past data, for the second year in a row. In addition, the 2019 result is eight percentage points below the result in 2015 (66%). This indicator of patient experience shows the sharpest rate of decline between 2018 and 2019 across the survey as a whole.

Q9: From the time you arrived at the hospital, did you feel that you had to wait a long time to get a bed on a ward? (Answer: 'No')



All respondents were asked this question.
 Total number of responses to question: 2010 (63,545), 2011 (68,446), 2012 (62,757), 2013 (60,791), 2014 (57,570), 2015 (80,012), 2016 (75,927), 2017 (70,920), 2018 (74,542), 2019 (75,080).

Overall, results show that people’s experiences of admission to hospital, to receive adult inpatient services, are gradually worsening with people feeling they are waiting longer to access services.

3. Meeting patients' fundamental needs

NICE highlights the importance of needs other than those related to a patient's treatment or condition. The guidance specifically mentions nutrition and pain management as being essential requirements of good care.

3.1 Nutrition and hydration

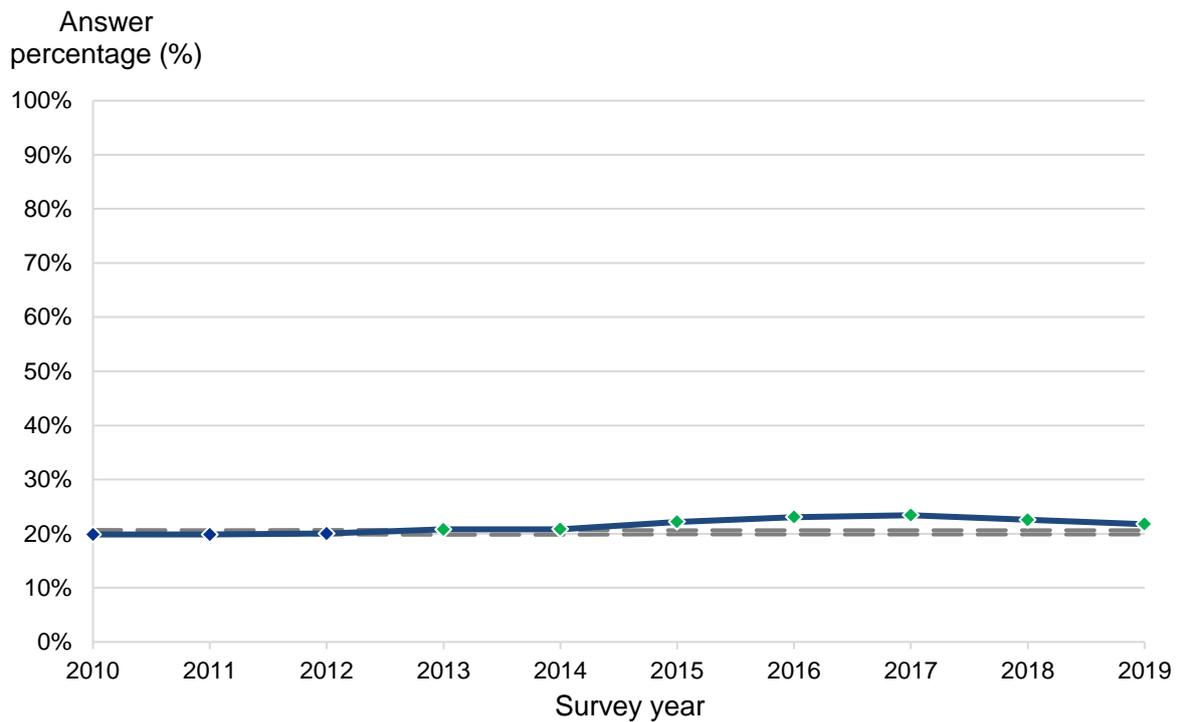
NICE quality standard 24, [Nutrition support in adults](#), highlights the negative impact malnutrition has on a person's basic health outcomes, making malnutrition a notable patient safety concern.⁷⁰ CQC have also addressed this in their model of regulation on [meeting nutritional and hydration needs](#).⁷¹ The guidance for providers is that they must include people's nutrition and hydration needs when making an initial assessment of care needs. It also states that providers should have a food and drink strategy that addressed the nutritional needs of service users.

In order to monitor performance with regard to non-clinical aspects of care, NHS Digital conduct annual [Patient-Led Assessments of the Care Environment](#) (PLACE).⁷² PLACE includes an assessment of the food and hydration domain, with scores being presented as percentages.^m Questions in this domain cover a number of areas, including choice of food, access to menus and appropriateness of serving temperature. In 2019, 1,892 food assessments were undertaken at 1,072 sites where meals are provided. Nationally, the average score for the food and hydration domain was 92.2%.

Respondents were asked how they would rate the hospital food offered during their stay. Over half of all respondents reported the hospital food as being 'very good' (22%) or 'good' (36%). The proportion of respondents saying food was 'very good' remains higher than where we would expect results to be, based on all results for this question since 2010. It should, however, be noted that although results are higher than we would expect based on past data, they are still very low. 14% of people said the hospital food was 'poor'. This is a significant increase of one percentage point compared with the result in 2018.

^m During the assessment, the teams visit various areas of the hospital and unit, filling out the relevant scorecards based on observations of conditions. A total score as a percentage is produced for each domain at site and organisational level, as well as a national and regional result. A full suite of assessment forms and guidance can be found here: <https://content.digital.nhs.uk/PLACE>.

Q19: How would you rate the hospital food? (Answer: 'Very good')



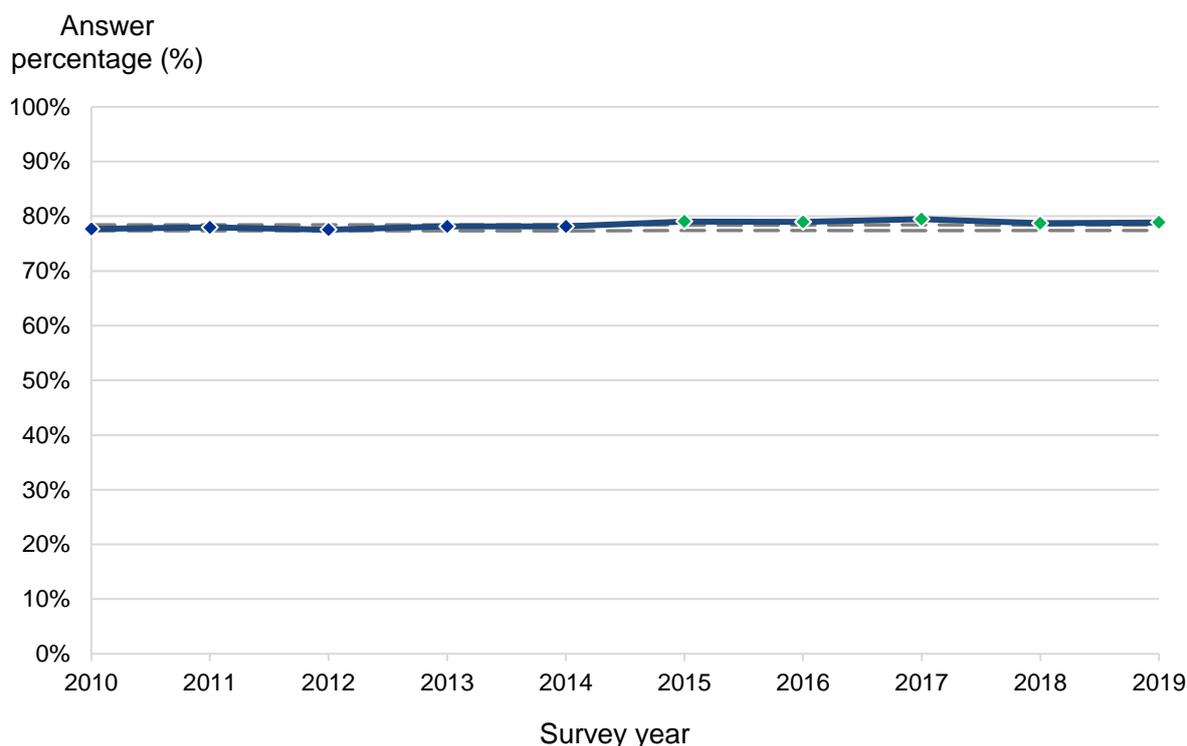
All respondents were asked this question.

Respondents who stated that they did not have any hospital food have been excluded.

Total number of responses to question: 2010 (62,277), 2011 (66,576), 2012 (60,661), 2013 (58,597), 2014 (55,151), 2015 (76,647), 2016 (72,405), 2017 (68,021), 2018 (71,406), 2019 (71,868).

Patients reported positive experiences of being offered choices of food. Seventy-nine per cent of people responded 'yes, always' when asked if they were given a choice of food. This result is above where we would expect results to be, based on past data, for the fifth year in a row. An additional 15% responded 'yes, sometimes'.

Q20: Were you offered a choice of food? (Answer: 'Yes, always')



All respondents were asked this question.

Total number of responses to question: 2010 (64,125), 2011 (68,564), 2012 (62,638), 2013 (60,464), 2014 (56,957), 2015 (79,284), 2016 (74,942), 2017 (70,287), 2018 (74,189), 2019 (74,323).

Sub-group analysis has shown patients who stayed more than one night in hospital reported better experiences of food choice than patients who stayed only one night. Worse than average experiences of food choice were found for patients who were Jewish.

CQC's model of regulation [meeting nutritional and hydration needs](#) also highlights the importance of encouraging patients to eat and drink, particularly older patients, to maintain strength and avoid frailty. Patients were asked if they received enough help from staff to eat their meals. Sixty-one per cent of people responded 'yes, always' which is unchanged from 2018. However, since 2015, there is a clear downwards trend for this response. There was also no improvement in the proportion of those who said they needed help with eating and didn't receive it (18%).

Poor hydration in older patients can lead to other health issues, such as urinary tract infections, increased risk of falls, confusion and pressure ulcers.⁷³ For patients with dementia or Alzheimer's disease, there are particular challenges when it comes to hydration, as in the later stages of dementia, people can experience difficulty swallowing. Therefore, it is extremely important that staff ensure patients remain hydrated during their stay in hospital. When measuring the experiences of patients with regard to hydration, 93% of people responded 'yes' when asked if during their time in hospital, they had enough to drink, though 7% said they did not, either because they did not get enough help to drink or they were not offered enough drinks. Poorer experiences of hydration were found for respondents with dementia or

Alzheimer's and for respondents who completed the questionnaire with the help of a healthcare professional.

While results show that almost half of patients did not rate the hospital food on offer positively, overall people were largely given a choice of food and help to eat it where required. They were also provided with enough to drink throughout their stay, showing that performance against nutrition and hydration indicators has been sustained over a number of years.

3.2 Pain management

Guidance provided by the General Medical Council (GMC) on good medical practice, highlights the importance of providing care which takes all possible measures to alleviate pain and distress.⁷⁴ NICE safe staffing guidelines recognise a delay of more than 30 minutes in providing pain relief as a nursing red flag event, suggesting insufficient staffing levels.⁷⁵

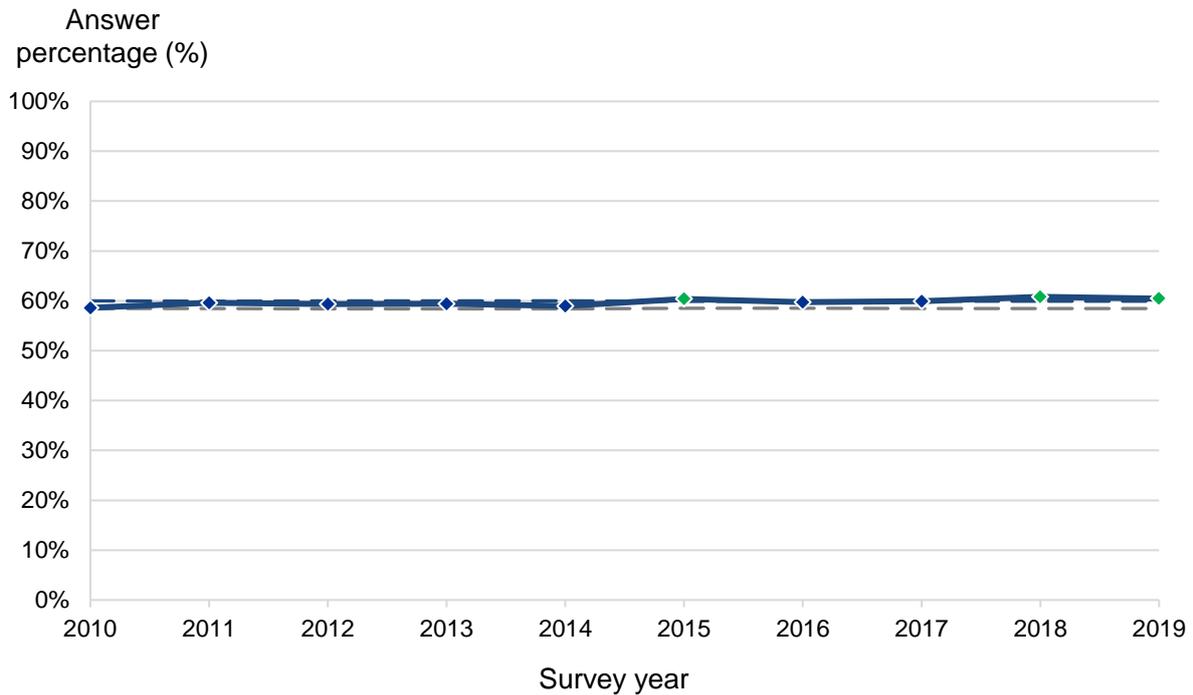
Of those people who experienced pain during their hospital stay, 67% felt staff 'definitely' did everything they could to help control their pain. A further 25% responded 'yes, to some extent', while 8% responded 'no'. These results remain largely unchanged throughout the 10-year analysis period.

3.3 Rest

Hormones responsible for physical repair and renewal are secreted during sleep, which is why sleep is a crucial factor in patient recovery.⁷⁶ However, research has shown that sleep deprivation is a major concern for patients in hospital.^{77,78} Factors such as noise, light and clinical care provided to a patient during the night can reduce the ability for patients to rest. Efforts have been made across different hospitals to reduce noise at night.⁷⁹

Patients were asked if they were ever bothered by noise at night from hospital staff or other patients. Results show that 40% were bothered by noise from other patients, while 20% of people were bothered by noise from hospital staff. The charts below show results were above where we would expect results to be for both questions, based on past data, for at least the last two survey iterations. Whilst total change over time is small over the reporting period, results show a gradual improvement.

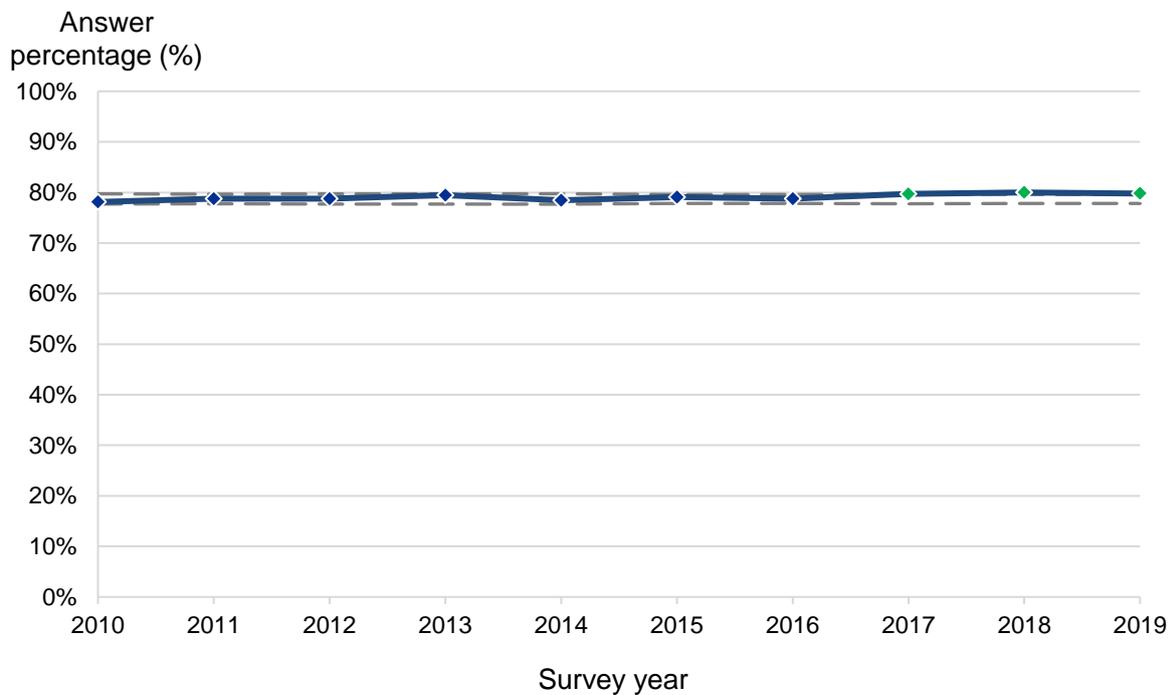
Q14: Were you ever bothered by noise at night from other patients? (Answer: 'No')



All respondents were asked this question.

Total number of responses to question: 2010 (64,009), 2011 (68,952), 2012 (62,930), 2013 (60,853), 2014 (57,579), 2015 (79,800), 2016 (76,122), 2017 (71,025), 2018 (74,676), 2019 (75,009).

Q15: Were you ever bother at night by noise from hospital staff? (Answer: 'No')



All respondents were asked this question.

Total number of responses to question: 2010 (63,972), 2011 (68,962), 2012 (63,039), 2013 (60,984), 2014 (57,549), 2015 (79,882), 2016 (76,072), 2017 (71,033), 2018 (74,771), 2019 (75,381).

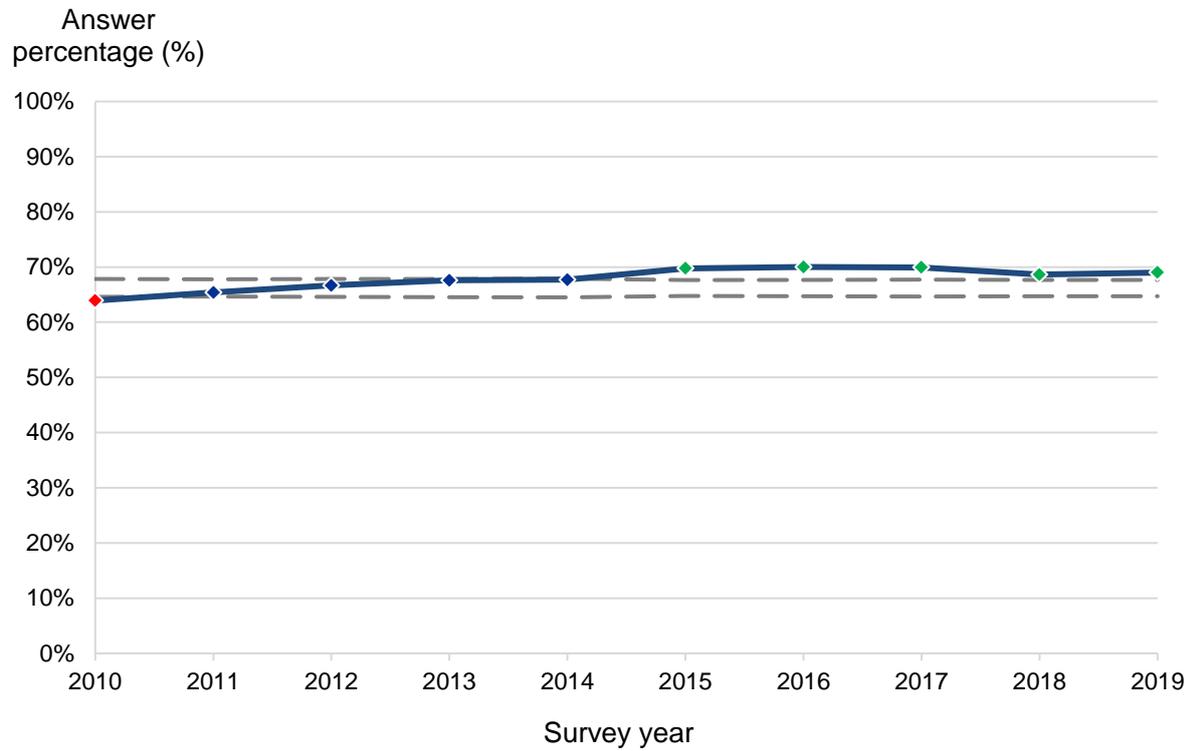
In addition, patients were asked if they moved wards at night, with 8% responding 'yes, but I would have preferred not to' and 16% responding 'yes, but I did not mind'. These people were then asked if hospital staff explained the reason for being moved in a way they could understand. Over half (53%) responded 'yes, completely', with a further 28% responding 'yes, to some extent'. One out of five respondents (19%) reported the reason for the move had not been explained to them in a way they could understand.

There are other factors which could affect a person's ability to relax during their hospital stay. For instance, [NHS Improvement](#) highlight the importance of avoiding mixed-sex wards as a way of ensuring patient safety, privacy and dignity while in hospital.⁸⁰ CQC monitor mixed-sex accommodation as part of their regulatory activity and note that this does not only include sleeping accommodation, but also toilets, bathrooms and the need for patients to pass through areas for the opposite sex in order to reach their own facilities.

This survey asks patients if they ever shared a sleeping area, for example a room or a bay, with patients of the opposite sex. Nine out of 10 people (91%) responded 'no', while one in 10 (9%) indicated they had shared a sleeping area with someone of the opposite sex. These results remain unchanged from those in 2018 and 2017.

In addition to fighting infection, the cleanliness of a person's environment while in hospital could also have an impact on their ability to relax and rest during their stay. When asked to give their opinion on the cleanliness of the hospital room or ward they were in, 69% of people responded, 'very clean'. This is the same as the 2018 result and is above where we would expect results to be for a fifth consecutive year. This also shows an increase of five percentage points over the 10-year reporting period. Three per cent of people reported that their room or ward was unclean, with 3% responding 'not very clean' and 1% responding 'not at all clean'.

Q16: In your opinion, how clean was the hospital room or ward that you were in? (Answer: 'Very clean')



All respondents were asked this question.

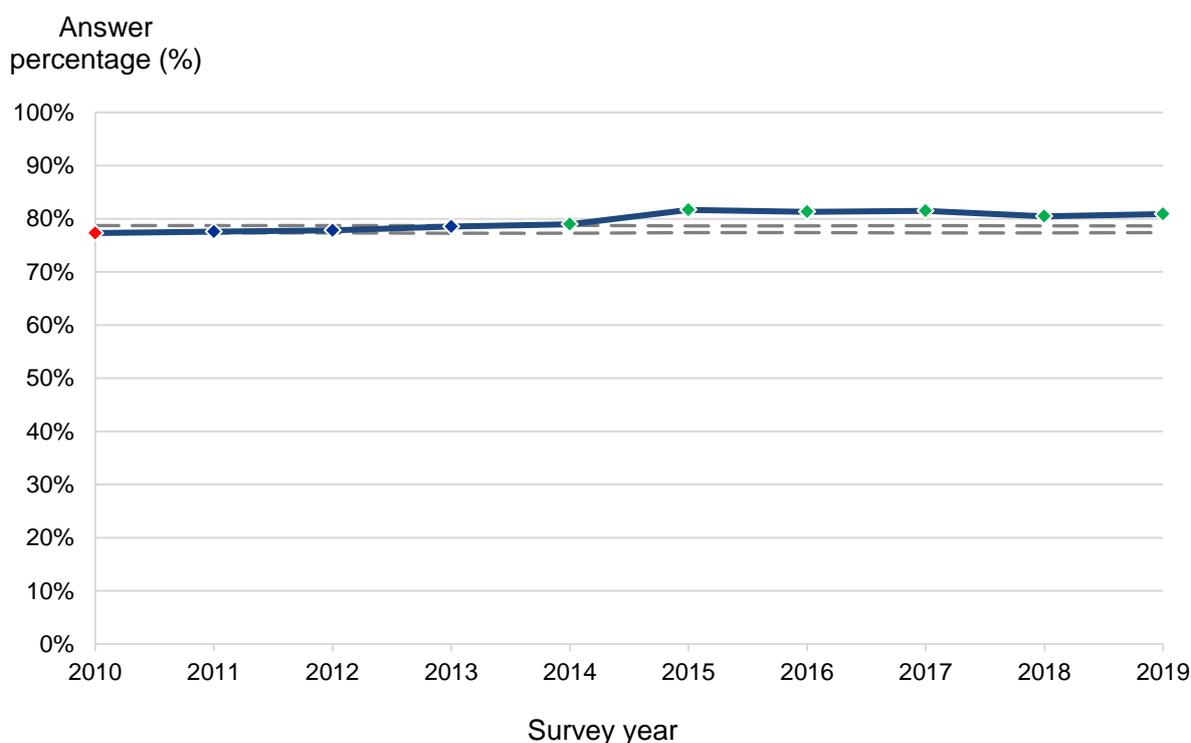
Total number of responses to question: 2010 (64,644), 2011 (69,619), 2012 (63,563), 2013 (61,469), 2014 (57,954), 2015 (80,510), 2016 (76,357), 2017 (71,649), 2018 (75,333), 2019 (75,870).

4. Dignity and respect

Treating people with dignity and respect is a statutory requirement of the [Health and Social Care Act 2008](#), with the [Care Quality Commission](#) taking regulatory action against providers who are in breach of this regulation.^{81,82} Dignity and respect is also highlighted as a fundamental component of care in [NICE quality statement 15](#) and the [NHS Constitution](#), which emphasises how important it is in all NHS activity.⁸³

Respondents to the survey were asked if overall, they felt like they were treated with respect and dignity while they were in hospital. The majority of people (81%) responded 'yes, always', which is an increase of half a percentage point when compared to the 2018 result and four percentage points over the 10-year analysis period. Positive responses for this question are above where we'd expect results to be, based on past data, for the sixth consecutive year.

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



All respondents were asked this question.

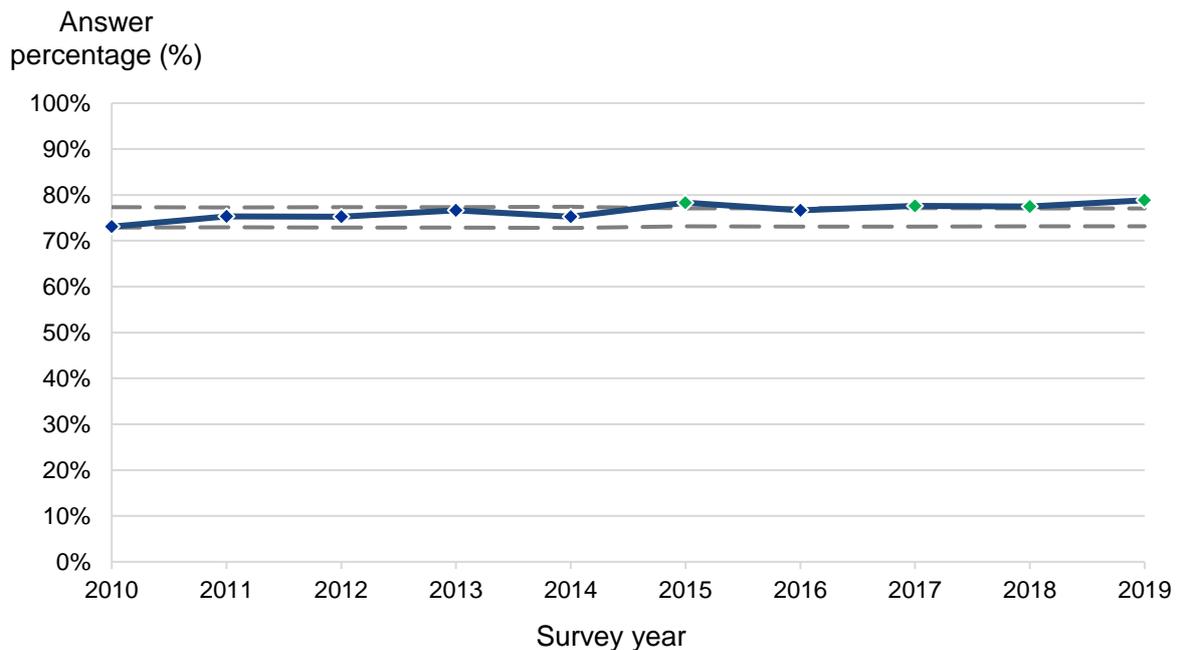
Total number of responses to question: 2010 (64,261), 2011 (68,786), 2012 (63,198), 2013 (60,849), 2014 (57,952), 2015 (80,423), 2016 (76,118), 2017 (71,099), 2018 (74,800), 2019 (75,246).

Poorer experiences for being treated with respect and dignity were found for respondents: aged 16 to 35, who preferred not to state their religion, with dementia or Alzheimer's or with a neurological condition.

Allowing people to maintain comfortable levels of privacy is a key component of treating people with dignity and respect. As a result, this survey asks people to report their experiences of privacy at different points of their hospital stay.

People who accessed adult inpatient services by first visiting A&E, were asked if they were given enough privacy when being examined or treated in the A&E department. Most people (79%) responded 'yes, definitely', which is a significant increase of two percentage points when compared to the same response in 2018. Over the 10-year reporting period, we have seen an increase of six percentage points, showing clear improvement. Results have now been above where we would expect them to be, based on past data, for three years in a row.

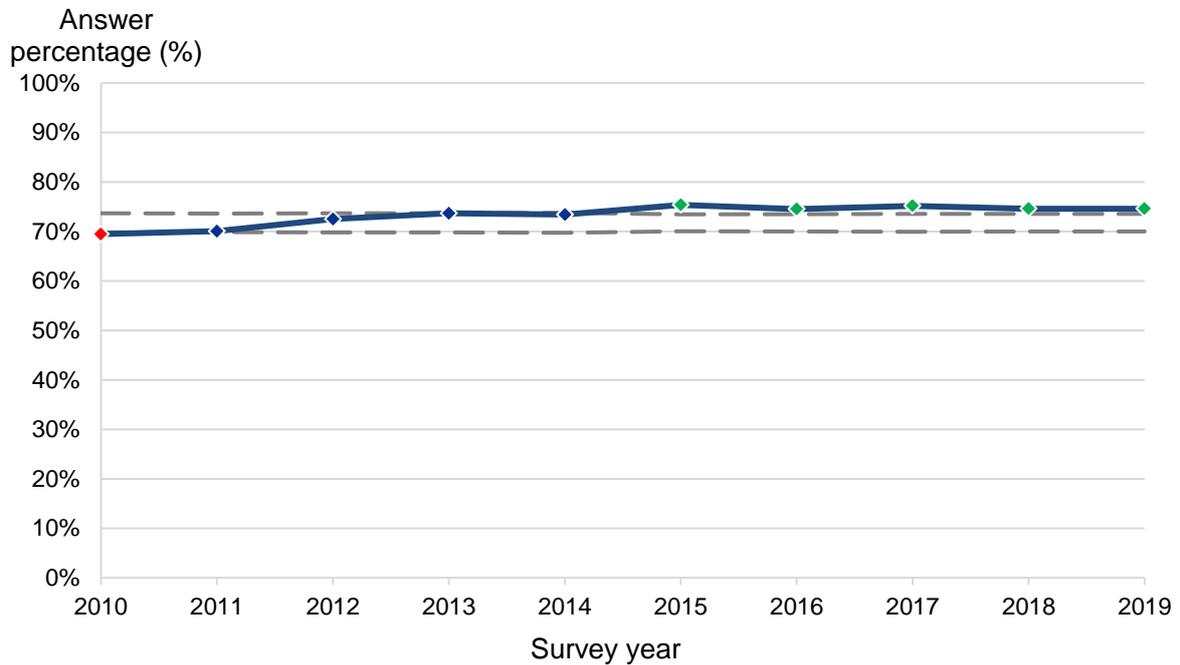
Q4: Were you given enough privacy when being examined or treated in the A&E department? (Answer: 'Yes, definitely')



Answered by those whose most recent hospital admission was an emergency, urgent or something else, and who went to the A&E Department once they arrived at the hospital.
 Total number of responses to question: 2010 (35,148), 2011 (38,155), 2012 (35,655), 2013 (34,694), 2014 (32,743), 2015 (45,684), 2016 (44,396), 2017 (41,948), 2018 (45,036), 2019 (46,665).

People were also asked if they were given enough privacy when discussing their condition or treatment while using adult inpatient services. Three quarters of people (75%) responded 'yes, always'. This is the same as the result in 2018 and is higher than we would expect, based on past results, for the fifth year in a row. A further 19% responded 'yes, sometimes' and 7% responded 'no'.

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

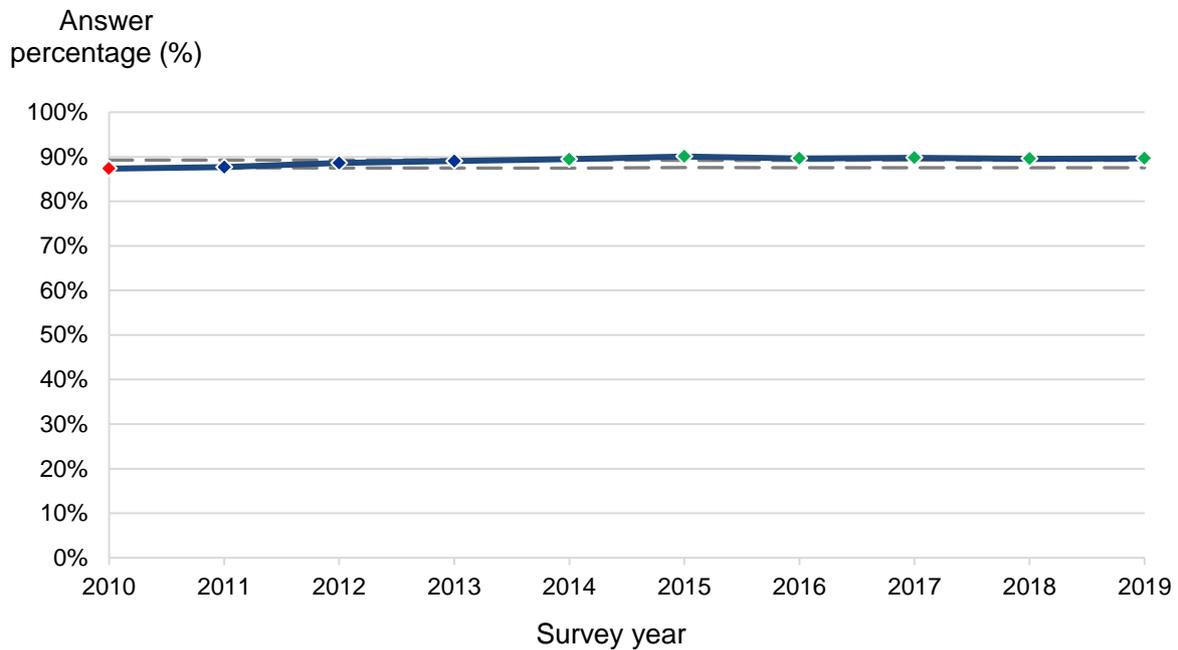


All respondents were asked this question.

Total number of responses to question: 2010 (64,264), 2011 (69,013), 2012 (62,954), 2013 (60,907), 2014 (57,704), 2015 (80,127), 2016 (76,016), 2017 (70,596), 2018 (74,520), 2019 (74,332).

Ninety per cent of people also reported 'always' receiving enough privacy when being examined or treated. This is an increase of three percentage points over the 10-year reporting period, showing steady improvement. In addition, results for this question have now been above where we would expect results to be, based on past data, for six consecutive years.

**Q40: Were you given enough privacy when being examined or treated?
(Answer: 'Yes, always')**



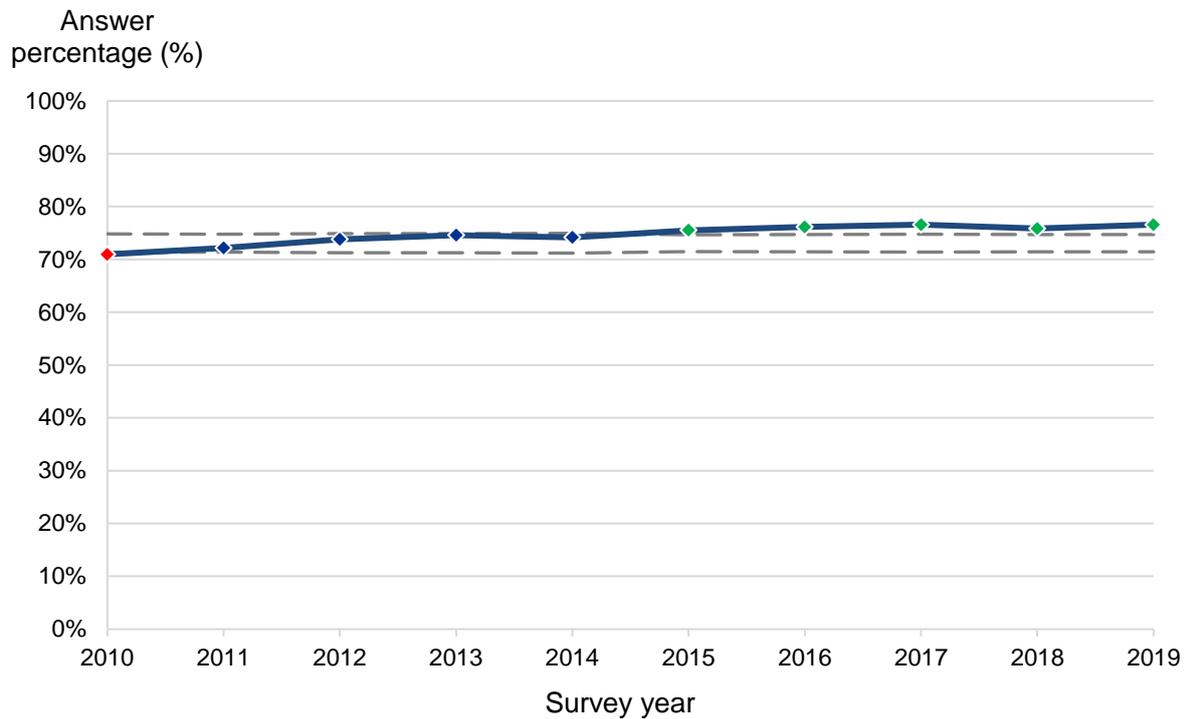
All respondents were asked this question.

Total number of responses to question: 2010 (65,025), 2011 (69,419), 2012 (63,434), 2013 (61,233), 2014 (57,928), 2015 (80,563), 2016 (76,338), 2017 (71,008), 2018 (74,890), 2019 (74,913).

Ensuring people are consulted with and included in discussions about their care and treatment is another important way of ensuring patients experience respect and dignity during their stay in hospital.

The percentage of people experiencing doctors and nurses talking in front of them as if they weren't there has significantly declined. Seventy-seven percent of people responded 'no' when asked if doctors talked in front of them as if they weren't there. This is a statistically significant increase of one percentage point when compared to the 2018 results and an increase of six percentage points over the 10-year reporting period.

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

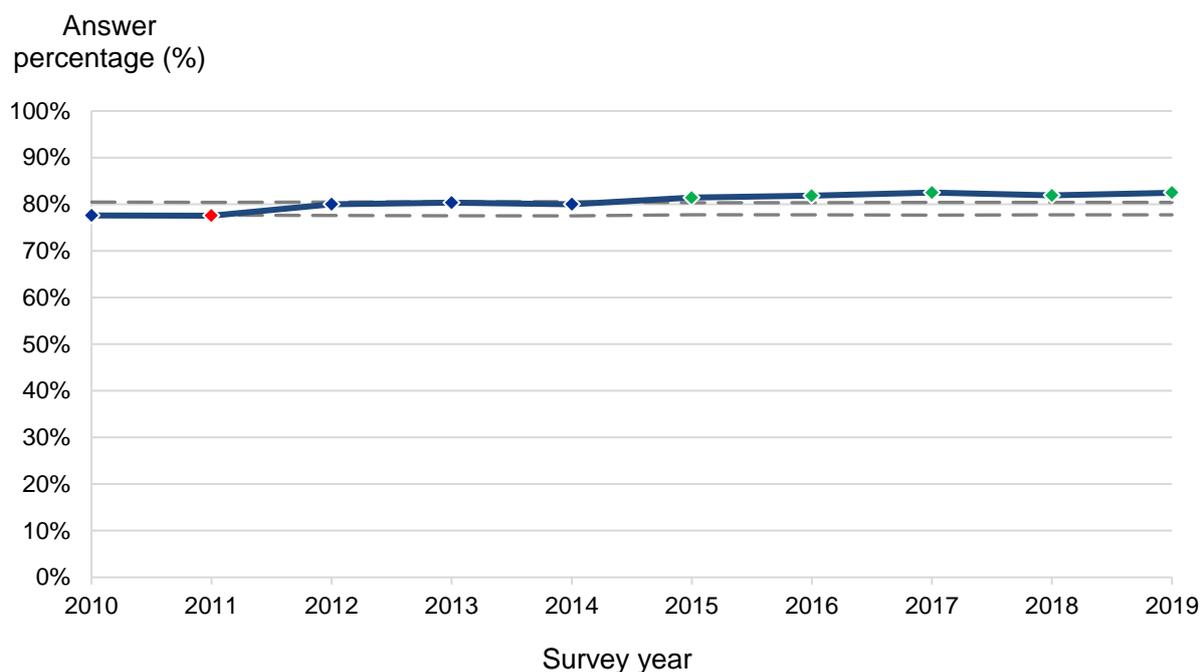


All respondents were asked this question.

Total number of responses to question: 2010 (64,779), 2011 (69,221), 2012 (62,883), 2013 (61,068), 2014 (57,637), 2015 (80,125), 2016 (75,801), 2017 (71,020), 2018 (74,896), 2019 (74,797).

When asked the same question about nursing staff, 82% of people responded 'no'. Again, this is a significant increase when compared to the 2018 results and an overall increase of five percentage points from 2010.

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



All respondents were asked this question.

Total number of responses to question: 2010 (65,096), 2011 (69,461), 2012 (63,332), 2013 (60,899), 2014 (57,805), 2015 (80,396), 2016 (76,052), 2017 (71,194), 2018 (75,143), 2019 (75,094).

In addition, enabling patients to maintain their usual standards of personal hygiene is extremely important to overall wellbeing and ensuring people are treated with dignity and respect. Of those who needed help to wash or keep themselves clean, one in 10 reported they did not receive it (11%). This is a significant increase of one percentage point since the 2018 result and an increase of two percentage points since the question was first asked in 2016. Sixty-eight per cent reported that they always received help to wash or keep themselves clean, with the remaining 22% stating they 'sometimes' received this help.

Overall, there is sustained improvement across multiple questions within this section. However, where patients require additional care, there are signs of gradual decline, with the percentage of people needed help to wash and keep clean increasing for two of the three years after this question was introduced to the survey.

5. Patient discharge from hospital and integrated care

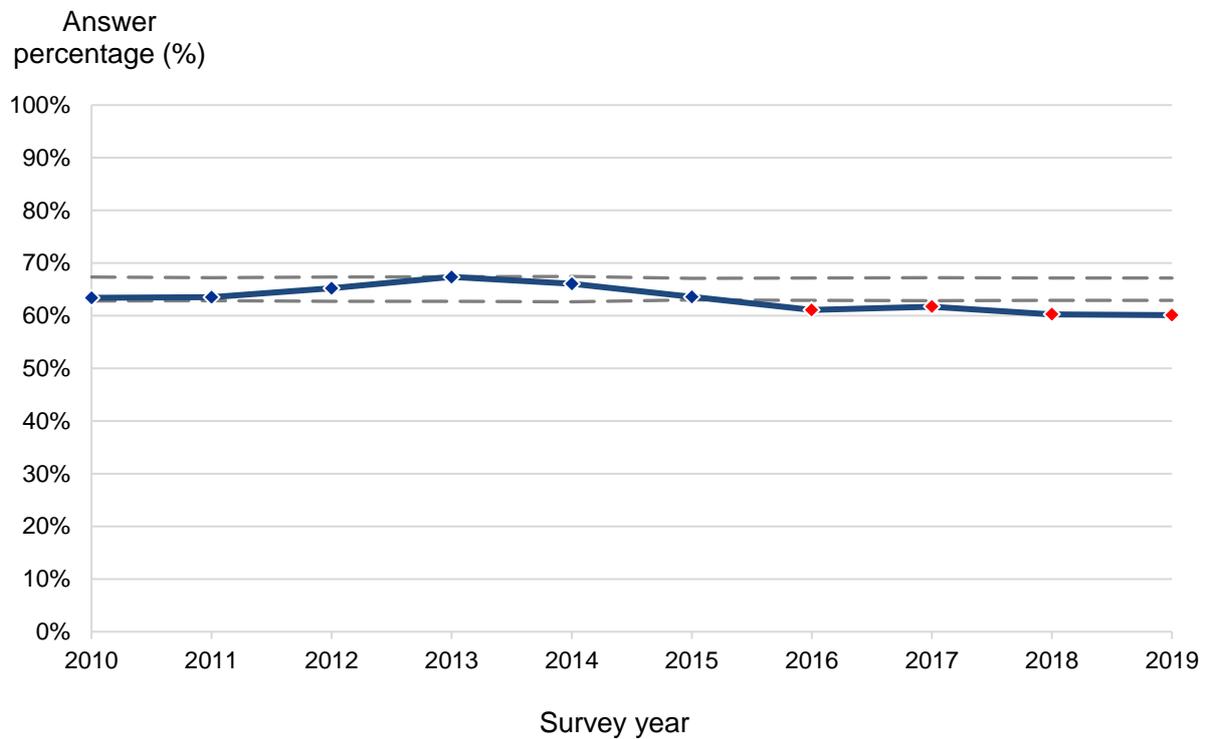
In an integrated health and care system which is working effectively, patient transition between acute hospital-based care and community or primary care is smooth and well-coordinated. The system would ensure that patients are discharged from hospital in a timely fashion and the appropriate primary or community services are in place, so care is uninterrupted.⁸⁴ As discussed earlier, delayed transfers of care can prevent new patients from accessing the care services they need. Therefore, this is a key area of focus for the NHS.

5.1 Coordination of care at hospital discharge

According to NHS Improvement, discharge should be included as part of a patient's treatment plan, in full agreement with the medical team and should be planned as early as possible.⁸⁵ In addition, NICE recommends that medical teams should start planning a patient's discharge at the time of admission.⁸⁶ However, results show that a large proportion of patients are not informed or made aware of these plans. For instance, respondents were asked if they were given enough notice about when they would be discharged. Fifty-three per cent responded 'yes, definitely' while 15% of people said they did not receive enough notice about their discharge. In addition, people were asked if they knew what would happen next with their care when they left hospital. Less than half of all respondents (48%) responded 'yes, definitely'. This is a decrease of one percentage point in the last 12 months.

When asked if, before they left hospital, they were given any written or printed information about what they should do or should not do after leaving hospital, two in five people (40%) responded 'no'. There has been a decline of seven percentage points since 2013 and results are now lower than where we would expect, based on past data, the fourth consecutive year.

Q56: Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital? (Answer: 'Yes')

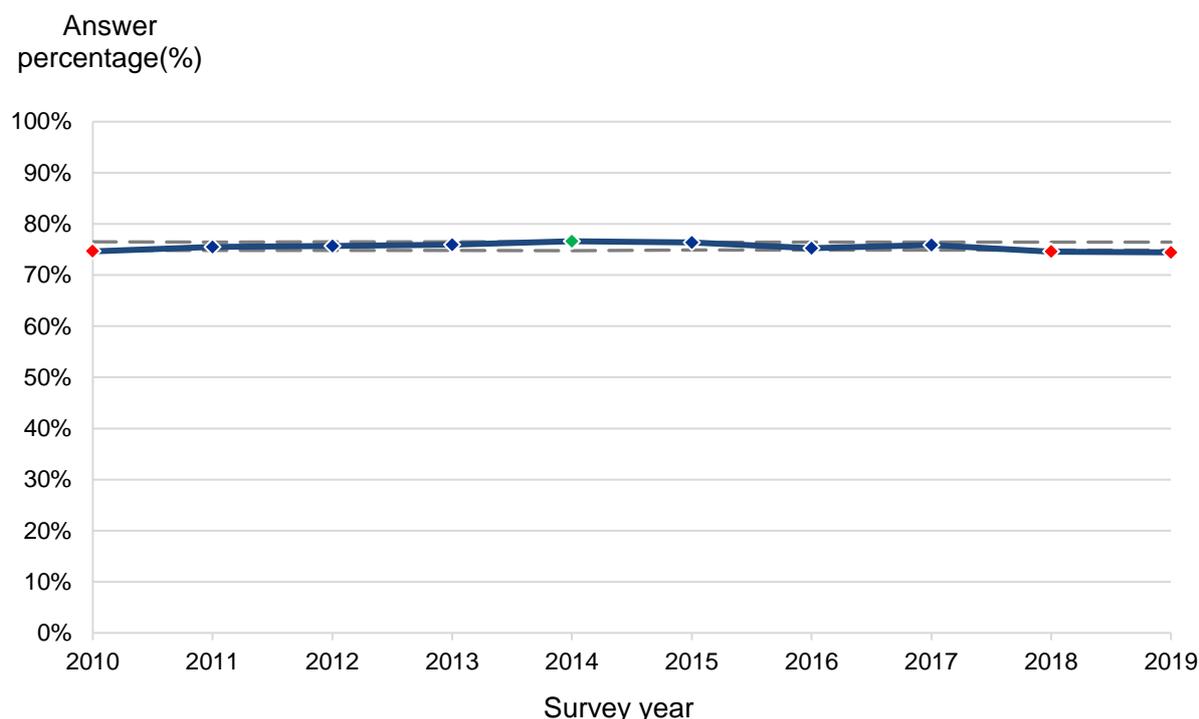


All respondents were asked this question.

Total number of responses to question: 2010 (63,616), 2011 (68,020), 2012 (61,859), 2013 (60,196), 2014 (56,991), 2015 (78,756), 2016 (74,518), 2017 (69,939), 2018 (73,738), 2019 (73,715).

Respondents were also asked if they were told by a member of staff about any danger signals they should watch for after they went home. Almost two in five people (38%) responded 'no' which is an increase of one percentage point since 2018. In addition, people were asked if they were told who to contact should they have any worries about their condition after they left hospital. A quarter of people (26%) reported they had not been told, which is also a one percentage point increase from 25% in 2018. As shown in the chart below, results for this question improved between 2010 and 2014. However, this improvement was not maintained, and results have since returned back to 2010 levels. Results have now been below where we would expect them to be, based on past data, for two consecutive years.

Q63: Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital? (Answer: 'Yes')



All respondents were asked this question.

Respondents who stated that they didn't know / couldn't remember have been excluded.

Total number of responses to question: 2010 (59,252), 2011 (62,026), 2012 (57,209), 2013 (55,210), 2014 (52,109), 2015 (72,685), 2016 (68,068), 2017 (63,929), 2018 (67,213), 2019 (67,006).

This year for the first time, additional analysis was undertaken to better understand the experiences of patients who self-reported as being frail. For the above question, 39% of people who were frail, had not been told who to contact if they were worried about their condition or treatment after leaving hospital. This is 15 percentage points higher than those who are not frail (24%), and is a statistically significant difference.

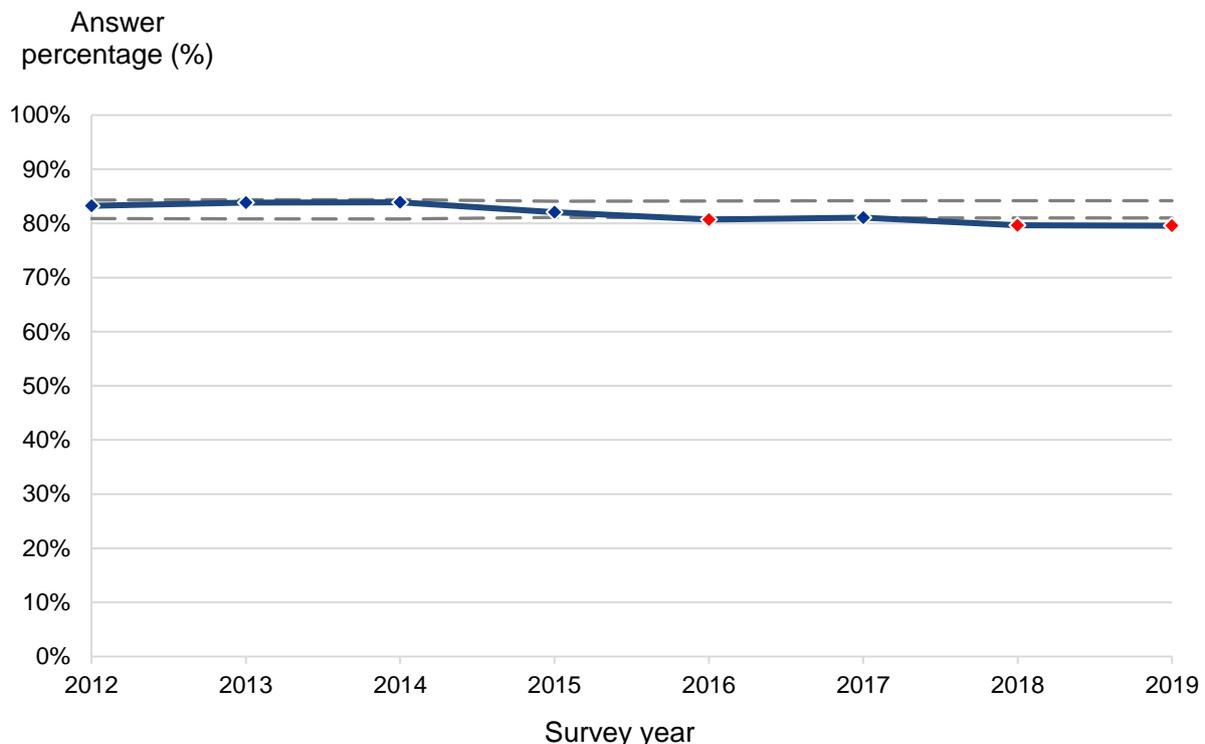
When a person is discharged from hospital, a discharge assessment is carried out to determine if the patient requires more care and support when they return home or to alternative accommodation. Those who do not require additional support are classified as a 'minimal' discharge, yet the NHS still recommends that patients ask a friend or family member to collect them from hospital and to stay with them or visit regularly once they are discharged.⁸⁷ However, the support of a family member or friend is not an option for all patients, and in addition, their previous housing situation may no longer be suitable. Without a proper plan in place to address these issues, undue stress and worry can be experienced by the patient.

Fifty-eight per cent of people felt their family or home situations were 'completely' taken into consideration when planning their discharge and 22% said this happened 'to some extent'. This left one in five people (20%) saying their situations were not taken into account. Furthermore, a quarter (26%) of patients responded 'no', when asked if doctors and nurses had given their family, friends or carers all the information needed to help care for them. Forty-seven per cent responded 'yes, definitely'. These results are the same as those reported in 2018, showing no indication of improvement.

If a discharge is classified as complex, meaning that the patient requires support after leaving the hospital, measures need to be implemented to ensure that the patient has continuity of care. According to [NHS guidance](#) for patients, health professionals should consult with patients to ascertain their views when carrying out a discharge assessment.

Respondents were asked if hospital staff discussed whether they may need any further health or social care services after leaving hospital. Eighty per cent of people responded positively ('yes'), however the remaining 20% of people did not discuss any further health and social care needs they had, before leaving hospital. Results for this question have seen a gradual decline of four percentage points since 2014. They are also lower than where we would expect results to be, based on past data for a second year in a row, indicating a significant and meaningful change.

Q65: Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital (e.g. services from a GP, physiotherapist or community nurse, or assistance from social services or the voluntary sector)? (Answer: 'Yes')

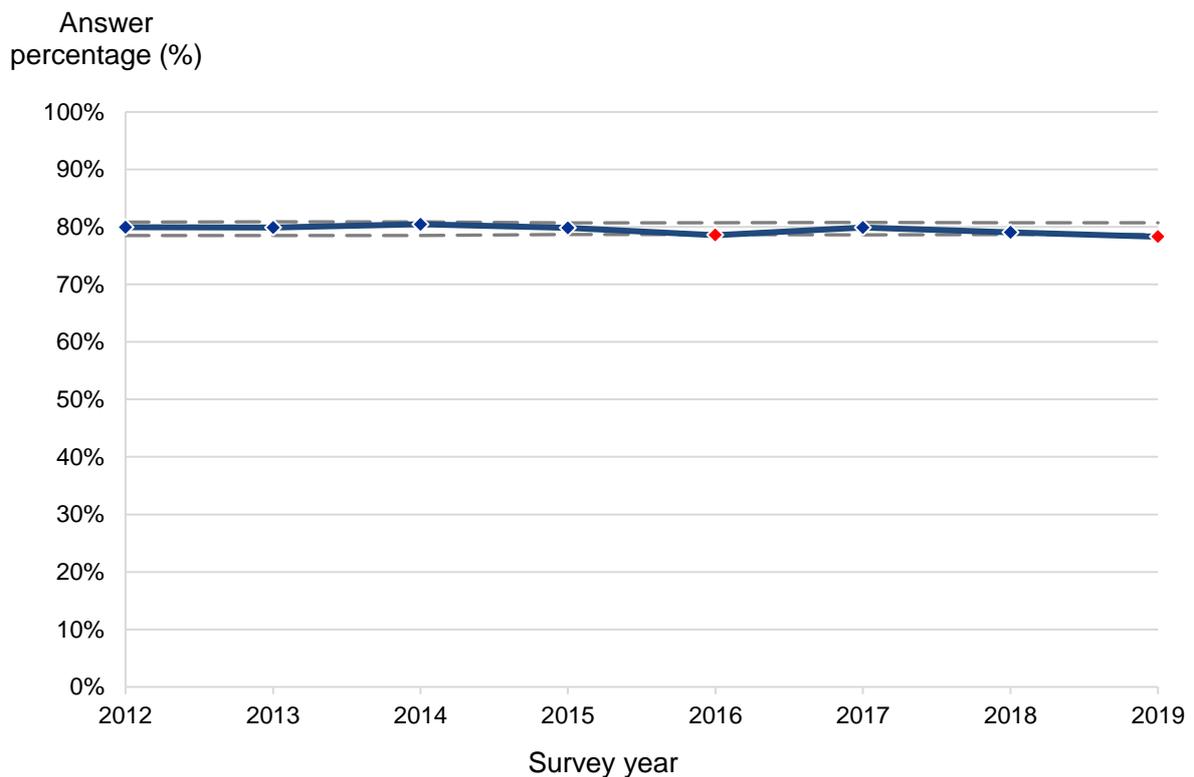


All respondents were asked this question. Respondents who stated that it was not necessary to discuss it have been excluded. Total number of responses to question: 2012 (32,493), 2013 (32,012), 2014 (30,575), 2015 (43,894), 2016 (40,727), 2017 (37,943), 2018 (39,707), 2019 (39,580).

In addition, there are clear disparities between the responses of frail patients and those who are not frail for this question. Seventy per cent of those self-reporting as frail responded 'yes', when asked if staff had discussed with them their needs for further health or social care support after leaving hospital. This is 11 percentage points lower than those who were not frail (81%) and is a statistically significant difference.

People were also asked if hospital staff discussed with them whether they would need any additional equipment in their home, or adaptations made to their home, after leaving the hospital. Of all the people who thought this discussion was necessary, almost a quarter (22%) indicated that hospital staff did not speak to them about additional equipment or adaptations to their home. This is an increase of one percentage point from 2018. The remaining 78% responded 'yes', which is lower than where we would expect results to be, based on past findings, for the first time since 2016, indicating a meaningful change.

Q64: Did hospital staff discuss with you whether you would need any additional equipment in your home, or adaptations to your home, after leaving hospital? (Answer: 'Yes')



All respondents were asked this question. Respondents who stated that it was not necessary to discuss it have been excluded. Total number of responses to question: 2012 (17,426), 2013 (17,302), 2014 (17,032), 2015 (23,403), 2016 (21,970), 2017 (20,641), 2018 (22,136), 2019 (22,312).

Further analysis was undertaken to understand the experiences of patients who self-reported as being frail. This analysis found that 30% of frail patients did not discuss with staff the need for additional equipment, or adaptations needed to their home, to help them recover after leaving hospital, but they would have like the discussion. This is significantly higher than patients who were not frail (21%).

The majority of people (94%) returned home after their stay in hospital (90%) or went to stay with family or friends (4%). Of these people, half (51%) 'definitely' received enough support from health or social care professionals to help them recover and manage their condition after leaving hospital. This is four percentage points lower than the result in 2015 when the question was first introduced and continues a trend

of gradual decline. Almost a quarter (23%) of the same group did not receive this support when it would have been helpful.

In addition, for the first time, all patients were asked if, after being discharged from hospital, the care and support they expected was available when they needed it. Seventy-nine per cent of people responded 'yes', but the remaining 21%, reported that the support they expected was not made available. Additional analysis of this question was undertaken to better understand the experiences of frail patients. Analysis found that 67% of frail patients responded 'yes' when asked this question, compared to 80% of non-frail patients. This is a statistically significant difference of 13 percentage points.

The analysis of a subset of questions relating to coordination and integration of careⁿ found above average experiences for older respondents (aged 66 to 80 and aged 81+) and those with chapter code XVII (Congenital malformations, deformations and chromosomal abnormalities).

Overall, there are continuing patterns of decline in patient experience for most questions that consider coordination of care at discharge. Many of these questions show patterns of sustained decline over time, with a number of results being below expected limits of variation for multiple years. As discussed in earlier sections, most recent national healthcare policy discusses plans to promote a more integrated approach to healthcare, with an emphasis on care in community-based settings.

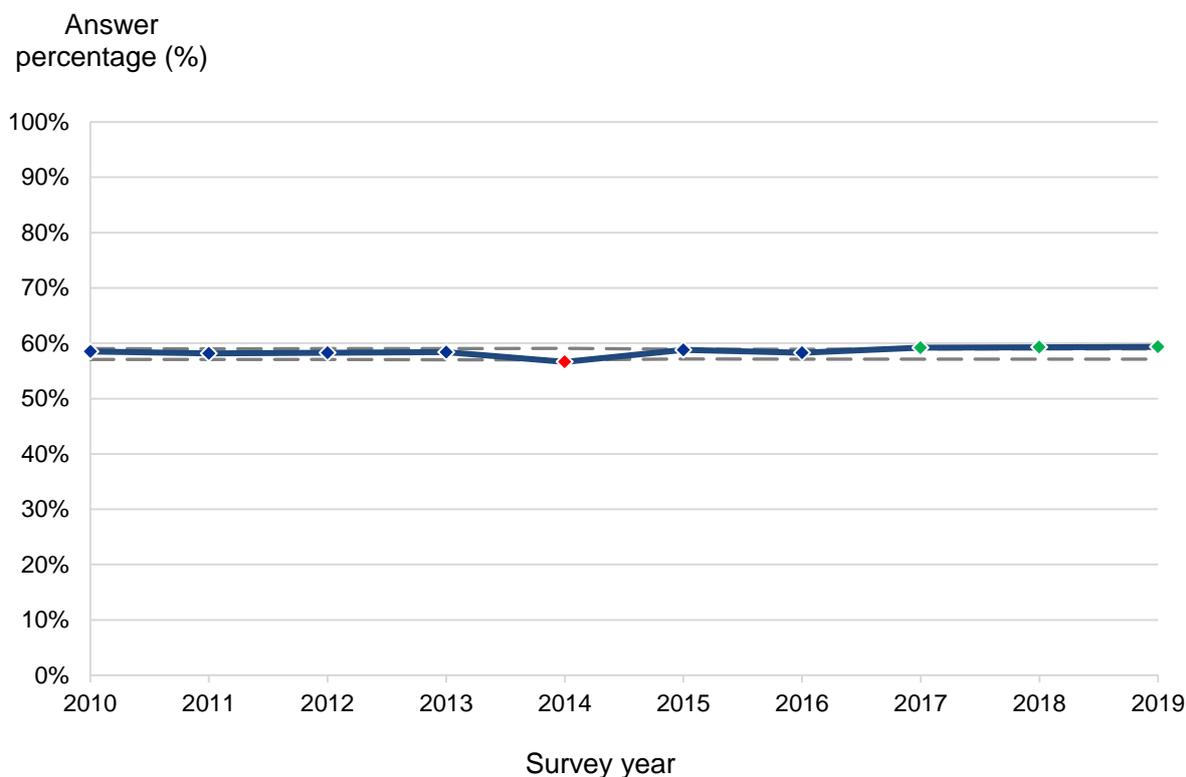
5.2 Discharge delays

Research shows that in patients over the age of 80, 10 days spent inactive in a hospital bed can equate to 10 years of muscle wastage. This is also known as deconditioning.⁸⁸ In addition, a prolonged, inactive stay in hospital can lead to higher risks of infection and a decline in function.⁸⁹ Therefore, it is essential that long hospital stays are avoided where possible and people can return to their normal environment where they can be active.

Patients were asked if, on the day they left hospital, their discharge was delayed for any reason. Most people (59%) reported their discharge as not being delayed. This result remains unchanged since 2017 and has been higher than we would expect, based on past results, for three years in a row. However, it should be noted that two in five people (41%) did experience delays in their discharge from hospital.

ⁿ The analysis included the following questions: Q32: In your opinion, did the members of staff caring for you work well together?, Q54: After leaving hospital, did you get enough support from health or social care professionals to help you recover and manage your condition?, Q61: Did hospital staff take your family or home situation into account when planning your discharge?, Q65: Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital (e.g. services from a GP, physiotherapist or community nurse, or assistance from social services or the voluntary sector)?

**Q50: On the day you left hospital, was your discharge delayed for any reason?
(Answer: 'No')**



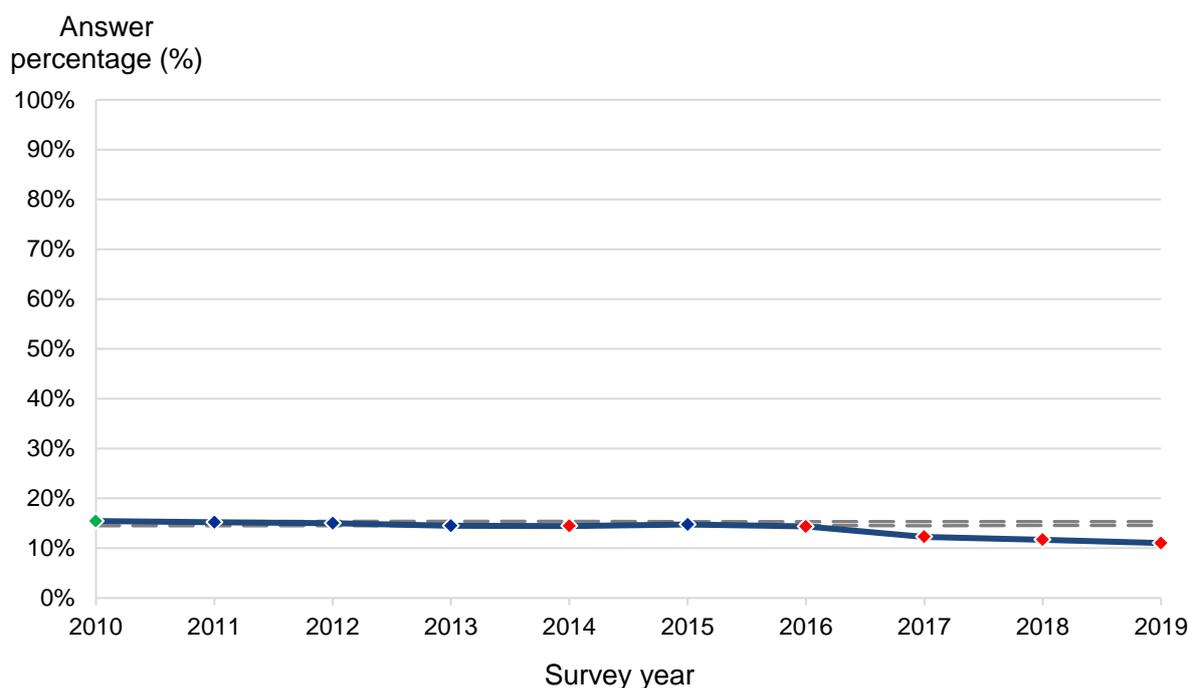
All respondents were asked this question.

Total number of responses to question: 2010 (64,170), 2011 (68,835), 2012 (62,914), 2013 (60,580), 2014 (57,359), 2015 (79,769), 2016 (75,597), 2017 (70,626), 2018 (74,446), 2019 (74,289).

These results reflect [NHS England's Delayed Transfer of Care Data](#), which shows that the number of people delayed per day in an acute setting to be decreasing.⁹⁰ For instance, the average number of people delayed per day in July 2019 was 2,971, compared to 3,996 in July 2016.

While the number of delayed discharges appear to be improving, the length of delays is increasing. Patients who reported delayed discharges were asked how long the delay lasted. Results found that 89% of people waited longer than one hour, with over a quarter of people (26%) experiencing delays longer than 4 hours. Results also show 11% of people experienced a delay of up to an hour, which is a significant decrease of one percentage point from 2018. Following a period of little variation between 2010 and 2015, the results dropped below where we would expect them to be, based on past data, in 2016. They have declined further since this point and are now below expected limits of variation for the fourth consecutive year.

Q52: How long was the delay? (Answer: 'Up to 1 hour')



Answered by those whose discharge was delayed.

Total number of responses to question: 2010 (26,490), 2011 (28,616), 2012 (25,953), 2013 (25,179), 2014 (24,741), 2015 (32,531), 2016 (31,051), 2017 (28,637), 2018 (30,127), 2019 (30,294).

Those who experienced delays were also asked to share the reason for the delay, these were:

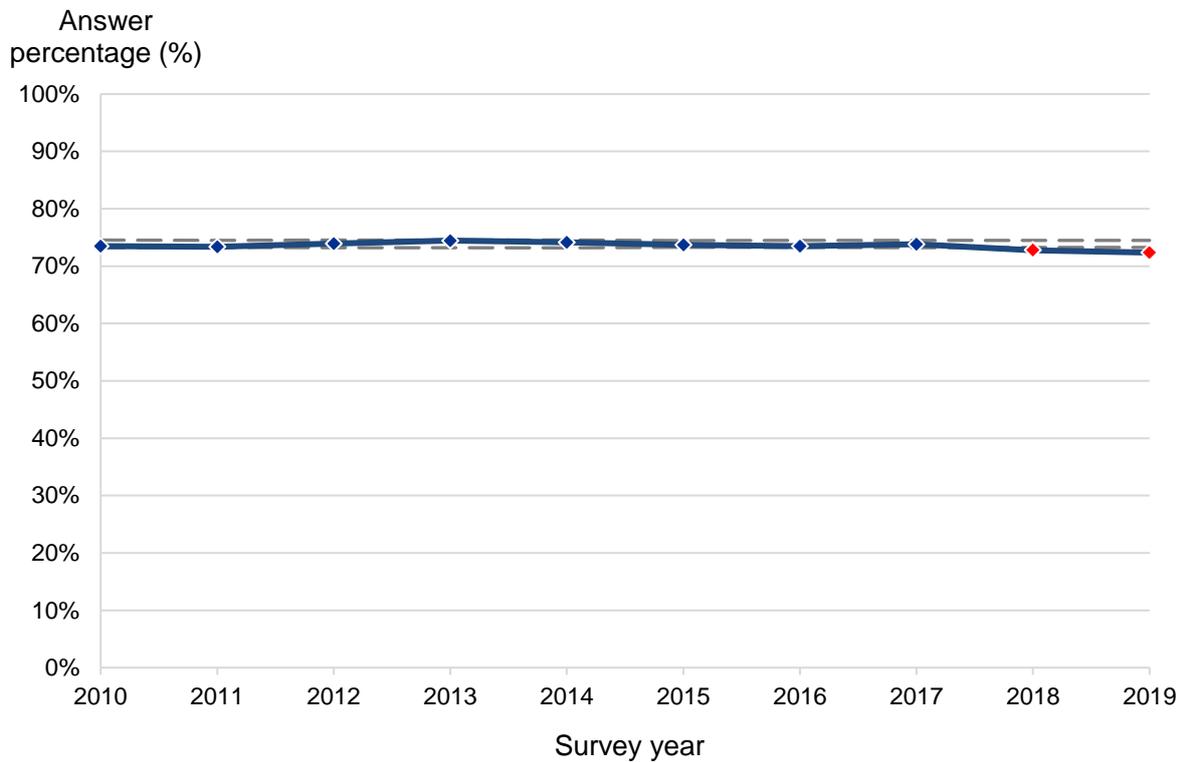
- I had to wait for medicine – 71%
- I had to wait to see the doctor – 15%
- I had to wait for hospital transport – 14%

5.3 Information about medicines when leaving the hospital

Research has shown that poor provision of information around the benefits and risks of prescribed medicines can lead to non-adherence and medicines-related harm (MRH), resulting in negative health outcomes. However, when medical professionals share information about medicines in a way that patients understand, improving their knowledge on medicines as well as how to manage their own medication when they leave hospital, adherence is improved.⁹¹

Respondents were asked if a member of staff explained the purpose of their medicines they were to take home, in a way they could understand. Results show that 72% of patients responded 'yes, completely'. This is a decrease of one percentage point from 2018 and is below where we would expect results to be, based on past data, for a second consecutive year, indicating significant and meaningful change. One in 10 people (10%) indicated that the purpose of their medicines had not been explained to them in a way they could understand. This is a significant increase of one percentage point from 2018.

Q57: Did a member of staff explain the purpose of the medicines you were to take home in a way you could understand? (Answer: 'Yes, completely')



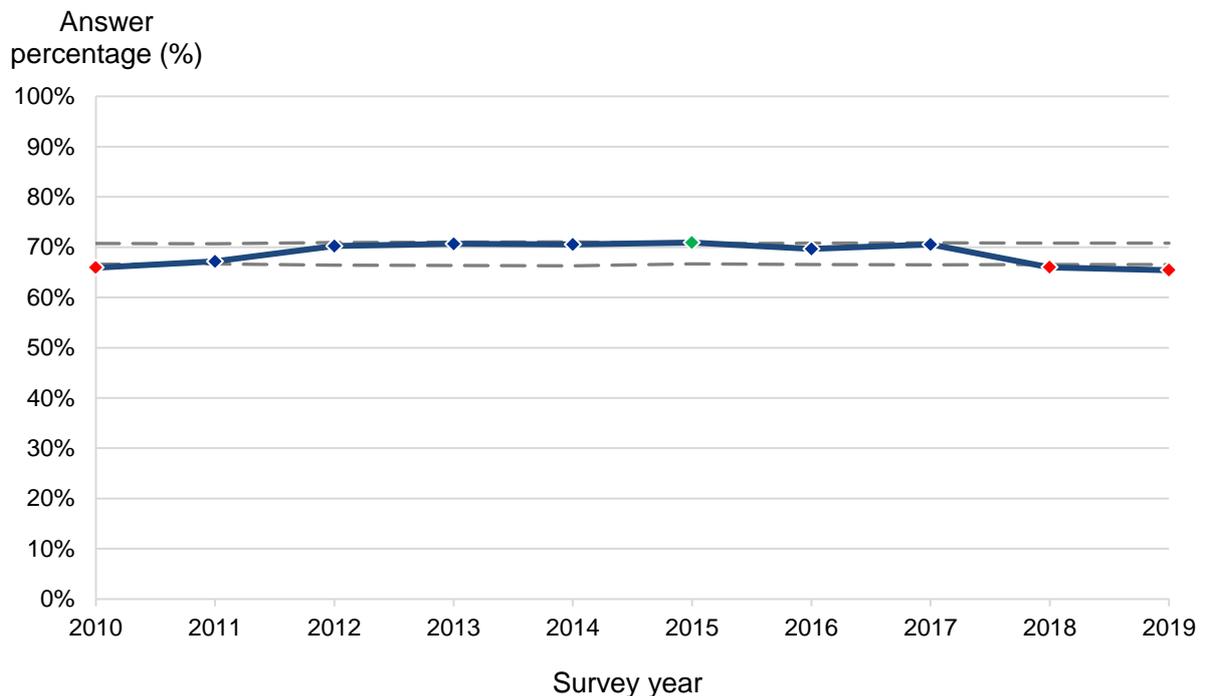
All respondents were asked this question.

Respondents who stated that they did not need an explanation or had no medicines have been excluded.

Total number of responses to question: 2010 (49,294), 2011 (52,861), 2012 (47,924), 2013 (46,202), 2014 (43,875), 2015 (60,754), 2016 (54,527), 2017 (50,897), 2018 (53,480), 2019 (53,696).

Furthermore, patients who were given medicines to take home were asked if they were given clear written or printed information about their medicines. Sixty-five per cent of people responded 'yes, completely'. This is below where we would expect results to be, based on past findings, for a second year in a row and a decrease of six percentage points since 2017. Significant improvements were made between 2010 and 2012, with these improvements being sustained until 2017.

Q59: Were you given clear written or printed information about your medicines? (Answer: 'Yes, completely')



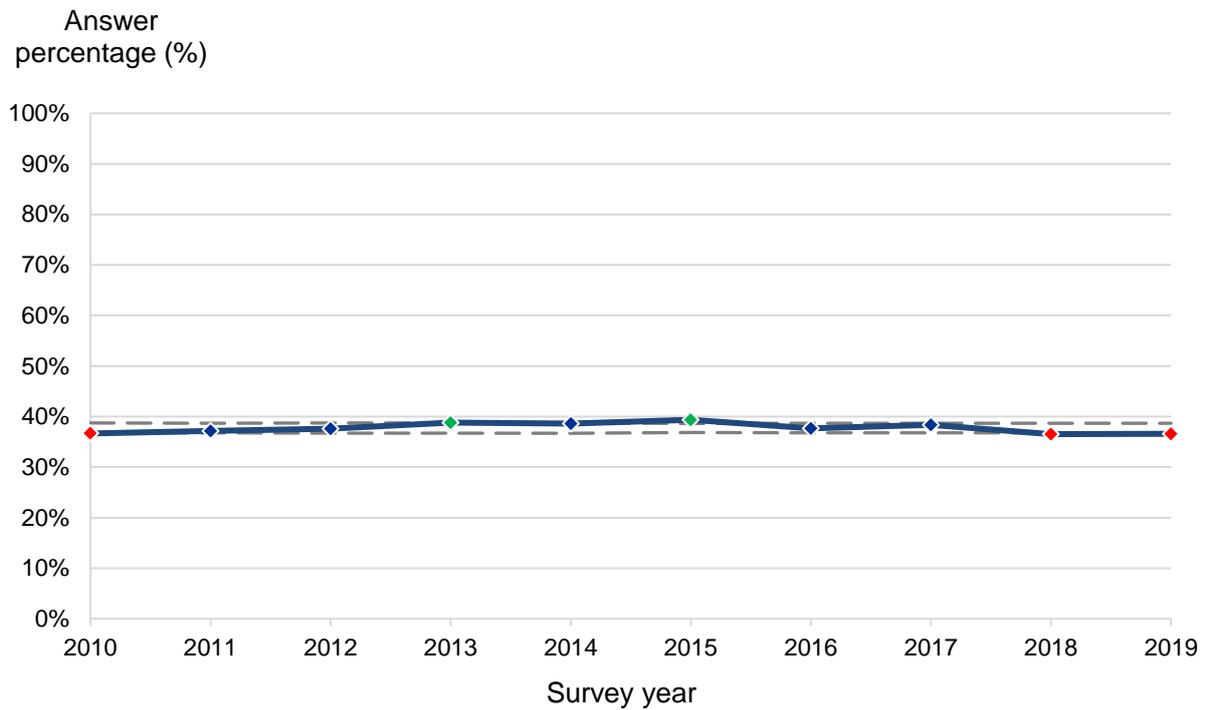
Answered by those who were given medicines to take at home.

Respondents who stated that they did not need this or didn't know / couldn't remember have been excluded.

Total number of responses to question: 2010 (53,005), 2011 (56,315), 2012 (43,791), 2013 (42,802), 2014 (40,000), 2015 (55,923), 2016 (49,995), 2017 (46,795), 2018 (49,628), 2019 (49,588).

Respondents were also asked if a member of staff told them about the side effects of medicines to watch for when they went home. Over two in five respondents (44%) reported they were not told about side effects to watch out for. This is the same result as 2018 and an increase of one percentage point from 2017. Results show 37% of people responded 'yes, completely'; a result which is now below where we expect results to be, based on past findings, for two consecutive years.

Q58: Did a member of staff tell you about medication side effects to watch for when you went home? (Answer: 'Yes, completely')



Answered by those who were given medicines to take at home.

Respondents who stated that they did not need an explanation have been excluded.

Total number of responses to question: 2010 (42,638), 2011 (45,412), 2012 (41,519), 2013 (40,281), 2014 (38,384), 2015 (52,554), 2016 (46,951), 2017 (43,719), 2018 (46,269), 2019 (46,313).

6. Availability of staff

As discussed in the policy section of this report, staff shortages in the NHS is a major concern. [NHS vacancy data](#) for the time in which the respondents would be receiving care shows a vacancy rate of 12.1% for nursing staff and 7.1% for medical staff. This has resulted in CQC raising concerns about the impact of staffing levels on patient safety. CQC's [guidance on regulation 18 on staffing](#), stated that providers "must provide sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the people using the service at all times and the other regulatory requirements set out in this part of the [Health and Social Care act 2008]".

To assess the impact of staffing levels on patient experience, respondents were asked if, in their opinion, there were enough nurses on duty to care for them in hospital. Over half of all respondents (58%) stated there were 'always or nearly always enough nurses'. However, 12% stated there were 'rarely or never enough nurses', with an additional 30% responding there were 'sometimes enough nurses' to care for them. These results are the same as those in 2018, but they show decline since 2017.

The [National Quality Board](#) (NQB) advises that information about the nurses, midwives and care staff should be presented clearly on each ward, as well as what their roles are.⁹² A patient's ability to easily identify members of staff can help them to get the help they need more quickly. Patients were asked if they knew which nurse was in charge of looking after them. This would have been a different person after every shift change. Half of all respondents (49%) responded 'yes, always', while one in five people indicated they did not know who was in charge of their care. These results remain unchanged from 2018 and continue a steady trend across the four years this question has been include in the survey.

Respondents were also asked if, when they needed attention, they were always able to get a member of staff to help them within a reasonable amount of time. Results show 59% of people responding 'yes, always'. This is the same result as 2018, but a decrease of two percentage points since 2017. Almost one in 10 people (8%) were not able to get help from a member of staff in a reasonable amount of time. In addition, the survey also asked patients if they felt well looked after by the non-clinical hospital staff, such as cleaners, porters and catering staff. The majority of people (83%) indicated that they 'always' felt looked after by non-clinical staff. This is a significant increase of one percentage point from the 2018 result.

The NQB also highlights the importance of ensuring the right mix of professions in the ward as a way to maximise the skills of each individual and avoid an uneven distribution of pressure on any one profession. When asked if, in their opinion, the members of staff caring for them worked well as a team, 75% of respondents answered 'yes, always'. An additional 21% responded 'yes, sometimes'.

Overall, results show no sign of improvement with regard to experiences of there being enough nursing staff available to care for patients and communicating with patients who is in charge of their care. However, results show that generally, the staff available do work well together.

7. Recruiting patients to participate in research

As discussed in the policy section, research conducted by the [National Institute for Health Research \(NIHR\)](#) has shown that research-active hospitals have better health outcomes for patients. In addition, the [NHS Long Term Plan](#) aims to increase the number of people registering to participate in health research to one million by 2023/24. While this figure extends to the broader population, there is a need to engage with current inpatients whose conditions are already diagnosed.

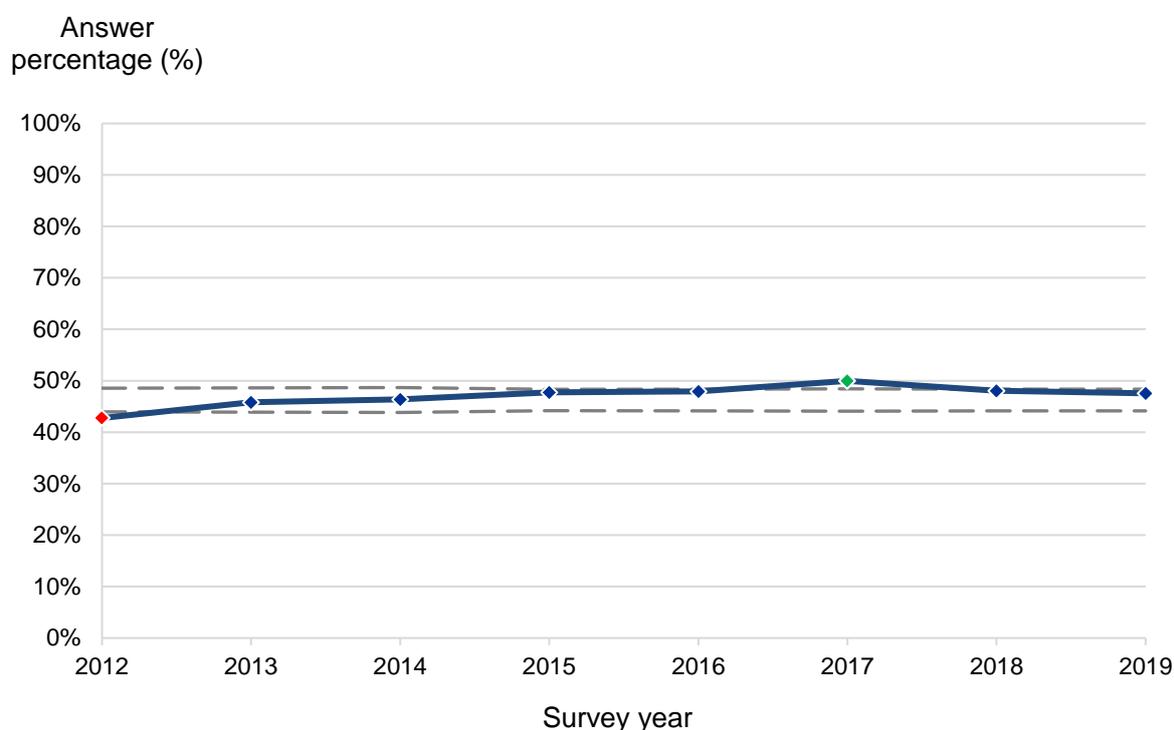
When asked if during their stay, anyone had discussed with them whether they would like to take part in a research study, most people (87%) responded 'no'. This is a significant increase from the 2018 result of one percentage point. Of those asked to take part, most people agreed - 10% of people indicated that they were asked and agreed to take part, while the remaining 3% were asked but did not want to take part.

8. Overall experience

Results from the survey are mixed, with good performance and improvement being seen in some areas, such as communication around operations; and sustained decline being evident in others, such as delays and communication at discharge.

Therefore, it is important to ask patients how they found their experience of adult inpatients services overall. When asked to provide a score for their overall experience from '0 – I had a very poor experience' to '10 – I had a very good experience', almost half (48%) gave a score of 9 or 10. This is the same result as in 2018 and an increase of five percentage points since 2012.

Q68: Overall experience



All respondents were asked this question.

Total number of responses to question: 2012 (61,379), 2013 (59,015), 2014 (56,172), 2015 (76,411), 2016 (73,240), 2017 (69,496), 2018 (72,319), 2019 (73,163).

As in 2018 we found poorer experiences for overall experience for respondents aged 16 to 35. This year, poorer experiences were also found for respondents: who preferred not to say their religion, who preferred not to say their sexuality, with dementia or Alzheimer's, with a neurological condition and with chapter code V (Mental and behavioural disorders).

9. Subgroup analysis

Background

This additional analysis compares how different groups of patients rated their experiences of being a hospital inpatient by using a 'multi-level model analysis'. This analysis compares the mean scores for a subset of questions by different groups of patients and allows us to explore potential relationships between patients' characteristics and their experiences.

Differences that are equivalent to at least 0.1 standard deviations from the overall mean of the target variable are treated as being noteworthy, provided that the confidence interval does not overlap the mean line.

Nine themes were selected for analysis based on key national policy and good practice for patient experience as set out in the [NHS Patient Experience Framework](#).

Five of these themes are composites using similar questions, and four are individual questions. The questions included in these themes [and the charts used for the analysis may be found in Appendix H](#). Further information about the analysis methodology is detailed in [Appendix A](#).

Summary

As found in previous surveys analysis showed that, generally, older people (aged 66+) report experiences that are more positive. Conversely, younger respondents (aged 16 to 35) report more negative experiences and had a worse than average experience across six out of the nine themes: respect (for patient-centred values, preferences and expressed needs); confidence and trust; coordination and integration of care; hydration; respect and dignity and overall experience. This is also consistent with findings across other surveys such as the [2018 Urgent & Emergency Care \(UEC\) Survey](#)

Poorer experiences were found for respondents with dementia or Alzheimer's for five out of nine themes: information, communication and education; respect (for patient-centred values, preferences and expressed needs); hydration; respect and dignity and overall experience. This is consistent with findings from the 2018 and 2017 inpatient surveys.

As found in [previous inpatient surveys](#) carried out in 2018, 2017 and 2016 poorer experiences were found for respondents with ICD-10 chapter code V (Mental and behavioural disorders) which were poorer for four themes in 2019: information, communication and education; respect (for patient-centred values, preferences and expressed needs); confidence and trust and overall experience. This is also consistent with findings across other surveys such as the [2018 Urgent & Emergency Care \(UEC\) Survey](#), which found poorer experiences for people who self-reported as having a mental health condition.

We also found that respondents who had an emergency admission (admitted after a visit to A&E) reported poorer experiences than respondents who had an elective (planned) admission. Again, this is consistent with findings from [previous inpatient surveys](#).

Age

The analysis showed a general trend of older patients reporting more positive experiences. This is consistent both with findings from previous inpatient surveys and with findings across other surveys such as the [2018 Urgent & Emergency Care \(UEC\) Survey](#). Respondents aged 16 to 35 had a worse than average experience across six out of the nine themes: respect (for patient-centred values, preferences and expressed needs); confidence and trust; coordination and integration of care; hydration; respect and dignity and overall experience. Scores for the 36 to 50 subgroup were below average for two themes: confidence and trust and coordination and integration of care.

In contrast, respondents aged 66 to 80 had an above average experience across five of the nine themes: respect (for patient-centred values, preferences and expressed needs); confidence and trust; coordination and integration of care; respect and dignity and overall experience. Scores for people aged 81+ were above average for four of the nine themes: confidence and trust; coordination and integration of care; respect and dignity and overall experience.

The exception to this is for the information, communication and education theme where poorer experiences were only found for the oldest respondent group (81+).

Gender

There were no noteworthy differences by gender.

Religion

Respondents who said that they would prefer not to state their religion had a worse than average experience across six out of the nine themes: information, communication and education; respect (for patient-centred values, preferences and expressed needs); emotional support; confidence and trust; respect and dignity and overall experience. This is consistent both with findings from previous inpatient surveys and with findings across other surveys such as the 2018 Urgent & Emergency Care (UEC) Survey which also found that people who prefer not to state their religion had a worse than average experience across several themes.

It is difficult to know the characteristics of people who prefer not to state their religion. However, research into the rise in the numbers of people reporting having no religion suggests it may be reasonable to assume that those who prefer not to state their religion have 'no religion', with the exception of small numbers who do not wish to identify themselves for reasons such as historic persecution.⁹³

The Office for National Statistics (ONS) looked into reasons why people 'prefer not to say' when responding to questions about their sexuality and it may be reasonable to assume some of the same reasons may apply here.⁹⁴ Reasons include concerns regarding privacy and confidentiality or risk of being identified, and a belief that the question should not be asked (people who preferred not to state their sexuality also preferred not to say for other questions such as ethnicity).

Respondents who were Jewish had a worse than average experience for two themes: food choice and Information, communication and education.

People who identified as Christian had an above average experience for four themes: emotional support; coordination and integration of care; food choice and overall experience.

Sexual orientation

Respondents who said that they would prefer not to state their sexuality had a worse than average experience for two themes: respect (for patient-centred values, preferences and expressed needs) and overall experience. Poorer experiences were also found for respondents who described themselves as bisexual for the hydration theme.

Ethnicity

There were no noteworthy differences by ethnicity.

Long-term conditions

As found in previous inpatient surveys carried out in 2018 and 2017, poorer experiences were found for respondents with dementia or Alzheimer's which were poorer for five out of nine themes in 2019: information, communication and education; respect (for patient-centred values, preferences and expressed needs); hydration; respect and dignity and overall experience. Three of these themes (information, communication and education; respect; and hydration) were also poorer in both 2018 and 2019.

Poorer experiences were also found for respondents with a neurological condition for three out of nine themes: confidence and trust; respect and dignity and overall experience.

ICD-10 chapter code

ICD-10 chapter codes are used by healthcare professionals to classify symptoms and diagnoses. Please see [appendix I](#) for full details.

Poorer experiences were found for respondents across the themes listed in the table below:

ICD10 Chapter codes with poorer experiences

Chapter code	Themes with poorer experiences:
XVIII (Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified)	information, communication and education; respect (for patient-centred values, preferences and expressed needs); emotional support; confidence and trust; coordination and integration of care.
V (Mental and behavioural disorders)	information, communication and education; respect (for patient-centred values, preferences and expressed needs); confidence and trust overall experience.
code VI (Diseases of the nervous system)	emotional support.
XIV (Diseases of the genitourinary system)	emotional support; coordination and integration of care.

Above average experiences were found for respondents across the themes listed in the table below:

ICD10 Chapter codes with above average experiences

Chapter code	Themes with above average experiences:
XVII (Congenital malformations, deformations and chromosomal abnormalities)	respect (for patient-centred values, preferences and expressed needs); emotional support; coordination and integration of care; overall experience.
IX (Diseases of the circulatory system)	information, communication and education; confidence and trust; overall experience.
VIII (Diseases of the ear and mastoid process)	respect (for patient-centred values, preferences and expressed needs); respect and dignity.
II (Neoplasms)	information, communication and education.
III (Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism)	food choice.

Route of admission

The analysis showed a general trend that respondents who had an emergency admission (admitted after a visit to A&E) reported poorer experiences than respondents who had an elective (planned) admission. Poorer experiences for people who had an emergency admission were found for three out of nine themes: information, communication and education; respect (for patient-centred values, preferences and expressed needs) and confidence and trust. Conversely, above average experiences were found for respondents who had an elective admission for these themes. These three themes were also flagged in findings for the [2018 Adult Inpatient Survey](#).

Case type

There were no noteworthy findings by case type (medical or surgical).

Length of stay

As in 2018 poorer experiences were found for respondents who stayed for only one night for the food choice theme. Conversely, above average experiences were found for respondents who stayed for more than one night.

Respondents

As in 2018 the analysis showed a general trend that more positive responses were received from respondents who completed the questionnaire themselves. Above average experiences were found for respondents who completed the questionnaire themselves for seven out of nine themes: information, communication and education; respect (for patient-centred values, preferences and expressed needs); emotional support; confidence and trust; hydration; respect and dignity and overall experience. Conversely, poorer experiences were found for respondents who completed the questionnaire with the help of a healthcare professional for two themes: respect (for patient-centred values, preferences and expressed needs); and hydration.

Appendix A: Survey methodology

This appendix summarises the survey methodology covering questionnaire design, sampling, fieldwork and analysis. For more detailed information and for information on data limitations, please see the [Quality & methodology report](#).

1. Questionnaire design

To make sure that the [questionnaire](#) is up-to-date and reflects current policy and practice, we review the questions before each survey to determine whether any new questions are needed.

Questionnaire development work makes sure that questions are important to people who use services and to other stakeholders who use the survey data in their work.

Wherever possible, questions remain the same over time to measure change. However, when necessary, we make changes to reflect changes in policy and methodological best practices and to reflect feedback from stakeholders to make sure that questions stay relevant. The 2019 questionnaire was kept as similar as possible to that used in 2018 to enable comparisons. In 2019 one question was added and four questions were modified. No questions were removed. The new question is designed to give an assessment of the frailty of respondents. The question is a key focus for NHS England and was taken from the national [GP Patient Survey](#). The front page of the questionnaire was also changed, with instructions updated and colour added throughout.

All changes are detailed in the [Survey development report](#) and [Appendix F](#) provides a list of these changes.

2. Comparability with previous years

The comparable reporting period used for this iteration of the survey is 2010 to 2019 unless stated otherwise. Although data may be available dating back to 2004 for some questions, these data points have not been included within the control charts for trend analysis, owing to a change of weighting method implemented in 2010.

3. Survey methods

As with all surveys in the NHS Patient Survey Programme, the adult inpatient survey used a postal questionnaire for survey data collection. The sample members received their first survey pack containing a questionnaire, covering letter and a leaflet offering guidance on multi-language options for completing the questionnaire. This was followed by a reminder to all non-respondents, then a final reminder containing another questionnaire. The second mailing took place five working days after the first one and the third mailing three weeks after the second one. Patients who had died or opted-out from the survey were removed from subsequent mailings.

Fieldwork for the survey (the time during which questionnaires were sent out and returned) took place between August 2019 and January 2020. The length of fieldwork varied from trust to trust depending on the date of approval of their sample.

4. Sampling

Trusts drew a sample of 1,250 patients, aged 16 or over who had stayed at least one night in hospital during July 2019. Trusts were required to include every consecutive discharge counting back from 31 July until they had reached the 1,250 target. A small number of trusts with smaller patient throughput (such as specialist trusts) had to sample back to earlier months.

Certain groups of patients were excluded before the trusts drew their sample, including:

- patients who had died
- children or young people under 16 years old at the time of drawing their sample
- women using obstetrics or maternity services, including those who had a spontaneous miscarriage
- patients admitted for planned termination of pregnancy
- psychiatry patients (patients who received treatment for a mental health condition)
- day case patients (patients who arrived and left hospital on the same day)
- private patients (non-NHS)
- NHS patients treated at private hospitals
- any patients who were known to be inpatients at the time samples were drawn
- patients without a UK postal address or patients whose address was unusable because it was incomplete
- patients who opted out of having their details used for anything except clinical care.

No trusts were excluded from analysis because of sampling errors.

The sample size was enough to allow analysis of results at individual trust level. Full details of the sampling are available in the [instruction manual for the survey](#).

5. Analysis

Data cleaning

'Data cleaning' refers to all editing processes carried out on survey data once the survey has been completed and the data has been entered and collated. This is done to ensure data quality and make sure that it is comparable across trusts. For further information please see the [data cleaning document](#).

Weighting

The data presented in this report has been weighted with two weights:

1. A 'trust weight', which aims to weight responses from each trust to ensure that each trust has an equal influence on England results. As some trusts have a higher response rate than others, they have a larger share of respondents in the total respondent's population for England. Without weighting, the views of respondents from these trusts would be over-represented in the England-level results. The weighting is therefore designed so that each trust that participated contributes equally to the overall results for England, regardless of differences in response rates.
2. A 'population weight', which weight responses for each individual to make sure it is representative of the trust's own population (based on the initial eligible sample). This involves weighting based on variables that are related to how people respond: age group, sex and route of admission (planned or emergency).

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. These questions are presented without weights applied, as it is more appropriate to present the real percentages of respondents to describe the profile, rather than adjust figures.

Rounding

The results 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 2019 compared with 2018.

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

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

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

- rounding figures up or down makes a difference appear larger than it actually is.
- generally speaking, the larger the sample size, the more likely that findings will be statistically significant, and we can be more confident in the result. In contrast, the fewer people that answer a question, there has to be a greater difference to be statistically significant.

The amount of variation also affects whether the difference is significant. 'Variation' means the differences in the way people respond to the question. If there is a lot of variance then differences are less likely to be statistically significant.

The [Quality & methodology report](#) contains relevant background information to help readers to understand the survey data, including response rates, sampling errors and data limitations.

6. Subgroup analysis

The multi-level analysis of subgroups highlights the experiences of different demographic sub-populations. 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 within themes, derived from composites of questions, illustrated in the charts. This model takes into account trust clustering, as trusts are likely to have a big effect on reported patient experience at a national level.

To assess whether experience differs by demographic factors, statistical significance tests were carried out. F tests were performed on each factor (fixed effect) as a predictor of the target variable. P-values were also generated which showed how likely it is that the observed differences between groups could have arisen from a population where there were no actual differences. They relate to the demographic factor as a whole, rather than specific categories within the factor. Variables were also checked for multicollinearity.

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, provided that the confidence interval does not overlap the mean line. Composites were created with questions about NHS patient experience framework. See [Appendix H](#) for the charts, please note that the x-axis scale shows the average score-point difference associated with each demographic subgroup.

Appendix B: Demographic tables

The tables below show the demographic characteristics of respondents to the 2019 adult inpatient survey. The figures in these tables are unweighted.

Q74: Do you have any physical or mental health conditions, disabilities or illnesses that have lasted or are expected to last for 12 months or more?	
Yes	67%
No	33%
Number of respondents	64,984

Answered by all

Q75: Do you have any of the following long-standing conditions?	
Breathing problem, such as asthma	30%
Blindness or partial sight	7%
Cancer in the last 5 years	20%
Dementia or Alzheimer's disease	5%
Deafness or hearing loss	23%
Diabetes	23%
Heart problem, such as angina	28%
Joint problem, such as arthritis	48%
Kidney or liver disease	11%
Learning disability	2%
Mental health condition	10%
Neurological condition	10%
Another long-term condition	27%
Total	51,546

Answered by those with a long-standing condition

Q76: Do any of these reduce your ability to carry out day-to-day activities?	
Yes, a lot	42%
Yes, a little	40%
No, not at all	18%
Number of respondents	50,868

Answered by those with a long-standing condition

Q77: Have you experienced any of the following in the last twelve months?	
Problems with your physical mobility, such as difficulty getting about your home	43%
Two or more falls that have needed medical attention	8%
Feeling isolated from others	8%
None of these	50%
Number of respondents	70,811

Answered by all

Proportions responding to the survey by sex	
Male	48%
Female	52%
Number of respondents	76,915

Answered by all (sample data used if response is missing)

Proportions responding to the survey by age	
16-35	5%
36-50	8%
51-65	22%
66-80	41%
>80	24%
Number of respondents	76,915

Answered by all (sample data used if response is missing)

Q80: What is your religion?	
No religion	18%
Buddhist	0%
Christian (including Church of England, Catholic, Protestant, and other Christian denominations)	74%
Hindu	1%
Jewish	0%
Muslim	2%
Sikh	0%
Other	1%
I would prefer not to say	3%
Number of respondents	73,311

Answered by all

Q81: Which of the following best describes how you think of yourself?	
Heterosexual / straight	93%
Gay / lesbian	1%
Bisexual	1%
Other	1%
I would prefer not to say	4%
Number of respondents	71,053

Answered by all

Q82: What is your ethnic group?	
White	95%
Mixed	1%
Asian or Asian British	3%
Black or Black British	1%
Arab or other ethnic group	0%
Number of respondents	74,218

Answered by all

Appendix C: Comparisons with other data

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

United Kingdom

Scotland

The Scottish [Inpatient Experience Survey](#) is a biennial postal survey sent out in January every other year to a random sample of people aged 16 years or over who had an overnight hospital stay between April and September of the previous year. The latest survey was carried out in 2018. The survey asks about patients' experiences of: admission to hospital, the hospital and ward environment, care and treatment in hospital, staff, operations and procedures, 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 (2018)
	%
0 (Negative)	1
1	1
2	1
3	2
4	2
5	4
6	4
7	9
8	20
9	21
10 (positive)	36

Northern Ireland

The most recent Inpatient Experience Survey for Northern Ireland was carried out in 2017. This survey had many questions similar to the CQC adult inpatient survey questionnaire.

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

Response	
	%
Very satisfied	60
Satisfied	32
Neither	5
Dissatisfied	2
Very dissatisfied	1

More information on the Northern Ireland Inpatient Patient Experience survey is available at:

<https://www.health-ni.gov.uk/articles/inpatient-patient-experience-survey>.

The rest of the world

Ireland

The first adult inpatient survey in Ireland was conducted in May 2018, and the second in May 2019. This survey used similar methodology to the CQC adult inpatient survey, with the addition of a web completion option. The 61-item questionnaire shares many questions with the CQC inpatient questionnaire and some adjusting to Irish healthcare quality policy.

When asked to rate their overall inpatient experience from 0 to 10, the majority of respondents gave a positive response.

Rating	
	%
9-10 (Very good)	56
7-8 (Good)	28
0-6 (Fair to poor)	16

More information of the Irish National Patient Experience Survey is available at:

<https://www.patientexperience.ie/>.

New Zealand

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

The 20 items/questions cover four key domains of patient experience: communication, partnership, co-ordination, and physical and emotional need. Many of the questions are the same as those in the adult inpatient survey 2019.

For more information on New Zealand's National Patient Experience Survey is available at: <https://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/patient-experience/adult-inpatient-experience/>.

Appendix D: Further information and feedback

Further information

The 'technical document' describes the methodology for analysing results at NHS trust level and a 'quality and methodology' document provides information about survey development, methodology and limitations of analysis:

www.cqc.org.uk/inpatientsurvey.

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

<https://nhssurveys.org/surveys/survey/02-adults-inpatients/year/2019/>

More information on the patient survey programme, including results from other surveys and a programme of current and forthcoming surveys can be found at:

www.cqc.org.uk/surveys.

Further questions

This summary has been produced by CQC's Survey Team and reflects the findings of the 2019 adult inpatient survey. The guidance above should help answer any questions about the programme. If you wish to contact the team directly, please contact Tamatha Webster, Surveys Manager, at Patient.Survey@cqc.org.uk.

Feedback

We welcome 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 Tamatha Webster, Surveys Manager at 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 Office for Statistics Regulation. The Authority considers whether the statistics meet the highest standards of Code compliance, including the value they add to public decisions and debate.



Appendix E: 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 reviewed 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.

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 is used in CQC Insight, an intelligence tool that indicates potential changes in the quality of care to support decision-making about our regulatory response. Results will also form a key source of evidence to support the judgements and ratings published for trusts.

NHS trusts and commissioners

Trusts, and those who commission services, use the results to identify and make the changes 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.

NHS England and NHS Improvement

NHS England and NHS Improvement will use the data to inform how it addresses the challenges currently facing the NHS across the country.

Questions from the NHS Patient Survey Programme (specifically the inpatient, community mental health and urgent and emergency care surveys) are used to produce a separate index measure called the Overall Patient Experience Score (OPES). The score forms part of a regular statistical series that is updated alongside the publication of each respective survey. Due to pressures of COVID-19 work, the OPES update following the publication of this survey has been suspended. More information is available at: <http://www.england.nhs.uk/statistics/statistical-work-areas/pat-exp/>.

Department of Health and Social Care

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 adult inpatient survey, among other data sources.

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 respondent data that is contained within

this report. For more information see: <https://digital.nhs.uk/data-and-information/publications/clinical-indicators/nhs-outcomes-framework>.

Appendix F: Changes to the questionnaire

The 2019 Adult Inpatient Survey has remained largely the same as the 2018 survey. The changes to questions are described below.

One new question was added.

Q77 Have you experienced any of the following in the last twelve months?
(Cross ALL that apply)

- Problems with your physical mobility, such as difficulty getting about your home
- Two or more falls that have needed medical attention
- Feeling isolated from others
- None of these

Four questions (Q12, Q51, Q56 and Q80) were modified.

No questions were removed.

For full details please see the [survey development report](#).

Appendix G: 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. These indicators 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 website:

<https://digital.nhs.uk/data-and-information/publications/ci-hub/nhs-outcomes-framework>

Waiting times

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

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

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

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

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

Staffing

For further information on counts of qualified nursing staff (including qualified nursing, midwifery and health visiting staff) please see the NHS Digital's 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:

<https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics>

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/>

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 6 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 H: Subgroup analysis charts

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, sexual orientation, marriage, and civil partnership. The Act provides an important legal framework that should improve the experience of all people using NHS services.

We include additional analysis to compare how different groups of people using adult inpatient services rated their experience by using a multilevel model analysis.

This subgroup analysis compares the mean scores for a subset of questions by different groups. With this model, we can more effectively explore the relationships between respondent characteristics and their experiences.

The analysis modelled the mean scores^o of different subgroups for a set of composite questions based on the [NHS Patient Experience Framework](#).

The subgroups used in the analysis were:

- **Age group:** 16 to 35 years, 36 to 50 years, 51 to 65 years, 66 to 80 years and 80+ year olds
- **Gender:** Male, Female
- **Religion:** No religion, Buddhist, Christian, Hindu, Jewish, Muslim, Sikh, Other, I would prefer not to say
- **Sexual orientation:** Heterosexual / straight, Gay / lesbian, Bisexual, Other, I would prefer not to say
- **Ethnicity:** White, Mixed, Asian or Asian British, Black or Black British, Arab or other ethnic group, Not known
- **Long-term condition:** No breathing problem, Breathing problem, No blindness, Blindness, No cancer, Cancer, No dementia, Dementia, No deafness, Deafness, No diabetes, Diabetes, No heart problem, Heart problem, No joint problem, Joint problem, No kidney / liver disease, Kidney / liver disease, No learning disability, Learning disability, No mental health condition, A mental health condition, No neurological condition, Neurological condition, No other long-term condition, Other long-term condition
- **ICD10 chapter codes** (for those present in the dataset): see [Appendix I](#) for details
- **Admission route:** Emergency, Elective
- **Case type:** Medical, Surgical
- **Length of stay:** 1 night, More than 1 night
- **Respondent:** If the questionnaire was completed by: Patient, Friend or relative of patient, Patient and friend / relative together, Patient with help of health professional

^o The sum of question scores divided by the number of questions in the composite.

The themes and composite questions are:

Information, communication and education

- **Q30:** Did you know which nurse was in charge of looking after you (this would have been a different person after each shift change)?
- **Q36:** How much information about your condition or treatment was given to you?
- **Q56:** Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?
- **Q63:** Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

Respect for patient-centred values, preferences, and expressed needs

- **Q23:** When you had important questions to ask a doctor, did you get answers that you could understand?
- **Q26:** When you had important questions to ask a nurse, did you get answers that you could understand?
- **Q34:** Were you involved as much as you wanted to be in decisions about your care and treatment?
- **Q39:** Were you given enough privacy when discussing your condition or treatment?
- **Q48:** Did you feel you were involved in decisions about your discharge from hospital?

Emotional support

- **Q37:** Did you find someone on the hospital staff to talk to about your worries and fears?
- **Q38:** Do you feel you got enough emotional support from hospital staff during your stay?

Confidence and trust

- **Q24:** Did you have confidence and trust in the doctors treating you?
- **Q27:** Did you have confidence and trust in the nurses treating you?
- **Q35:** Did you have confidence in the decisions made about your condition or treatment?

Coordination and integration of care

- **Q32:** In your opinion, did the members of staff caring for you work well together?
- **Q54:** After leaving hospital, did you get enough support from health or social care professionals to help you recover and manage your condition?
- **Q61:** Did hospital staff take your family or home situation into account when planning your discharge?
- **Q65:** Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital (e.g. services from a GP, physiotherapist or community nurse, or assistance from social services or the voluntary sector)?

Food choice

- **Q20:** Were you offered a choice of food?

Hydration

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

Respect and Dignity

- **Q67:** Overall, did you feel you were treated with respect and dignity while you were in the hospital?

Overall

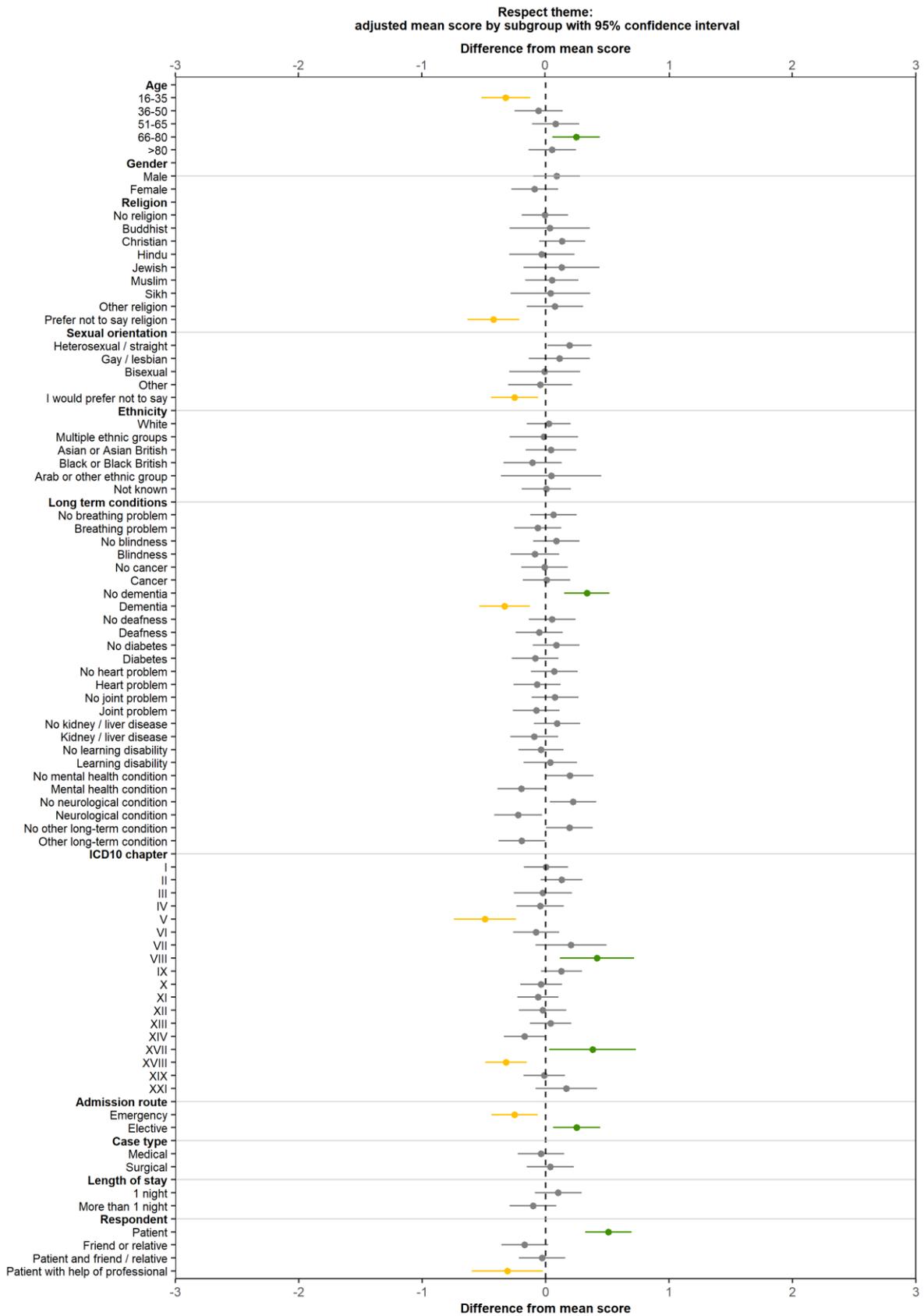
- **Q68:** Overall... (Please circle a number)

Interpreting the charts

In this report, differences that are equivalent to at least 0.1 standard deviations from the overall mean of the target variable are treated as being noteworthy, provided that the confidence interval does not overlap the mean line.

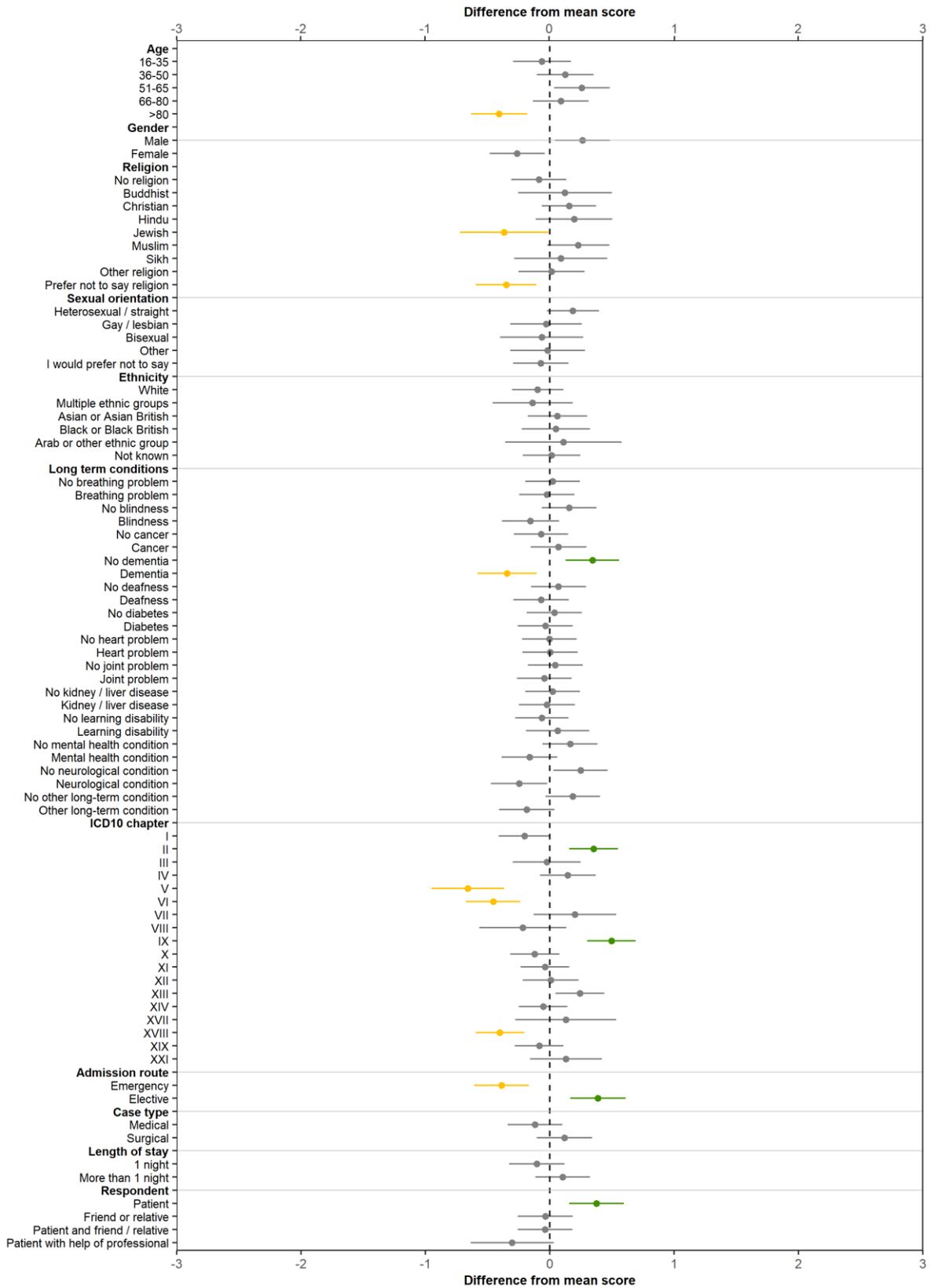
For more information about how the analysis was completed or about the methodology of the subgroup analysis, see [Appendix A](#), section 6.

The graphs in this section highlight better than average experiences that are significant in green. Significantly worse than average experiences are highlighted in yellow.

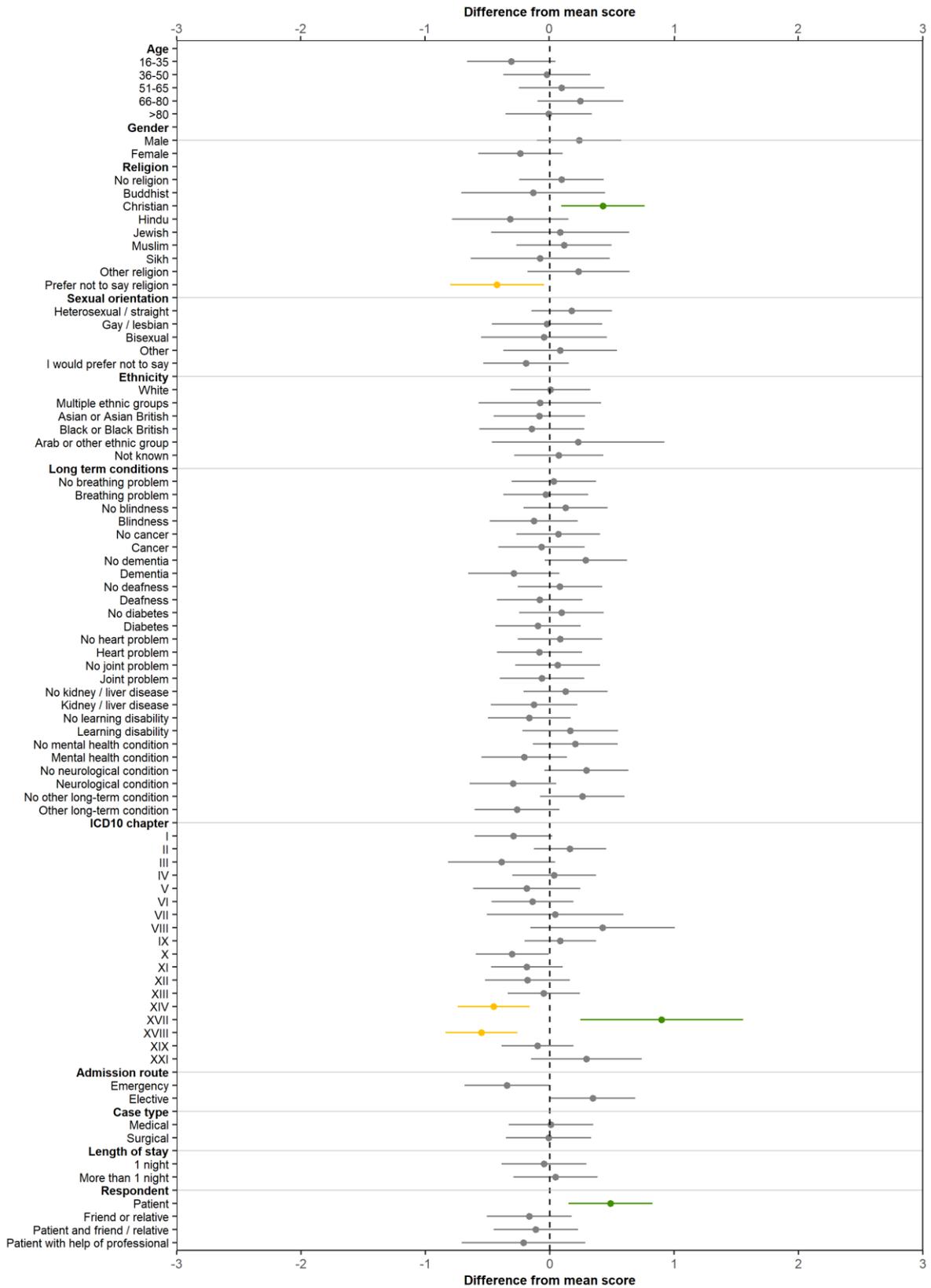


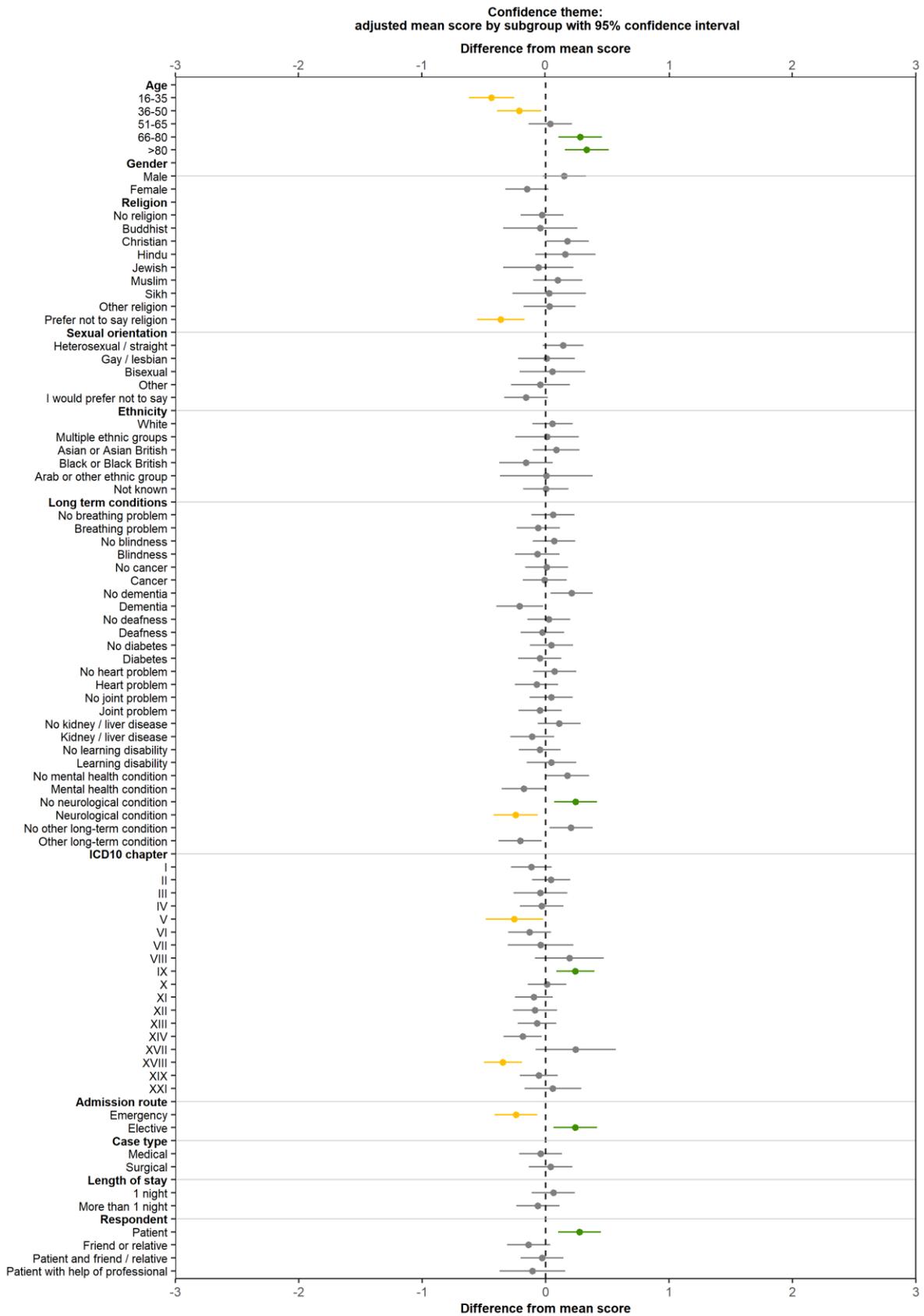


Information theme:
adjusted mean score by subgroup with 95% confidence interval

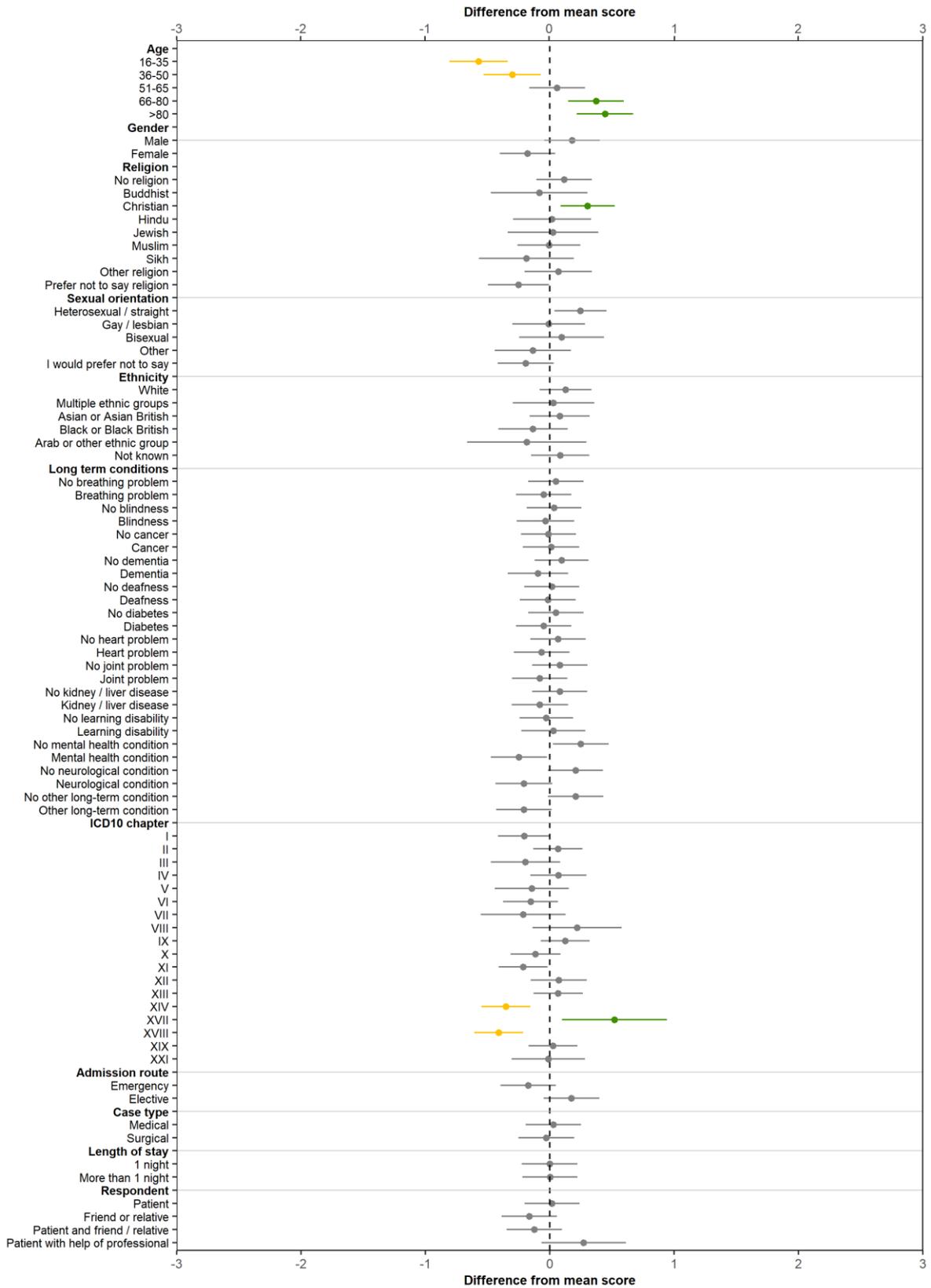


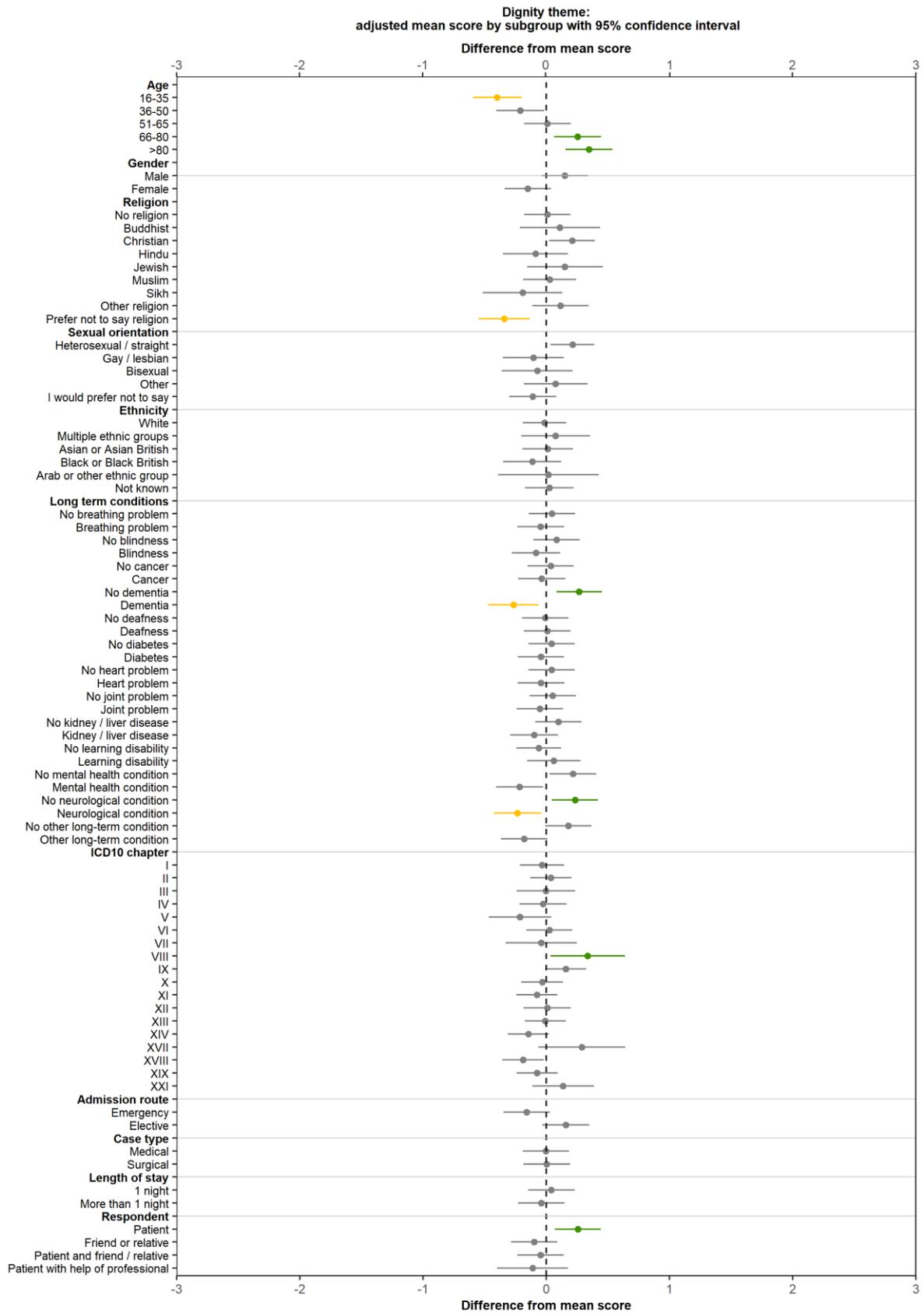
Support theme:
adjusted mean score by subgroup with 95% confidence interval



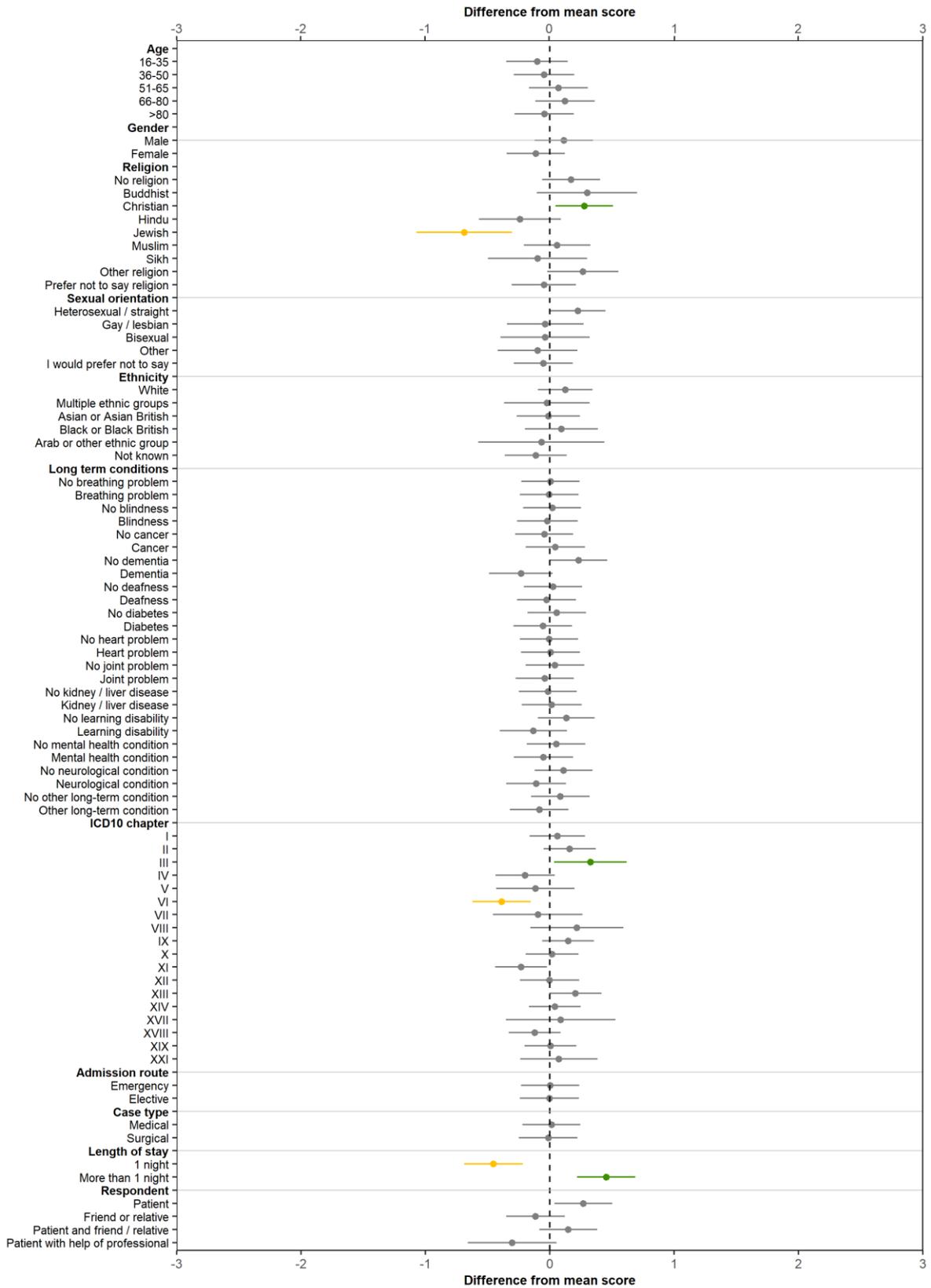


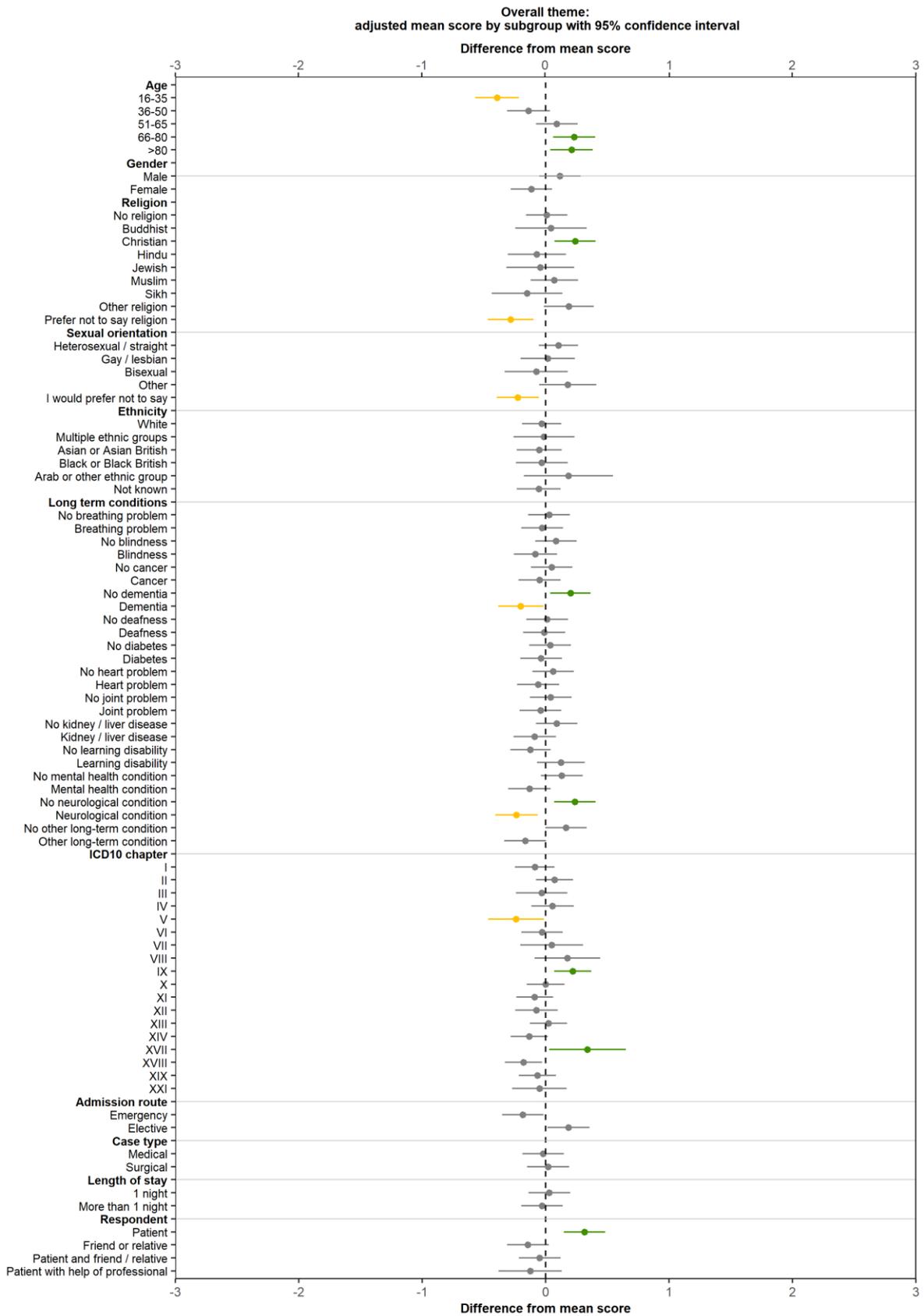
Coordination theme:
adjusted mean score by subgroup with 95% confidence interval





Food Choice theme:
adjusted mean score by subgroup with 95% confidence interval





Appendix I: ICD-10 chapter codes

A new classification of ICD chapter codes (ICD-11) was published in June 2018, including 11 chapters where the former classification included 10 codes. As trusts' patient records were based on the old classification, ICD-10 codes are used in reporting the results of the adult inpatient survey 2019, including for the purpose of computing the subgroup results.

The new ICD-11 classification can be found on the [website](#) of the World Health Organization. The table below presents the ICD-10 chapter codes

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

For more information visit the [World Health Organization's](#) website, or the [ICD-10 User guide](#).

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