

National NHS patient survey programme

Trends in the adult inpatient survey 2005-2014

Statistical release

Published November 2015
Independent data analysis

Contents

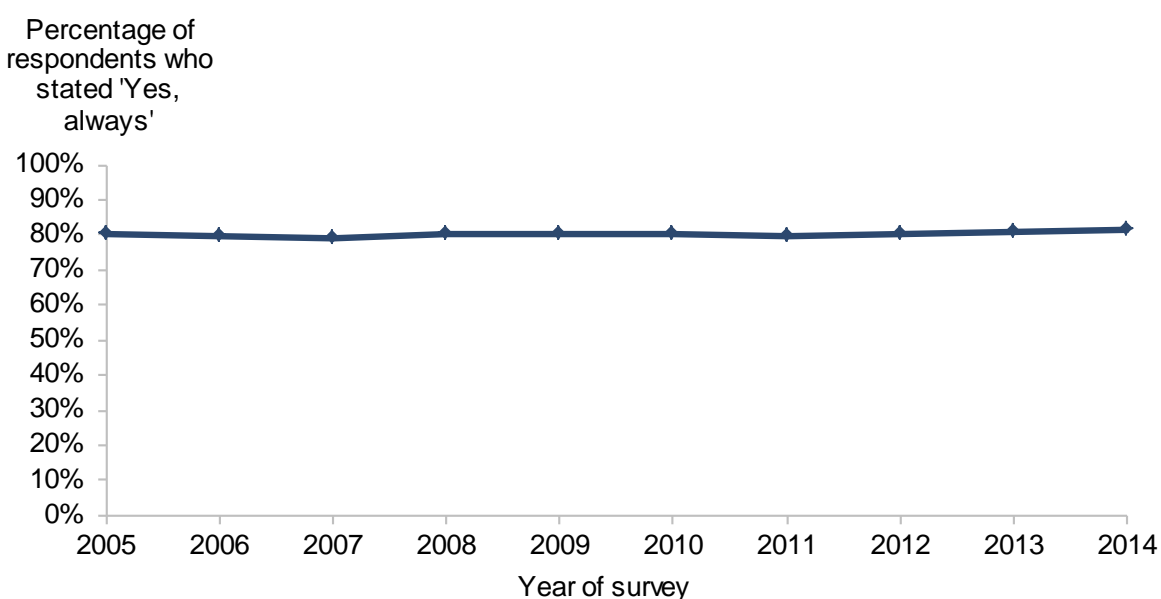
Summary	2
Introduction	6
Key findings	8
Admissions to hospital	8
The hospital and ward.....	9
Leaving hospital.....	14
Patient views on quality of care and treatment.....	16
About the adult inpatient survey	17
Questionnaire design	17
Survey methodology	18
Analysis methodology	19
Further information related to the survey findings	21
Appendix A: UK comparisons	24
Appendix B: Data limitations and revisions	26
Appendix C: Further information and feedback	31

Summary

With 10 years of insight into the experiences of inpatients in the NHS, this report looks back over the data gathered from the annual NHS adult inpatient surveys and focuses on how experiences have changed and where improvements have been made.

The findings show that people's experiences of inpatient care have remained largely consistent over the past decade. Experiences are generally good and have remained steady (for example, 80% of people reported that they were always treated with respect and dignity while in hospital).

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



Where substantial changes are evident, we have looked at corresponding policy introductions, although we are clear that there may be many factors behind such developments.

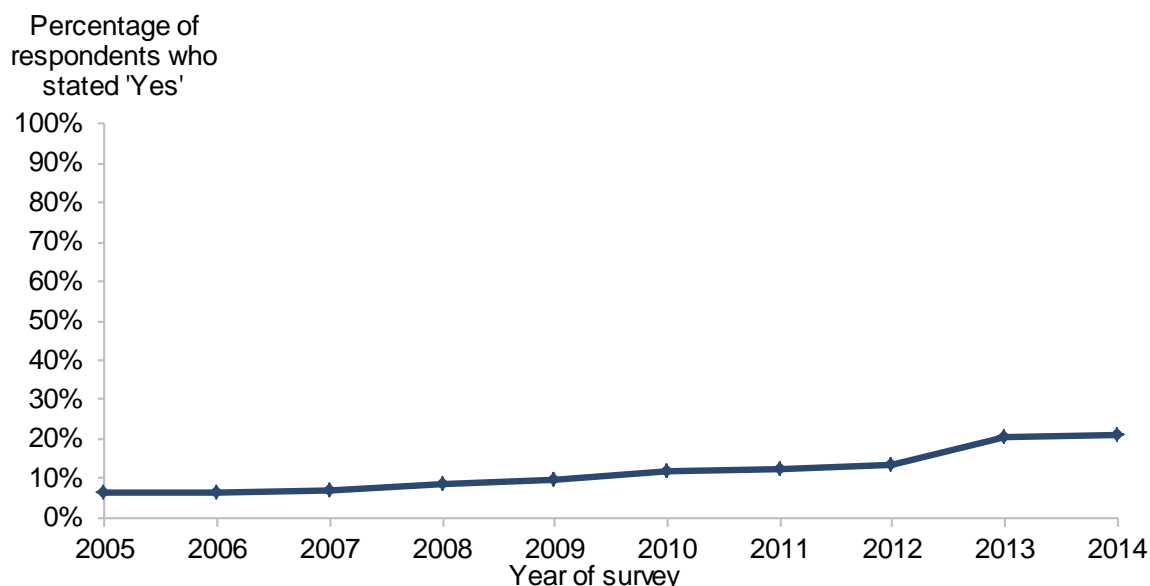
Improvements

The cleanliness of toilets, bathrooms, rooms and wards has significantly improved since 2007, corresponding with the introduction of Patient Environment Action Team (PEAT), Patient-Led Assessments of the Care Environment (PLACE) and the Code of Practice on the prevention and control of infections, under The Health and Social Act 2008.

Since the introduction of single sex accommodation in hospitals in 2007, the proportion of patients who reported that the sleeping and bathroom facilities were gender-specific has greatly increased.

There has also been a noteworthy increase in the proportion of patients who were asked to share their views on the quality of the care they received. This appears to coincide with the introduction of the Friends and Family Test in 2012. However, despite the improvement, latest figures showed that just 21% of respondents had been asked to give their views.

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



There have been slight improvements in the proportions of patients being given clear written or printed information about their medicines, and in those receiving information about what to do after leaving hospital. Both areas saw an increase of 4% between 2011 and 2013. Guidance from the National Institute for Health and Care Excellence (NICE), published in 2012, recommends that patients are given information (verbally and in written format) and that they receive the support and encouragement they need to be actively involved in their own care and to self-manage their conditions.¹ [The NHS Constitution](https://www.nice.org.uk/guidance/cg138/chapter/1-Guidance#tailoring-healthcare-services-for-each-patient) (2012) also makes a commitment to offer patients easily accessible, reliable and relevant information in a form they can understand, and support them to use it.

The survey also asks patients about their interactions with doctors. Since 2010 there has been a gradual and significant reduction in the number of patients who said that doctors talked in front of them as if they were not there.

1. <https://www.nice.org.uk/guidance/cg138/chapter/1-Guidance#tailoring-healthcare-services-for-each-patient>

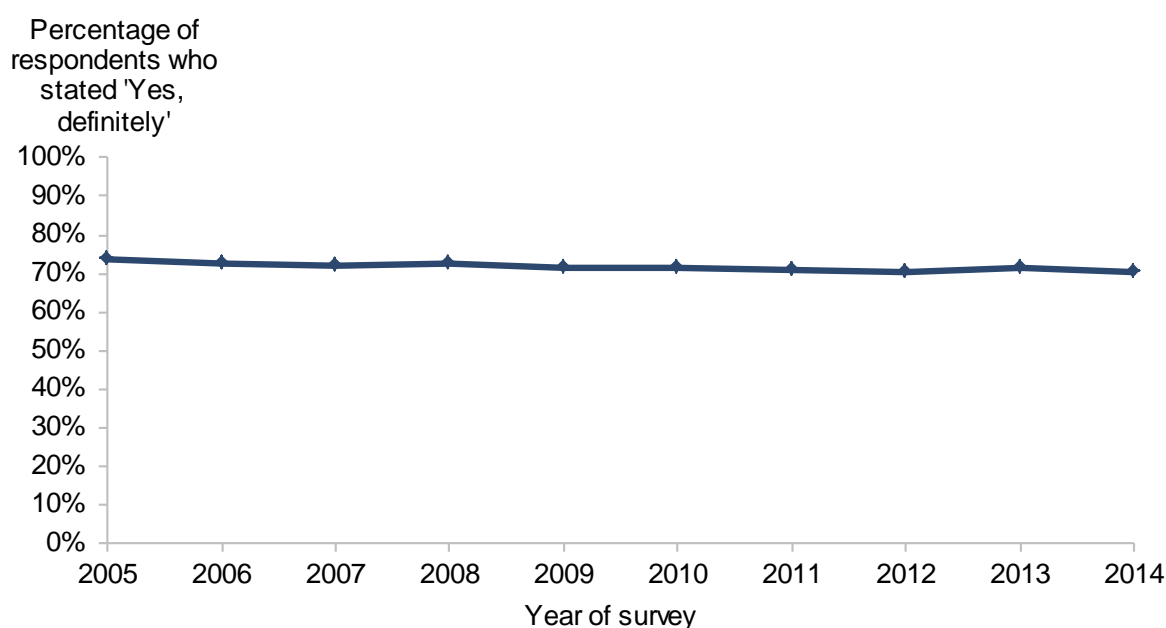
No meaningful change

Most other areas covered by the survey have seen no meaningful change over 10 years.

Patients' confidence and trust in doctors and nurses has not improved, nor has the perception that there are enough nurses on duty to provide adequate care.

Responses to the survey have also indicated that patients have seen little improvement in receiving adequate information before and after operations, having their pain sufficiently managed and experiencing delays to their discharge from hospital.

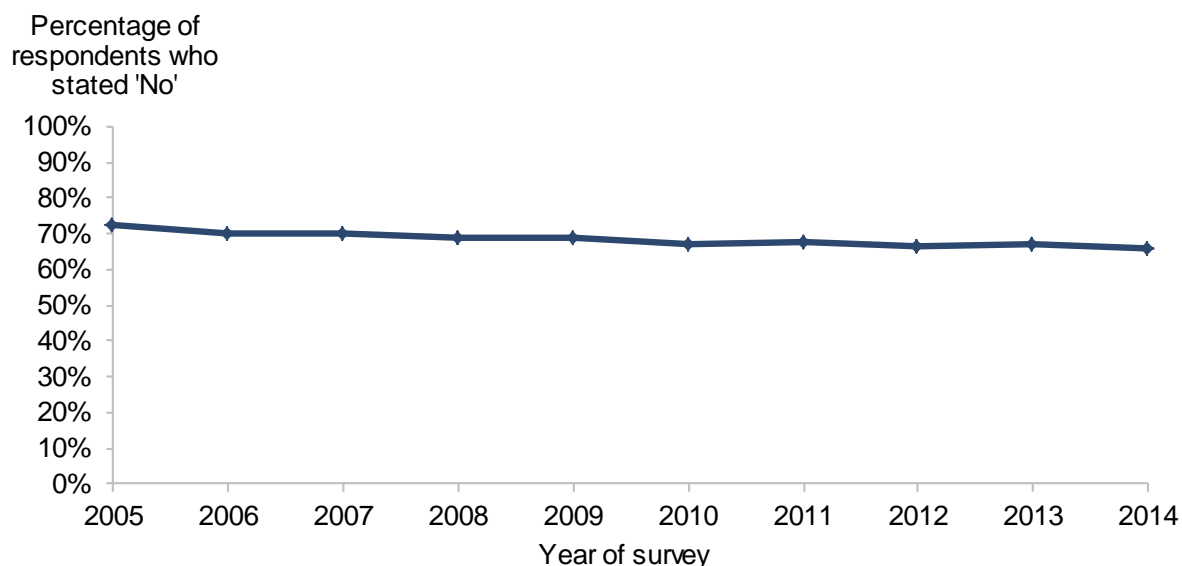
Do you think the hospital staff did everything they could to help control your pain?



Deterioration

Although most areas of patient experience have remained static or showed improvement, patients' perceptions of waiting times deteriorated in multiple areas of the patients' care pathway between 2005 and 2014. For example, the proportion of patients who felt they didn't wait long for a hospital bed has decreased from 72% in 2005 to 66% in 2014.

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



The survey has highlighted that over the last 10 years there has been a continual decrease in the proportion of patients who got the help they needed straight after using the call button.

Additionally, of the patients who reported a delay in being discharged from hospital, more stated that their delay was over an hour. It appears that whilst the proportion of patients experiencing delayed discharges has not changed, the length of the delays has increased.

The survey also highlighted a decrease (4% reduction from 31% in 2010) in the proportion of respondents who said they were offered a choice of hospital for their first appointment.

Introduction

The national inpatient survey is designed to assess the experiences of adults who are admitted to an NHS hospital for care and treatment. Each year the Care Quality Commission (CQC) analyse the responses and present an overview of the findings.

Understanding what a stay in hospital is like for patients who experience planned and emergency admissions provides key information about the quality of services across the country. This understanding can be used to drive improvements both nationally and locally.

This report looks back over data gathered between 2005 and 2014 from the Adult Inpatient Survey and focusses on how experiences have changed and where improvements have been made.

Evidence from academic research suggests that when people are involved in their own care, decisions are made more effectively and health outcomes improve.^{2, 3} The importance of people's experiences and the need to continue to improve is a central theme in various documents, initiatives, policies and quality standards published in recent years. Surveys such as those included in the National Patient Survey Programme are an important way to assess this. For example:

- In [High Quality Care for All](#) Lord Darzi established patient experience as one of the three elements of high-quality care, alongside clinical effectiveness and safety.
- In February 2012 the NHS National Quality Board (NQB) published the NHS Patient Experience Framework.⁴ This evidence-based framework outlines elements that are important to patients' experience of NHS services and is intended to help NHS trusts improve this. Included in this framework are: access to care; respect for people's values, needs and preferences; information and communication, emotional support and involving family and friends. All questionnaires in the National NHS Patient Survey Programme have been designed around this framework.
- Research conducted by the National Institute for Health and Care Excellence (NICE) outlines existing research and provides guidance for healthcare professionals to improve patient experience.⁵
- Improving the experience of people is at the centre of the NHS Constitution. This document sets out the rights to which patients, public, and staff are entitled. The NHS Constitution requires that NHS services reflect the needs and preferences of people using services, their families and their carers. The constitution also

2. www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/people-in-control-of-their-own-health-and-care-the-state-of-involvement-november-2014.pdf

3. <http://bmjopen.bmj.com/content/3/1/e001570.full>

4. www.gov.uk/government/uploads/system/uploads/attachment_data/file/215159/dh_132788.pdf

5. <https://www.nice.org.uk/guidance/cg138>

commits the NHS to encouraging feedback on people's experiences and using this to improve services. Principles from the NHS Constitution underpin all questionnaires in the National Patient Survey Programme.

Research, including that undertaken in the development work for the surveys, has identified the aspects of care that are important to people using services. These include: being informed and offered options; staff listening to them and spending enough time with them; and being enabled to be involved in their own care.⁶ These themes are included in all questionnaires in the National Patient Survey Programme.

This statistical release represents the impartial presentation of trends in the survey over a 10-year period, in adherence to the [Code of Practice for Official Statistics](#). CQC will publish a separate report that outlines our response as the regulator of providers of NHS care.

6. www.institute.nhs.uk/patient_experience/guide/what_matters_to_patients%3F.html

Key findings

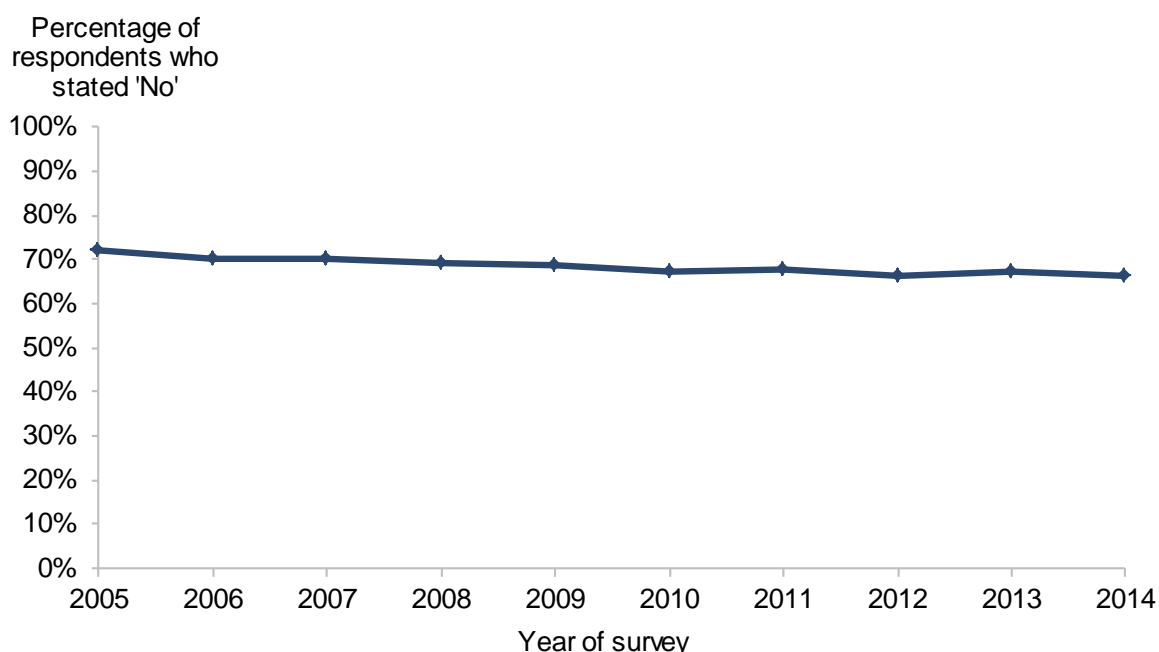
Admissions to hospital

Questions about admissions to hospital allow us to find out about people's experiences from the beginning of their inpatient journey and look at how long people wait to get a bed on a ward.

According to the [NICE quality standard](#), patients should experience care that is tailored to their needs and personal preferences, taking into account their circumstances, their ability to access services and their co-existing conditions. In relation to patient choice, over the last six years less than a third of patients have been offered the opportunity to decide which hospital to receive treatment in. In 2009, 31% of patients were given a choice of hospital for their first appointment. This has steadily decreased year-on-year to 27% in 2014.

Over the last 10 years, there has been a reduction in the proportion of respondents who did not wait long to get a bed on a ward. In 2005, 72% of patients said they did not wait a long time, compared to 66% in 2014 – a significant decrease of 6%. NHS England bed availability and occupancy data⁷ shows that from summer 2010 to summer 2014, bed occupancy rates did not fall below 85% and, in fact, appear to be very slowly rising. This NHS data supports the perceptions of the 34% of respondents in 2014 who said they waited too long for a bed.

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



7. <http://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/bed-data-overnight/>

The hospital and ward

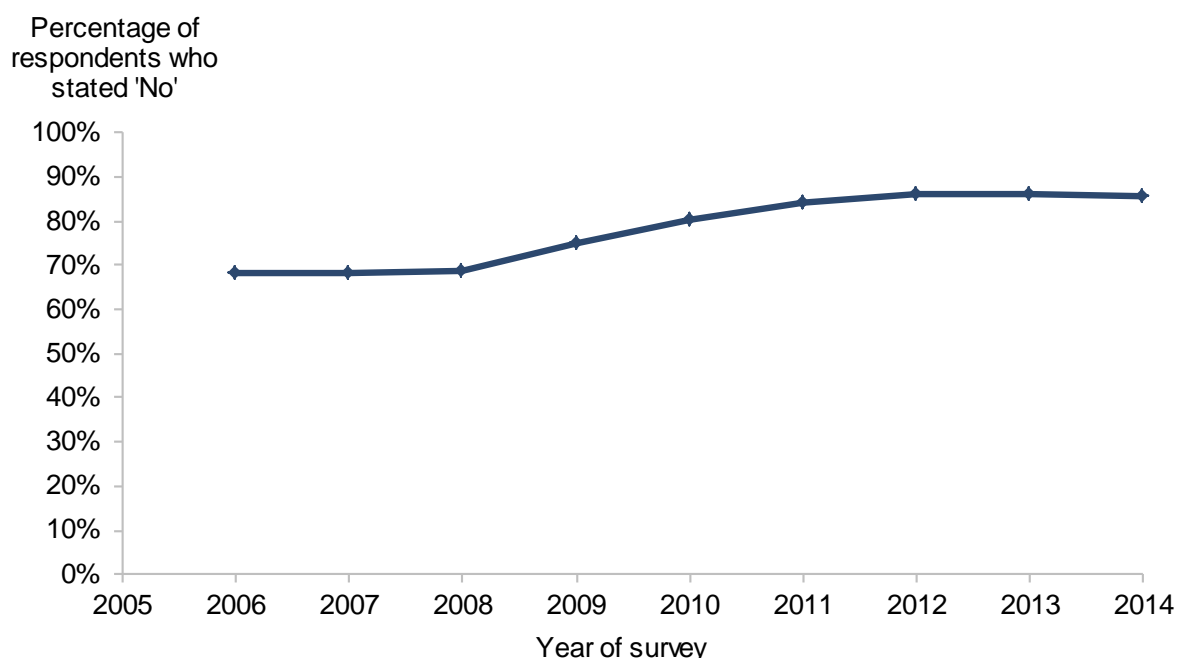
The survey asks patients about their experiences of the hospital ward, including whether they shared accommodation with members of the opposite sex, whether the environment was clean, whether they felt safe and whether the food was satisfactory.

Mixed-sex accommodation

Over the past nine years, there has been a substantial increase in the proportion of patients sharing a sleeping area with only patients of the same sex. Between 2006 and 2014, the percentage of patients sleeping in single sex accommodation rose from 74% to 90%. In 2005, 81% of respondents who were subsequently moved to a different bed were moved to single sex accommodation; rising to 93% in 2014.

Since 2006, the number of patients sharing a bathroom or shower area with only patients of the same sex has increased by 18%. The improvement seen in all these figures is most pronounced from 2008. During this period, the Department of Health launched a Dignity in Care campaign, advocating a zero-tolerance approach to lack of dignity and respect in health and social care services, including mixed sex-accommodation in hospitals.

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



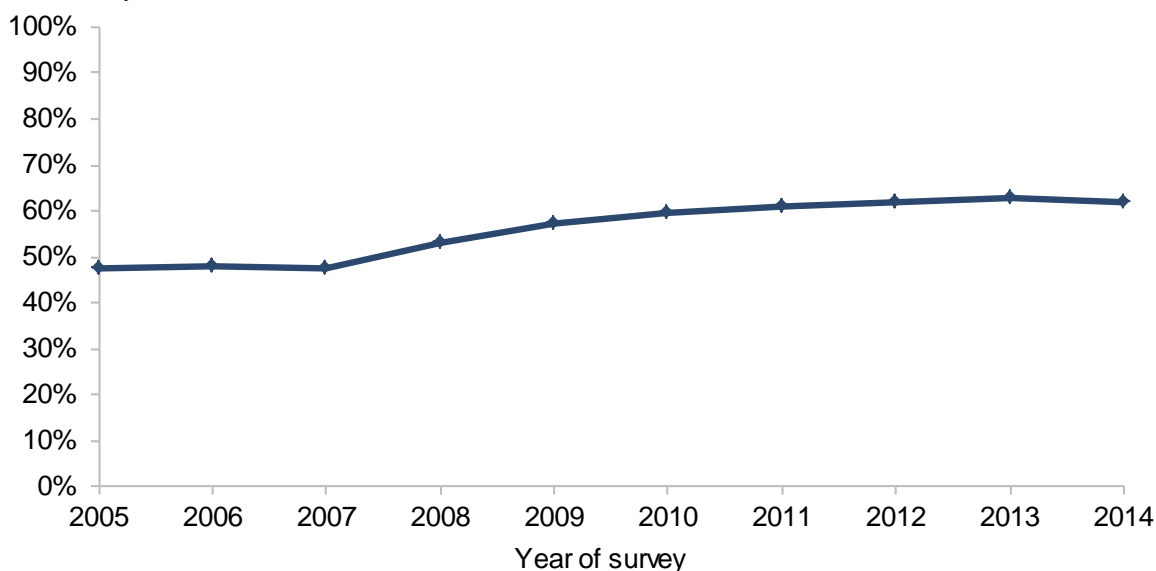
Cleanliness

The Code of Practice on the prevention and control of infections, under The Health and Social Act 2008, prescribes that good infection prevention (including cleanliness) is essential to ensure that people who use health and social care services receive safe and effective care. This description of all activities related to infection prevention and control (IPC) was adopted in response to the consultation on the revision of the code of practice in 2015 to make it clear to non-specialists that cleanliness is an integral part of IPC.⁸

Over the last 10 years there has been a substantial increase in the proportion of patients who consider hospital rooms and wards, as well as toilets and bathrooms, to be 'very clean'. Both measures increased between 14% and 16% from 2005 to 2014. There was a sharp increase from 2007, which coincides with the introduction of the [Patient Environment Action Team \(PEAT\) assessments](#) and national specifications for cleanliness.

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

Percentage of respondents who stated 'Very clean'



The PEAT assessment is a benchmarking tool to ensure that improvements are made in non-clinical aspects of patient care (for example, environment, food, privacy and dignity). The assessment results help to highlight areas for improvement and share best practice across healthcare organisations in England. In April 2013, PLACE was introduced, which is the new system for assessing the quality of the patient environment, replacing the old (PEAT) inspections. The assessments involve local people who go into hospitals as teams to assess how the environment supports

8.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/449049/Code_of_practice_280715_acc.pdf

patients' privacy and dignity, food, cleanliness and general building maintenance. The focus is entirely on the care environment and does not cover clinical care provision.⁹

Feelingsafe

A consistently high level (96%-97%) of patients over the last eight years did not feel threatened by other patients or visitors during their stay in hospital. This is important because [domain 5 of the NHS outcomes framework](#) states that people should be treated and cared for in a safe environment and be protected from avoidable harm.

Food

Since 2005, the number of patients rating hospital food as 'very good' has increased by just 2%. Food is also covered by NHS England's PLACE assessments. Approximately 36% of respondents considered food to be 'good' with a smaller proportion (14%) saying they found the quality of food to be 'poor'.

Doctors and nurses

It is important to patients that staff listen and spend time with them.¹⁰ Patients' experiences are clearly dependent upon their interactions with the staff providing their care.

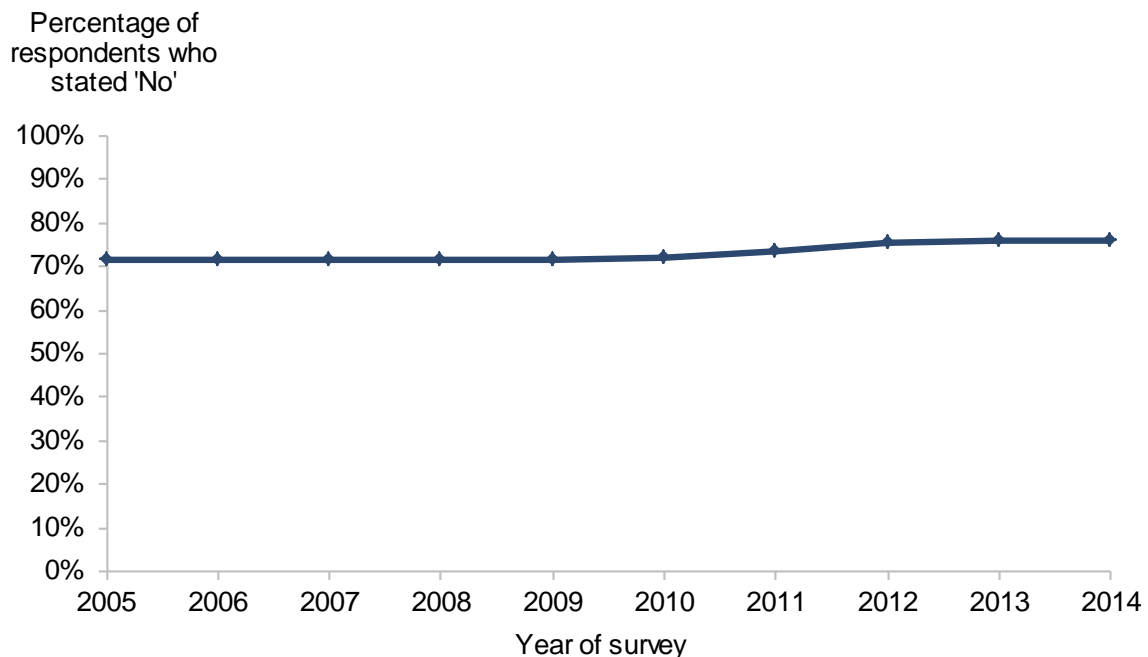
The survey includes questions about patients' experiences of care provided by the doctors and nurses who treated them. Every survey looks at people's involvement in their care and the information people receive, as well as key questions on privacy and how long it took to get help when they needed it.

Between 2005 and 2014, there was a significant increase of 5% (71%-76%) in the number of patients who said that doctors did not talk in front of them as if they were not there. Most of this increase (4%) was evident between 2010 and 2012, after which it has remained stable at 76%. In 2014, the remainder of respondents said doctors 'sometimes' (19%) or 'often' (5%) did this. This compares with 23% and 6% respectively in 2005.

9. <http://www.england.nhs.uk/ourwork/qual-clin-lead/place/>

10. www.institute.nhs.uk/patient_experience/guide/what_matters_to_patients%3F.html

Did doctors talk in front of you as if you weren't there?



In CQC's *State of Care* report (2014/15), it was stated that a major reason NHS trusts are rated inadequate for safety is because of insufficient numbers of staff and the use of temporary staff. While the NHS has seen an increase in the number of nurses employed (just over 319,000 full-time equivalent nurses, midwives and health visitors in March 2015 compared with just under 314,000 in March 2014, and up from just under 312,000 in March 2010), the RCN stated in [The fragile frontline](#), that actual headcount figures have decreased, concluding that fewer qualified nurses are delivering more hours of care than in 2010.

Health Education England said that 8% of organisations reported between 100 and 250 nurse vacancies in January 2014, partly due to a limited pool of qualified nurses to recruit from.¹¹

Between 2005 and 2014, just 56%-60% of patients thought there were always, or nearly always, enough nurses on duty to care for them.

Care and treatment

According to the NICE quality standard, patients should have their physical and psychological needs regularly assessed and addressed. Physical illness can have profound social and emotional consequences. According to the British Medical Association, the psychological and social needs of patients need to be considered and addressed as part of holistic healthcare delivery. In their report [The psychological and social needs for patients](#) report it is recommended that patients are treated with compassion, empathy and responsiveness to needs, values and expressed

11. <http://www.nhsemployers.org/case-studies-and-resources/2014/05/nhs-qualified-nurse-supply-and-demand-survey>

preferences, and that patients are provided with emotional support to relieve fear and anxiety. It is further recommended that doctors listen to patients, ask for and respect their views about their health, and respond to their concerns and preferences. In 2005, 42% of respondents said they could 'definitely' find someone in hospital to talk to about their worries and fears. The figure decreased to 39% in 2014.

Privacy

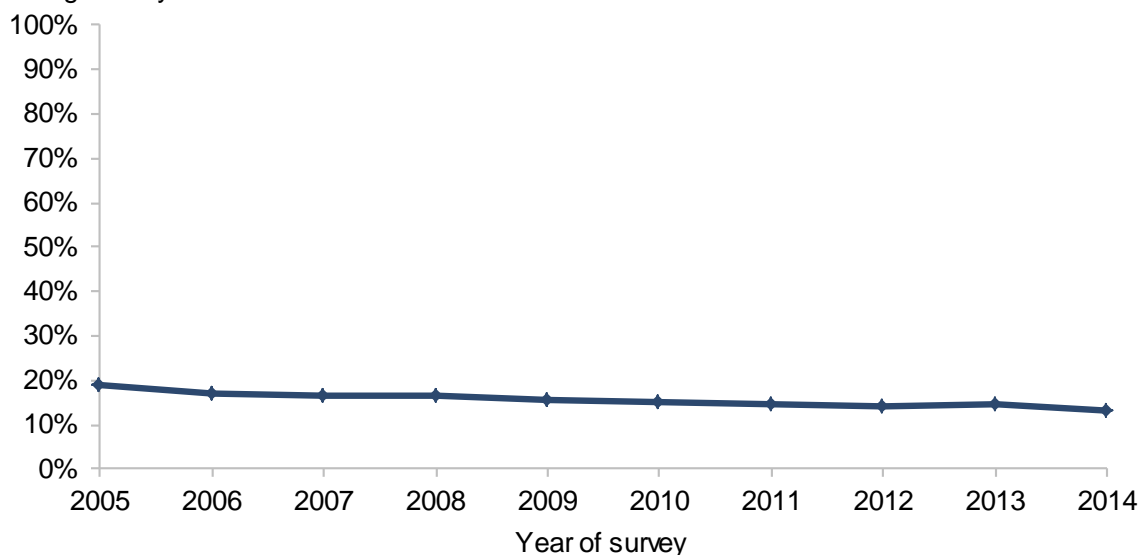
Patients' rights to dignity, kindness, compassion, courtesy, respect, understanding and honesty are set out in NICE quality standards and the NHS Constitution. From 89% in 2005, there has been a very small increase in the proportion of patients who said they were 'always' given enough privacy when being examined or treated (91% in 2014).

Call bell

From 2005 to 2014, there has been a significant decrease of 6% (from 19%) in the number of patients who got the help they needed immediately after using the call button. Most patients received a response within one to five minutes, though over 10 years, waits for help have been getting longer. Previously in this report we highlighted the fact that bed occupancy rates have consistently topped 85%, while in 2010 the Royal College of Nursing reported that nurse staffing levels have not risen to meet extra demand.¹² In 2014, CQC reported that hospital staff themselves were aware of the impact of staffing issues on patients, including concerns that call buttons not being answered promptly represents a safety issue.¹³

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

Percentage of respondents who stated '0 minutes / right away'



12. http://www.rcn.org.uk/_data/assets/pdf_file/0005/353237/003860.pdf

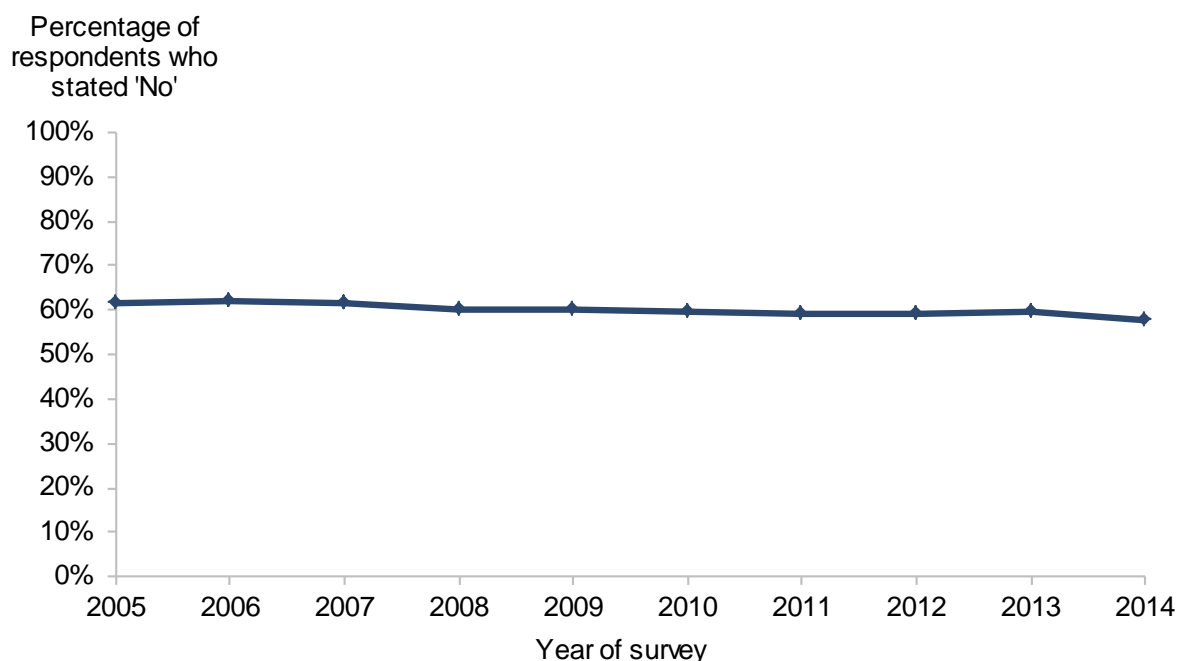
13. <http://www.cqc.org.uk/sites/default/files/state-of-care-201314-full-report-1.1.pdf>

Leaving hospital

It is important to ask patients about their experiences of leaving hospital, how involved they were in the process, and about the information they received at discharge. Adult inpatient surveys also assess how well different services are integrated, for example, by asking about equipment and services that patients may need once they leave hospital. All patients should be involved, as much as they would like to be, in decisions around leaving hospital and should receive the right information and support. Research shows that a structured discharge plan tailored to the individual patient brings about a reduction in length of stay and readmission rates and an increase in patient satisfaction.¹⁴

Between 2005 and 2014, there was a 4% decrease in the proportion of patients whose discharge from hospital was on time (down from 62% in 2005). Most delayed discharges over the entire period were as a result of patients waiting for medicine (approximately 61%). Consistently, a third of delays were between two to four hours long.

On the day you left hospital, was your discharge delayed for any reason?



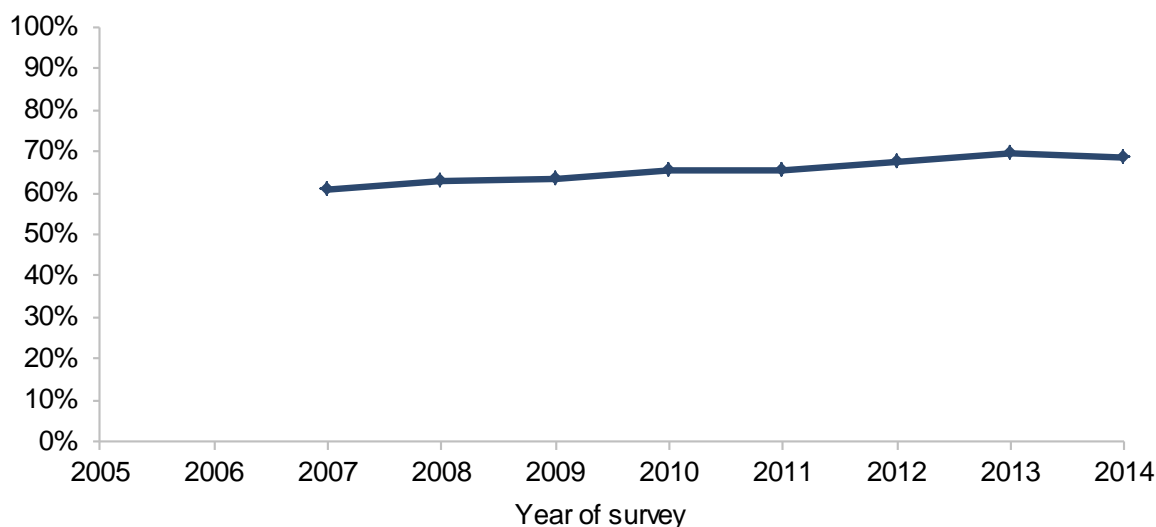
NICE quality standards recommend that patients are made aware of who to contact about their on-going healthcare needs. Since 2007, there has been a steady significant increase of 7% (to 68% in 2014) in the percentage of patients who were given written/printed information about what they should or should not do after leaving hospital.

14.

<http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD000313.pub4/abstract;jsessionid=9934569E14FF4DAD64070B28EE3DD1B8.f04t02>

Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?

Percentage of respondents who stated 'Yes'



NICE guidelines recommend involving patients in decisions about medicines. Since 2005, there has been an increase of 10% (62%-72%) in patients receiving clear written or printed information about their medicines.

The number of patients who were told about the danger signals to watch out for after being discharged has increased from 39% to 44% since 2005.

Since 2010, there has been a significant 5% increase (45%-50%) in patients reporting that doctors or nurses have given the patient's family, or someone close to them, all the information they needed to help care for the patient.

In the NHS Constitution the NHS commits to provide patients with the information and support they need to influence and scrutinise the planning and delivery of services, and to work in partnership with the patient, their family, carers and representatives.¹⁵ NICE guidelines further recommend that hospital staff should clarify with the patient how they would like their partner, family members and/or carers to be involved in key decisions about the management of their condition, if at all.¹⁶

15. <https://www.gov.uk/government/publications/the-nhs-constitution-for-england>

16. <https://www.nice.org.uk/guidance/cg138/chapter/1-Guidance#tailoring-healthcare-services-for-each-patient>

Patient views on quality of care and treatment

The NHS Constitution states that patients have the right to be treated with respect and dignity, and that the NHS should actively encourage feedback. The NICE Quality Standard for patient experience in adult NHS services includes ensuring that patients are treated with dignity and respect.

Since 2005, the proportion of patients who were asked to give their views on the quality of their care increased substantially, rising from 6% in 2005 to 21% in 2014. A sharp increase was evident between 2012 and 2013 (7%), which coincided with the introduction of the Friends and Family Test (FFT) in May 2012 with all trusts using it by May 2013. The test asks patients if they would recommend the services they have used. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience.¹⁷ Most respondents said they are still not asked to give their views. No relationship was identified between respondents reporting that they are being asked to share views on the quality of their care and the downward trend in the survey's response rates. Response rates can be found in [Appendix B: Data limitations and revisions](#). The high increase in 2012 could also be influenced by the launch of the NHS Commissioning Board's Compassion in Practice vision and strategy for nursing, midwifery and care staff in the same year. The vision and strategy's *Working with people to provide a positive experience of care* challenges staff to actively listen to, seek out and act on patient and carer feedback, identifying any themes or issues and ensuring the patient and carer voice is heard.¹⁸

The full open source data to accompany these key findings is available at: http://www.cqc.org.uk/sites/default/files/20151117_inpatient2005-14_open_source_data.ods

17. <http://www.england.nhs.uk/ourwork/pe/fft/>

18. <http://www.england.nhs.uk/nursingvision/>

About the adult inpatient survey

The adult inpatient survey was first conducted in 2002, but started running annually from 2004. The survey is part of a wider programme of NHS patient surveys that cover a range of topics including A&E services, children's inpatient and day-case services, maternity services and community mental health services. People are eligible for the survey if they are aged 16 years or older, spent at least one night in hospital during June, July or August, and were not admitted to maternity or psychiatric units.

We received responses from 702,610 patients, at a response rate of 53% over the 10 years. In 2005, the survey had the highest number of respondents (80,793) with a response rate of 59%. In 2014, the lowest number of people responded (59,083) at a response rate of 47%.

Information drawn from the questions is used by CQC in its assessment of trusts in England. The results are also used by NHS England and the Department of Health for performance assessment and improvement purposes. These include the NHS Outcomes Framework (domain 4: Ensuring patients have a positive experience), the NHS England overall patient experience measure, the NHS Performance Framework, the cross-Whitehall Public Services Transparency Framework and NICE Quality Standards. Results are used by researchers across the country to explore particular areas of interest.

This report complements analyses of long-term trust-level data undertaken by Picker Institute Europe and The King's Fund, which is due for publication in December 2015.

To find out more about the survey and to see the results from previous surveys, please see the web links in [Appendix C](#).

Questionnaire design

The questions selected for this analysis all feature in the 2014 survey and have remained unchanged for the last five years as a minimum. This gives us the opportunity to look beyond year-on-year comparisons and see how results have changed over a longer period.

Over the lifespan of the survey, questions have been amended, added and omitted to stay relevant to the ever-changing and evolving health and social care environment in England. Question content and wording have changed over time in response to feedback from key stakeholders, although requests are always balanced against the need to protect comparability as far as possible.

Where a new question has been added after 2005, analysis presented in graphs and data tables presents data starting from the year when the question was first added to the survey. For this reason, some questions might have missing data in the earliest years, but are presented for all available data points back to 2005 in the graphs.

Survey methodology

In line with other surveys in the NHS Patient Survey Programme, the adult inpatient survey used a postal methodology. However, to ensure that the questionnaire was as accessible as possible, people were able to complete the questionnaire over the phone in a language other than English. Up to two reminders were sent to people who did not respond.

Sampling

NHS trusts can choose to sample patients who used inpatient services in either June, July or August. Samples are selected by including patients counting back from the last day of their chosen month, including every consecutive discharge, up to a maximum of 850 patients (or, for a small number of specialist trusts who could not reach the required sample size, until they had reached 1 January).

Analysis methodology

Method of analysis

This report presents longitudinal data from the adult inpatient survey by examining comparable questions asked over the last 10 years. Results are presented, where possible, back to 2005 and are tested for statistical significance between the periods of 2005-2014 and 2010-2014.

Rounding

The tables present percentage figures rounded to the nearest whole number for each response. However, where response options have been combined and referred to within the text, these are re-calculated for accuracy. Sometimes this means a percentage quoted in the text may not exactly match the figure you would get if you added percentages for two responses together.

The percentage figures in the tables are rounded to the nearest whole number, so the values given for any question will not always add up to 100%.

Filter questions

Not all of the questions in the survey were intended to be answered by all respondents. Some questions were not applicable to everyone. For example:

42. During your stay in hospital, did you have an operation or procedure?

1 Yes

→ Go to 43

2 No

→ Go to 50

Weights/standardisation

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

To enable fairer comparisons between years, data was standardised to account for demographic differences in respondents. We adjusted the data using age group, gender and route of admission; these variables were chosen because they independently influence experiences reported by patients, and also to control for demographic changes over survey years. All data points were adjusted to the age, gender and admission route profile of respondents in 2014 (for example, this will then ensure that factors such as an aging population has been accounted for and is not impacting results).

Statistical significance

Statistical tests were used on the data to determine whether there had been any statistically significant difference in the results for 2005-2014 and 2010-2014 (a 'z-test' set to 95% significance was used to compare data between the two years). A statistically significant difference means that the change in the results is very unlikely to have occurred by chance. At the bottom of each chart, there is a note stating whether there has been a 'statistically significant' difference.

In some tables, the note suggests that there has been a significant change but the results look the same. This is because although the analysis was carried out on data to several decimal places, results presented in the tables have been rounded up or down to a whole number. If the results were presented to a number of decimal places, it would show a small observable difference. Some of the changes in the results are very small, but because of the large number of respondents, they are statistically significant.

Further information related to the survey findings

NHS National Outcomes Framework Indicators

The NHS Outcomes Framework indicators form part of the NHS Outcomes Framework. These indicators have been designed to provide national-level accountability for the outcomes the NHS delivers and drive transparency, quality improvement and outcome measurement throughout the NHS. They do not set out how these outcomes should be delivered; it is for NHS England to determine how best to deliver improvements by working with Clinical Commissioning Groups (CCGs) to make use of the tools at their disposal.¹⁹

For more information the NHS Outcome Framework please visit the Health & Social Care Information Centre and GOV.UK websites:

<http://www.hscic.gov.uk/nhsf>

<https://www.gov.uk/government/publications/nhs-outcomes-framework-2015-to-2016>

Waiting times

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

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:

www.england.nhs.uk/statistics/statistical-workareas/hospital-activity/quarterly-hospital-activity/.

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

Mixed sex accommodation

For further information on breaches on mixed sex accommodation please see NHS England's statistical release. The data includes all breaches to mixed sex accommodation including by provider on a monthly basis:

www.england.nhs.uk/statistics/statistical-workareas/mixed-sex-accommodation/msa-data/.

The data does not measure people's experiences of accommodation and is not directly comparable.

¹⁹ <http://www.hscic.gov.uk/nhsf>

Counts of nurses

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

The data includes the count of total qualified nursing staff:

www.hscic.gov.uk/catalogue/PUB16973.

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 not directly comparable. The data includes the count of patients with a delayed transfer of care and information on the cause of those delays:

www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/.

Why we ask the questions

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

Quality standard for patient experience in adult NHS services

For further information on the NICE quality standard, please see the link below.

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

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. The 14 quality statements are listed below:

1. Patients are treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty.
2. Patients experience effective interactions with staff who have demonstrated competency in relevant communication skills.
3. Patients are introduced to all healthcare professional involved in their care, and are made aware of the roles and responsibilities of the members of the healthcare team.

4. Patients have opportunities to discuss their health beliefs, concerns and preferences to inform their individualised care.
5. Patients are supported by healthcare professionals to understand relevant treatment options, including benefits, risks and potential consequences.
6. Patients are actively involved in shared decision making and supported by healthcare professionals to make fully informed choices about investigations, treatment and care that reflect which is important to them.
7. Patients are made aware that they have the right to choose, accept or decline treatment and these decisions are respected and supported.
8. Patients are made aware that they can ask for a second opinion.
9. Patients experience care that is tailored to their needs and personal preferences, taking into account their circumstances, their ability to access services and their coexisting conditions.
10. Patients have their physical and psychological needs regularly assessed and addressed, including nutrition, hydration, pain relief, personal hygiene and anxiety.
11. Patients experience continuity of care delivered, wherever possible, by the same healthcare professional or team throughout a single episode of care.
12. Patients experience coordinated care with clear and accurate information exchange between relevant health and social care professionals.
13. Patients' preferences of sharing information with their partner, family members and/or carers are established, respected and reviewed throughout their care.
14. Patients are made aware of who to contact, how to contact them and when to make contact about their on-going healthcare needs.

Appendix A: UK comparisons

Scotland and Northern Ireland also conduct surveys of inpatients, details of which can be found below. A similar survey is not currently undertaken in Wales.

Scotland

The results of the latest Scottish Inpatient Patient Experience survey were released on 26 August 2014. This survey was sent in January 2014 to a random sample of people aged 16 years or older who had an overnight hospital stay between April and September 2013. The 2014 survey was the fourth inpatient survey, with previous ones having been conducted in 2010, 2011 and 2012. The survey asks about patients' experiences of: admission to hospital; the hospital and ward environment, care and treatment including errors, operations, hospital staff, arrangements for leaving hospital, and care and support services after leaving hospital.

Overall, patients reported a positive experience from the 2010 to 2014 period, with 'overall' ratings improving for all but one section of the survey (care and support services after leaving hospital), which itself stayed the same.²⁰

Longer term comparisons are not possible at this time. The surveys are not directly comparable over the long term, as they reflect people's experiences of different healthcare systems using different methodologies and questions. Although the measures are not directly comparable to the equivalent question in the inpatient survey questionnaire, comparing some similar questions can provide useful context in limited areas. For example:

Privacy

The question '**Were you given enough privacy when being examined or treated?**' was asked to patients in both the CQC's Adult Inpatient survey and the Scottish Inpatient Patient Experience, but with different response options.

In the Scottish survey the result between 2010 and 2014 was that on average 94% of respondents "Strongly agree" or "Agree". In the CQC's survey on average we have, 98% for "Yes, always" or "Yes, sometimes" in the same period.

The question '**Were you given enough privacy when my condition and treatment was discussed?**' was also asked in both surveys with different response options. In the Scottish survey the result between 2010 and 2014 was that on average 87% of respondents "Strongly agree" or "Agree" with the question. In the CQC's survey, 93% of the respondents answered "Yes, always" or "Yes, sometimes".

²⁰ <http://www.gov.scot/Topics/Statistics/Browse/Health/InpatientSurvey>

Doctors and nurses

For the question in the Scottish survey '**Doctors didn't talk in front of me as if I was not there?**', on average 80% of respondents answered "Strongly agree" or "Agree" between 2010 and 2014. In the CQC survey 75% of respondents answered "No" to the questions '**Did doctors talk in front of you as if you weren't there?**'

For the question in the Scottish survey '**Nurses didn't talk in front of me as if I was not there?**', on average 83% of respondents answered "Strongly agree" or "Agree" between 2011 and 2014. In the CQC survey 80% of respondents answered "No" to the question '**Did nurses talk in front of you as if you weren't there?**'

More information on the Scottish Inpatient Patient Experience survey is available at: www.careexperience.scot.nhs.uk/index.html.

Northern Ireland

The first Inpatient Patient Experience Survey was undertaken in Northern Ireland in 2014.²¹

Longer term comparisons are not possible at this time.

More information on the Northern Ireland Inpatient Patient Experience survey is available at: www.dhsspsni.gov.uk/index/statistics/safetyquality/patient-experience.

21 <http://www.dhsspsni.gov.uk/index/statistics/safetyquality/patient-experience>

Appendix B: Data limitations and revisions

Data limitations

This appendix sets out data limitations and revisions impacting on England level results. A different technique is applied to analyse NHS trust data and standardised scores are provided at NHS trust level. A technical document is published setting out the methodology used for the trust scores (please see further information section, [Appendix C](#)).

As with any survey, statistics based on results from the inpatient survey are subject to different sources of error and these needs to be considered in the responses to the survey and/or the design of the survey. Although there are a number of potential sources of error, these are carefully controlled through rigorous development work in both the design of the questionnaire and sampling strategy, and extensive quality assurance at every stage. These statistics relate to people who used NHS inpatient services at a particular point in time and the results are an indication of the average or typical quality of experience for that population.

Seasonal effects

The sampling period for the Adult Inpatient Survey has remained the same since the 2005 Adult Inpatient Survey. Each participating organisation selects patients who were discharged from hospital on or before the last day of June, July or August. The vast majority of respondents were treated during this period, although in some smaller trusts the sample period also covered earlier months. Trusts are always asked to retain the same sampling month as previous years for purposes of consistency.

Given that patients are discharged during summer months, it is possible that experiences may differ from patients staying in hospital at other times of the year, over the winter months for example when there can be more pressures on the system than at other time of the year. Winter pressures in the NHS come every year but despite planning the NHS faces considerable challenge. It is not simply about A&E attendances, which are at their lowest in the winter months. The major issue centres on emergency admissions and the number of people requiring hospital care predominantly with respiratory conditions or decompensating other conditions.²² Inpatient surveys conducted during 2002 and 2004 sampled patients during September, October and November with results in line with the 2005 survey.²³

²² <https://www.england.nhs.uk/statistics/tag/winter-pressures/>

²³ http://www.nhssurveys.org/Filestore//Inpatient_2005/Key_Findings_Report_for_the_2005_Inpatient_Survey.pdf

Response rates

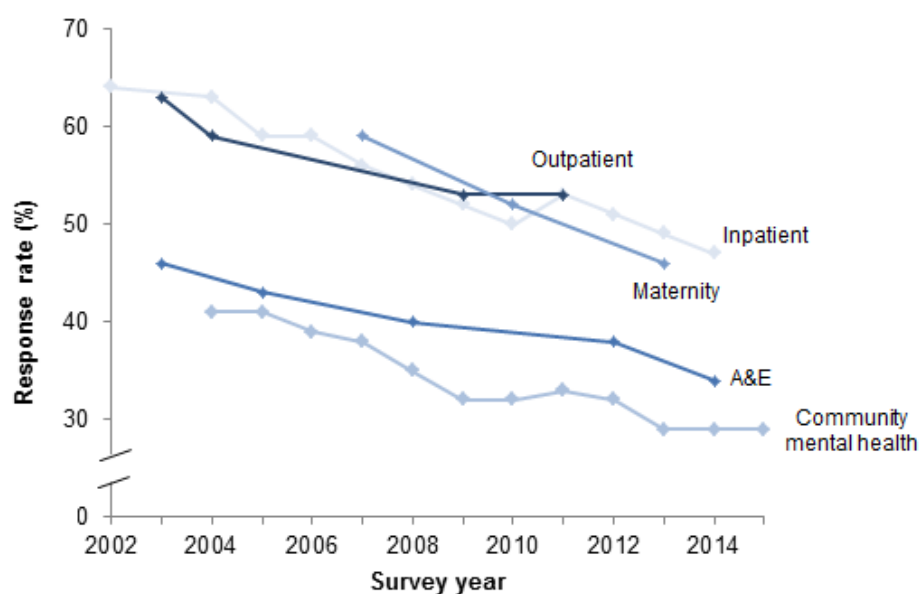
Response rates within the Adult Inpatient Survey 2005-2014

Year	Response rate	
	Count	%
2005	80,793	59
2006	80,694	59
2007	75,949	56
2008	72,584	54
2009	69,348	52
2010	66,348	50
2011	70,863	53
2012	64,505	51
2013	62,443	49
2014	59,083	47

Response rates for the survey have dropped since it was first launched. This is consistent both with other surveys in the National Patient Survey Programme and industry wide trends in social and market research.

Figure 1 below illustrates response rate trends for the more established surveys in the National Patient Survey Programme. Please note that not all types of surveys have been carried out annually. There is a clear downwards trend across all surveys. The acute inpatient survey generally has the highest response rates and the community mental health and A&E surveys the lowest. The English Adult Inpatient Survey has response rates equivalent to the Scottish Inpatient Patient Experience Survey.

Figure 1. Response rates within the NHS Patient Survey Programme



Pilot study to improve response rates

A pilot study is being run alongside the 2015 survey to test two methods (pre-approach letters and a re-designed questionnaire) that may help to boost response rates. The response rate for the inpatient survey has slowly declined since 2005 and, if the pilot study provides evidence of their efficacy, the new methods could be included as part of the standard survey protocol in future years.

Pre-approach letters will be sent out approximately two weeks before participants receive their first survey mailing.

Non-response bias

One of the main issues that affect the survey results is non-response bias.

As the response rates for surveys decline, the risk of *non-response bias* increases. Non-response bias is caused when sampled individuals are unwilling to take part in a survey, causing the risk that those who chose to respond are different from those who chose not to respond. This type of bias might arise, for example, *if* people with more negative views of the service were more likely to respond.

However, it is difficult to assess whether we do have non-response bias, as we do not have any way of knowing how those people who did not respond would have answered.

A further factor is that we do not always know the split between those who did not receive a questionnaire, and therefore could not respond, versus those who chose not to respond. The number of questionnaires that were 'returned undelivered' was logged during the course of the survey. However, there may be another group of individuals who had changed address but not informed the trust, and therefore did not receive the questionnaire. When logging the outcome of sending a questionnaire, those individuals are placed in the group 'Outcome unknown', alongside others who have chosen not to return the questionnaire nor notify us of their decision not to. For that group, we cannot determine whether each individual received a questionnaire or not. Therefore an unknown proportion of the samples from trusts have chosen not to respond – and they may have a variety of reasons for doing so.

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

Sample error

The sample for the inpatient survey is of consecutive discharges from the chosen sampling month and counting backwards to achieve a sample size of 850. NHS records are large enough to minimise any *sampling error* (for example, errors arising, by chance, by selecting a set of patients who happened to have a more positive experience). The number of received responses is also large, usually around 60,000

for the Inpatient Survey, and sufficient to ensure that sampling error is very small. This sampling approach approximates a 'simple random sample' and can be considered representative of the population of all inpatients, providing the sample period is not atypical. This is unlikely given the size of samples selected. The risk of sample bias is therefore small.

The chances of *sampling mistakes* being made by NHS trusts (for example, mistakes arising due to incorrect sampling, such as by accidentally excluding certain patients) are minimised by multi-stage sample checks. Trusts receive a checklist to review their drawn sample. Those trusts that appoint an 'approved contractor'²⁴ to undertake the survey on their behalf will have their sample reviewed by this company. Finally, all samples are checked by the Survey Co-ordination Centre at the [Picker Institute Europe](#), who will look for extraordinary errors that are more noticeable when pooling data together (for example, unusual or skewed age distributions). A report of these errors is produced each year and is published on the [NHS surveys website](#).²⁵ Trusts and approved contractors are encouraged to review this report to minimise recurrence of previously detected errors.

The report shows that the incidence of both major and minor errors has decreased since centralised sample checking was introduced in 2006. In 2014, a 'sampling checklist and declaration form' was introduced, which trusts are required to sign and submit with their sample. As well as helping to ensure that trusts have followed the sampling methodology as specified in the survey guidance, this form also helps to ensure that trusts maintain confidentiality by taking the required steps as specified in the guidance, such as only sharing the required variables.

When errors in drawing samples are identified, the CQC Surveys team and the Survey Co-ordination Centre at the Picker Institute Europe examine all relevant detail to determine whether the error should be classed as 'minor' or 'major'. Minor errors mean that the data can be included in the full dataset, and trust level report. Major errors will automatically lead to data being excluded for the relevant trust, due to the scale of the effect on data quality and comparability.

Survey method

In terms of the design and implementation of the survey, a number of steps are taken to ensure its robustness. As with all surveys in the NHS patient survey programme, as well as consulting with relevant policy stakeholders (for example, NHS England, NHS trusts) patient involvement is fundamental to the design and development of a new questionnaire, or new questions. This helps to ensure that the content of the questionnaire reflects not only the requirements of stakeholders but also what is important and meaningful to patients.

Questionnaires are cognitively tested with patients to ensure that questions are understood as intended. Pilot studies are also undertaken if needed (such as during

24 These are companies that have been approved by the Care Quality Commission during a competitive tendering process to carry out surveys in the National Patient Survey Programme on behalf of NHS trusts. For more information please see: www.nhssurveys.org/approvedcontractors.

25 This website hosts all survey materials (questionnaires, covering letters, guidance manuals etc.) for all current and past surveys as well as results from previous surveys and development reports.

the development of a new survey) to test either the full methodology or the sampling approach. There is an ongoing programme of pilot work to test different approaches with the aim of increasing response rates and improving participation, particularly from groups known to be less likely to respond.

All surveys follow a strict methodology as specified in the survey guidance manual, which all trusts (or the contractors they appoint to run the survey on their behalf) must follow. Any deviation from the survey guidance, depending on severity, may result in data being excluded from published results.

Revisions

CQC publishes a [Revisions and Corrections Policy](#) relating to these statistics. The National Patient Experience Survey data is not subject to any scheduled revision as they capture the views of patients about their experiences of care at a specific point in time. All new survey results are therefore published on CQC's website and NHS Surveys, as appropriate, and previously published results for the same survey are not revised. This policy sets out how CQC will respond if an error is identified within this and it becomes necessary to correct published data and/or reports.

Appendix C: Further information and feedback

Further information

The full national results are on CQC's website, together with an A to Z list to view the results for each trust (alongside the technical document outlining the methodology and the scoring applied to each question):

<http://www.cqc.org.uk/content/inpatient-survey-2014>

The trust results for the adult inpatient surveys from 2002 and 2004-2013 are available at:

www.nhssurveys.org/surveys/425

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

www.nhssurveys.org/surveys/767

More information on the programme of NHS patient surveys is available at:

www.cqc.org.uk/public/reports-surveys-and-reviews/surveys

Further questions

This trend analysis has been drafted by CQC's Survey Team based on analysis conducted by the Survey Co-ordination Centre at Picker Institute Europe. If you wish to contact the Team directly, please contact Paul Williamson, User Voice Development Manager, Patient.Survey@cqc.org.uk.

Please contact us if you would like to receive updates on the programme and contribute to developing the programme in the future.

Feedback

If you have any views, comments or suggestions on how we could improve this publication, please contact Paul Williamson, User Voice Development Manager, Patient.Survey@cqc.org.uk.

CQC will review the information you provide and use it, as appropriate, to improve the statistics that we publish across the National Patient Survey Programme.

How to contact us

Call us on: **03000 616161**

Email us at: enquiries@cqc.org.uk

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

Write to us at: Care Quality Commission
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Follow us on Twitter: [@CareQualityComm](https://twitter.com/CareQualityComm)

Please contact us if you would like a summary of this document in another language or format.