

NHS Patient Survey Programme

2018 Adult Inpatient Survey

Statistical release

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Independent data analysis

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Summary of findings

The 2018 adult inpatient survey received feedback from 76,668 patients across England who received inpatient care in an NHS hospital during July 2018. The response rate was 45%, which is an increase from 2017 (41%).

The survey covers a variety of issues such as communication with staff, patients feeling involved in decisions, emotional support and being informed about the next steps in their care. The aim of this research is to give a snapshot of care solely through patients' eyes, which makes it a unique indicator of quality. The survey has been running for 15 years, but every year brings a new perspective. In this year's survey there have been more emergency admissions (69% of patients), a percentage which has been steadily rising since 2009 (61%). Fewer patients are having operations while in hospital (56% in 2018, compared to 64% in 2009). We are also seeing more patients with long-term conditions participating in the survey.

The results show that many aspects of patient experience have remained relatively stable in the past 10 years. For example, trust in doctors and nurses remains relatively high, most patients (over 90%) report that they had enough privacy, and communication between patients and staff remains a positive experience for most. In other areas, such as waiting times (both at admission and discharge), information given to patients when leaving the hospital and medicines management, results are stagnant or declining. This year we are seeing declines of one to two percentage points across many themes since last year. Further, we are seeing lots of movement from the most positive responses to many questions across the survey (for example, "yes, definitely") to the middle options (for example "yes, to some extent", or "yes, sometimes"). Taken in isolation, these may not seem significant, but when seen across the board, it raises the question of whether there are wider shifts at play.

While last year we reported on a system still delivering improvements in patients' experiences despite growing pressure, this year, the improvement is not sustained. In 2018, there is a lot of evidence to suggest that pressure on the system is having a real impact on patients' experiences of care.

We also analysed results to check for variation in experience between different groups of patients. In four of the nine themes in the subgroup analysis (including information, communication and education, emotional support, respect for patient-centred values, and confidence and trust), emergency patients reported poorer experiences than patients whose admission was planned. As in 2017 and 2016, patients with a mental health condition are reporting poorer experiences during their inpatient stay. Patients with dementia, Alzheimer's and those with an ICD-10 code of V (mental and behavioural conditions) also reported poorer than average experiences, particularly around 'respect for patient-centred values'. Younger patients (under 50 years old) were more negative about most aspects of their care.

Positive findings

Results show that relationships with the medical and nursing staff are usually positive. Overall, doctors answered patients' questions in a way that they understood; 66% of respondents said they "always" got answers for important questions they understood from doctors, and 27% said they "sometimes" did. From nurses, 68% of respondents said they "always" got answers they understood. However, it should be noted that though results are generally positive in the area of communication, we have seen a shift this year from the most positive, or 'top box' response ("yes, always") to the 'middle' response ("yes, sometimes"). For both doctors and nurses, the top box option for this question is down one percentage point from 2017, and the middle response option is up one percentage point from last year.

Those who had an operation or procedure reported that staff provided clear answers when they had questions (80% of respondents said members of staff answered their questions "completely" in a way they could understand). Though this is one percentage point lower than 2017, it is the second year in a row that the top box answer is above control limits, which indicates a sustained change over time.

The survey shows that the fundamental needs of most patients are being met in terms of food, hydration, rest and privacy. Patient satisfaction with hospital food has improved over the years, with the proportion of those saying that it was "very good" increasing from 19% in 2009 to 23% in 2018. We also found that patients who stayed more than one night in hospital reported better experience of food.

The proportion of patients who were not bothered at night by noise from hospital staff remains high at 80%, and further analysis shows that there have been small but meaningful changes in terms of noise reduction on wards since 2009.

Respondents reported that they had enough privacy when being examined or treated either in the accident and emergency (A&E) department or on wards, which is unchanged since last year. Only 2% of respondents reported not being given enough privacy in both contexts.

Areas for improvement

Most results for the 2018 adult inpatient survey have slightly declined since last year, or remained static. However, there are key areas that consistently show poor patient experience, including waiting times (admission and discharge) the quality of information and involvement around hospital discharge, and experience of integrated care.

Waiting times

At admission and discharge, patients are reporting long waiting times. In 2018, 39% of respondents felt they had to wait a long time before getting a bed. Sixteen per cent "definitely" felt they had a long wait after arriving at hospital, 23% said this was true "to some extent" (both are small increases since 2017). For patients whose admission was planned, 72% considered that they had been admitted as soon as they thought was necessary. This figure is decreasing over time (75% in 2009, 74% in 2017), and mirrors the increase of patients saying they should have been admitted "a lot" sooner.

Over the past decade, the amount of time spent waiting for discharge has increased. In 2018, 12% of respondents whose discharge was delayed said they waited less than an hour compared to 16% in 2009. The proportion of respondents reporting waiting for over four hours has increased since last year, from 24% in 2017 to 26% in 2018. As in 2017, the main reason for discharge is waiting for medicines.

Providing information

Challenges also remain regarding patients' satisfaction with the information provided around discharge. The results show that at the time of being discharged, significant numbers of patients were unsure about their situation, for example when they would be discharged, and were not given appropriate information about their care after leaving hospital, for example what would happen next with their care. Fifteen per cent of respondents said they did not receive enough notice about when they were going to be discharged. Forty per cent of respondents said that they were not given written or printed information about what they should or should not do after leaving the hospital and 37% saying they were not told about danger signals to watch for, which has been increasing since 2017. A quarter of patients reported they were not told who they could contact if they were worried about their condition or treatment after they left the hospital. Almost half of respondents (44%) reported not being told about medication side effects to watch for when they went home.

Integrated care

People's experience of the integration of their care has got worse. This is visible through poorer experience at the moment of discharge from the hospital but also at admission, with more patients reporting that waits are longer than they expect. There has been a downward trend for the question around whether hospital staff discussed the need for further health or social care services after leaving hospital. In 2013, 84% of respondents said "yes" this was discussed, compared to 80% in 2018. Eighteen per cent of respondents said they did not know what would happen next with their care when they left the hospital, and nearly a quarter of patients (24%) said they did not get enough support from health or social care professionals to manage their conditions after leaving hospital. This is two percentage points up from last year.

Involving patients in their care

The involvement of patients in decisions regarding their discharge from hospital continues to be a key area for improvement in patient-centred care. Seventeen per cent of respondents said they did not feel they were involved in decisions about their discharge compared to 16% in 2017. There have been no improvements in this area in 10 years.

Only 15% of respondents said that they had been asked to give their views on the quality of their care during their stay compared to 20% in 2017. This was also visible in the decrease in the proportion of patients saying they saw or were given information explaining how to complain about the care they had received, which decreased from 26% in 2017 to 19% in 2018. This is the lowest since the question was introduced in the adult inpatient survey in 2012.

Respect and dignity

In 2018, 80% of respondents said they had always been treated with dignity and respect during their stay. This is a decrease from 82% in 2017 and marks a close to a trend of improvement seen since 2015.

Introduction

After celebrating the 70th anniversary of the NHS in 2018, 2019 started with the publication of the [NHS Long Term Plan](#). This aims to tailor a “new service model for the 21st century”, providing more integrated and patient-centred care. Services will need to evolve to incorporate these changes, and although the plan particularly focuses on redefining the roles of primary and community services, there will also be an impact on acute services.

The NHS Long Term plan also outlines proposals to introduce more personalised care and give up to 2.5 million people “the same choice and control over their mental and physical health they have come to expect in every other part of their life” by 2023/24.¹ This plan has new ambitions for community and social care that are meant to reduce pressure on acute services.

These changes take place within the context of an increasingly ageing population. We now live much longer than the previous generation did at the time the NHS was created. Women born in 2016 can expect to live 12.7 years longer than in 1948 and men 13.6 years longer.² However, living longer does not necessarily mean that people will be spending these extra years in good health as healthy life expectancy has not kept pace with the increase in overall 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.³ Although these years are spread over a person’s entire life, the majority of years lived in poorer health occur post-retirement age. This means that the NHS is required to provide more care for specific and more complex conditions occurring in old age and for a growing number of people. At the same time, it also needs to keep providing high-quality of care for new generations to ensure long-term public health.

This is all set within the wider context of an increasingly tight financial climate and limited capacity of the system to respond to growing demand. For example, in the [2017/18 State of Care report](#), CQC noted that cuts in social care funding are limiting the ability of social care services to provide people the care they need in the community, to avoid the need for admission to the hospital.⁴

By looking at patients’ experiences of care from hospital admission to discharge, the adult inpatient survey provides a unique insight on the current situation. The data supplements and supports the work of inspection and regulatory activities and is used beyond CQC across the health care system for monitoring purposes (see [Appendix E](#)).

Local-level results are also published alongside this England-level report. Data is disaggregated to clinical commissioning group (CCG), trust and site level to allow service providers to go in-depth into the experience of their patients. With questions asked to inpatients since 2009, it also provides a picture how services have evolved over the past 10 years.

Collecting feedback is now recognised as a key tool to improving patient experience across the NHS. The [NHS Constitution](#) pledges that providers should “encourage and welcome feedback on [people’s] health and care experiences and use this to improve services”. It is a principle used by CQC inspectors to assess whether the service is well-led (one of the key lines of enquiry during inspection being “Engagement and involvement”).⁵ The data from the survey is not only shared with

trusts, but also used to produce benchmark providers, allowing them to compare their results with others. The ability for trusts to demonstrate they do so is assessed during inspections as part of the assessment of whether the service is effective (as part of the key line of enquiry “Monitoring outcomes and comparing with similar services”)⁶.

The NHS Patient Experience Framework, published by the NHS National Quality Board in 2012, outlines elements that are important to patients’ experiences of NHS services. This includes respect and involvement, coordinated and integrated care, information and communication, physical comfort, emotional support and the involvement of family or friends.⁷

Evidence from academic research suggests that when people are involved in their own care, decisions are made more effectively, and health outcomes improve.⁸ Patient experience is also positively associated with patient safety, clinical effectiveness and staff wellbeing.⁹ These benefits are recognised by the National Institute for Health and Care Excellence (NICE), which provides guidance for healthcare professionals to improve patient experience.¹⁰

About the adult inpatient survey

The adult inpatient survey is part of a wider programme of NHS patient surveys, which cover 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. To find out more about the survey programme and to see the results from previous surveys, please see the links in the further information section ([Appendix D](#)).

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

The questionnaire is broadly similar to the 2017 questionnaire. However, two new questions were added and one removed. A full list of these can be found in [Appendix F](#).

This 2018 statistical release presents the key results from the survey and highlights statistically significant differences compared to 2017. Long-term trends dating back to 2009 are identified where appropriate. Results for all questions patients were asked are published on our website, www.cqc.org.uk/inpatientsurvey.

Inpatient services

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

Who participated in the survey?

The 2018 adult inpatient survey involved 144^a acute NHS trust and NHS foundation trusts in England that sent questionnaires to a total of 178,681 patients.^b Responses were received from 76,668 people, which is an adjusted response rate of 45%. This represents an increase of four percentage points from a response rate of 41% in 2017.

Trusts selected a sample of patients who received care in hospital during July 2018 by including every consecutive discharge counting back from 31 July until they had selected 1,250 patients.^c Fieldwork for the whole survey (the period during which questionnaires were sent out and returned) took place between August 2018 and January 2019. However, actual fieldwork for each trust varied during this period as samples were approved at different dates.

^a Two recently merged trusts took part separately in the 2018 adult inpatient survey, increasing the number of participating trusts to 145. However, due to an error in the mailing of the questionnaire for another trust, the data for this trust was excluded.

^b This excluded mental health, ambulance services, and community health trusts.

^c With the exception of the following trusts: The Clatterbridge Cancer Centre NHS Foundation Trust that sampled 724 patients, Liverpool Women's NHS Foundation Trust that sampled 986 patients, Birmingham Women's and Children's NHS Foundation Trust that sampled 717 patients. As specialist trusts they have relatively low throughputs of patients and sampling over a longer time period to achieve the full 1,250 sample would introduce difficulties in making inferences from their data.

Please refer to section 444 of [Appendix A](#) for details on specific groups of patients excluded from the survey.

Policy context

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

Integrated care

Enabling patients to receive care outside of acute hospitals is one of the key objectives of the NHS, which is stated in multiple areas of policy, such as the [NHS Constitution](#) and the [NHS Five Year Forward View](#). The recently published [NHS Long Term Plan](#) also focuses heavily on developing an integrated care system and emphasises the important role of primary and community services within this. Having an integrated care system is described in the plan as a way of easing the pressure on acute services, especially A&E. Providing better services outside of hospitals is expected to reduce emergency admissions and enabling patients to receive the same care in a different setting is expected to prevent other hospital admissions. This is particularly relevant for people with long-term and multiple conditions or people with conditions linked to ageing for which care needs can be identified in advance. For example, guidance from NHS England suggests that if frail older people are supported to live independently and manage their long-term conditions, they are less likely to reach crisis point and require urgent care support.¹¹ The aim of the long-term plan is to have a fully integrated care system in England by April 2021 (NHS England, Long term plan).

Good integrated care is a combination of focusing care on the patient themselves (person-centred) and on the geographical area in which different care providers sit (place-based). Taking a person-centred approach makes sure that the needs and preferences of the patients are listened to and put at the centre of how services are organised and delivered.¹² The adult inpatient survey supports this by helping acute trusts to collect feedback from inpatients and identify how to become more responsive to their needs.

Beyond NHS organisations, the integrated care approach also seeks to involve local authorities, the third sector, GP practices and CCGs.¹³

Several questions in the survey have been developed over the years to attempt and measure the extent to which inpatients benefit from the roll-out of integrated care.^a These questions are scored and trusts are encouraged to use them to monitor their performance in achieving care that is integrated and responsive to the patient needs. The results of these questions are not solely reflective of the trusts, but an indication of how well the system of integrated care is working at a local level. We have also published results at a CCG level to provide a broader picture.

Waiting times

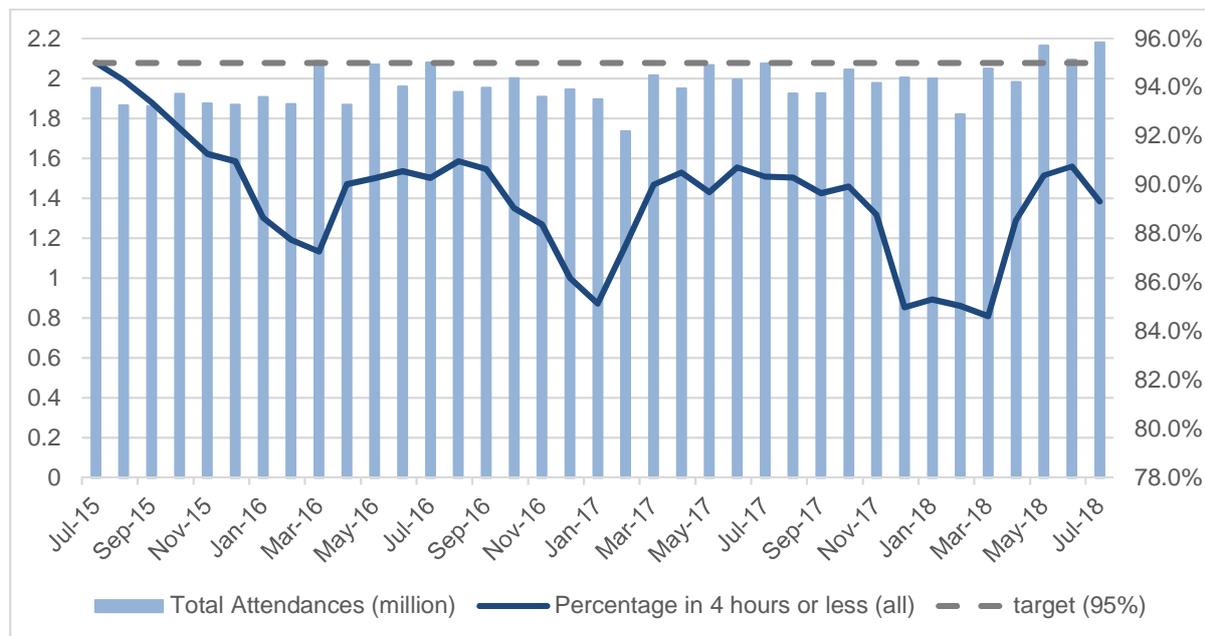
The [NHS constitution](#) sets out three key indicators around waiting times – at least 95% of A&E patients should be seen under four hours, at least 92% of patient should have a referral to treatment time (RTT) of less than 18 weeks, and less than 1% of

^a Question 5 and 8 are about patient referral to the hospital and questions 54, 55, 61, 62, 64, 65, 66 are about care following hospital discharge.

patients should wait more than six weeks to receive a diagnostic test (such as an MRI or a colonoscopy) when needed.

At the time of the survey, in July 2018, 89.3% of A&E patients were seen in under four hours, figure 1 below shows the evolution of the indicator over time.

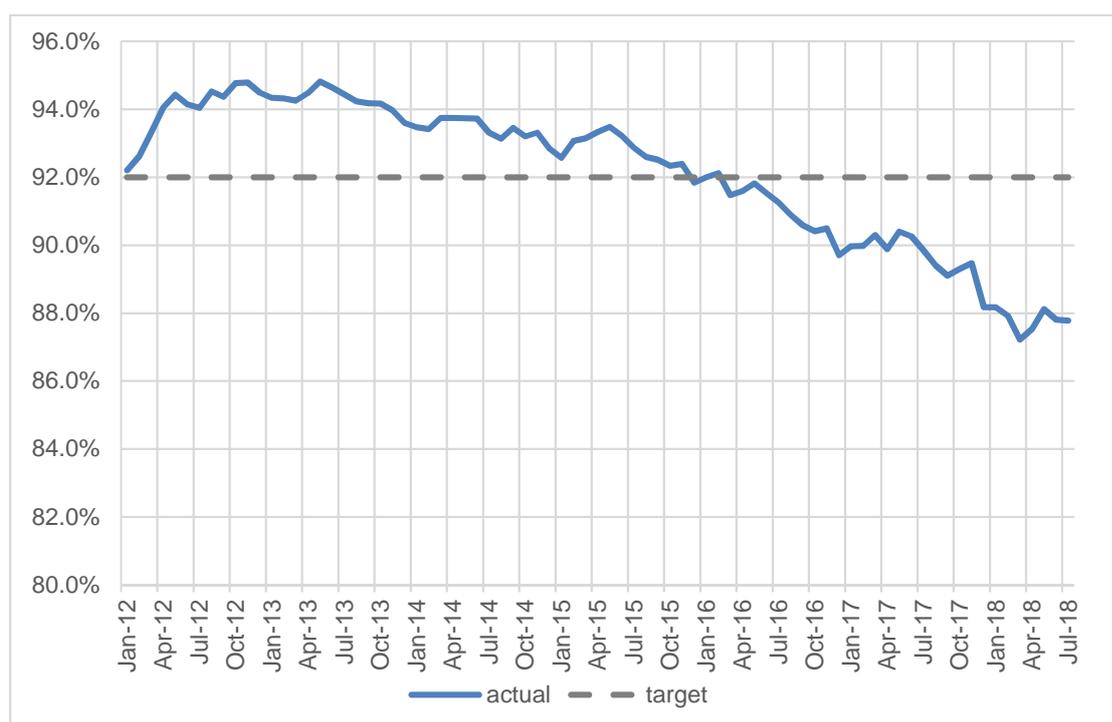
Figure 1: A&E attendances and proportion of A&E patients seen under four hours



Source: Produced from January 2019 A&E attendances & emergency admission statistics, NHS and independent sector organisations in England, NHS England. Available at <https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2019/02/January-2019-Timeseries-with-growth-charts-J3itq-1.xls>

The RTT target was not achieved at the time of the survey either, with 87.8% of patients with an RTT time of less than 18 weeks.¹⁴ As figure 2 shows, this target has not been achieved for the whole of England since February 2016.¹⁵

Figure 2: Proportion of patients with a RTT time of less than 18 weeks



Source: Produced from [Referral to Treatment \(RTT\) waiting times, England](#), NHS England.

Short waiting times are considered important to improve patients' experiences of a service, but in some cases, for conditions where early diagnosis improve chances of the treatment to be successful, they are a necessity to provide safe and effective care. In July 2018, none of the three waiting time targets were met at England level and the indicators used by the NHS to monitor these targets showed that the situation had deteriorated compared to the previous year. Longer waiting times will have an impact on many aspects of a patient's experience of care, which is likely to affect the survey results.

Delayed transfer of care

Delayed transfers of care (DToC) occur when patients are occupying a bed when they would otherwise be ready to leave the hospital. Sometimes referred to by the media as 'bed blocking', DToC can occur when suitable health or social care for patients outside of hospital is not available. This includes waiting for residential or nursing home placement, waiting for a care package in their own home or waiting for further non-acute NHS care. In 2016, The National Audit Office estimated that the gross annual cost to the NHS of treating older patients in hospital who no longer needed to receive acute clinical care was in the region of £820 million.¹⁶

DToC can reduce the number of beds available to patients needing acute care, which in turn can increase waiting times. DToC are also considered to have an adverse impact on patients, such as increasing the risk of mortality, infections, depression, reductions in patients' mobility and their daily activities.¹⁷ In addition, they are considered to be detrimental for nursing and medical staff by increasing stress and affecting interprofessional relationships.¹⁸

CQC's report, [Beyond barriers](#), highlighted the impact of DToC and the importance of services working together to ensure that when a person moves from one setting to another, they have the right care in place and at the right time to meet their needs.

Staffing levels

With 1.7 million employees, the NHS is considered to be one of the biggest employers in the world; nevertheless, all categories of NHS staff are affected by shortages. Between July and September 2018, there were 102,821 staff vacancies^a (whole time equivalent) in trusts across England.¹⁹ This amounts to a vacancy rate of 8.7%. Having the right number and mix of skilled, permanent staff is a key factor in an organisation's ability to provide high-quality care.²⁰ During its inquiry on Nursing Workforce in 2018, the House of Commons' Health Committee received evidence of the risk that understaffing could place on the quality of care delivered to patients.^{b,21} The decrease seen in NHS staff satisfaction with the quality of care delivered to patients in recent years^c could be one of the consequences of this staffing issue.²² Recruitment is somewhat challenging for trusts competing for the same pool of qualified and experienced professionals. Recent efforts were made to train more nurses and increase the number of new graduates entering the profession, but barriers remain. For example, concerns were raised around the effects of removing the bursary for trainee nurses. This lack of financial support has discouraged students to pursue nursing studies, especially mature students who would turn to nursing studies following a change of academic track.²³ The NHS Long Term Plan proposes to address these issues by widening the possible routes into a nursing career, including the setup of an online nursing degree. In addition, the introduction of the new nursing associate role aims to help bridge the gap between health and care assistants and registered nurses. While this has the potential to ease pressure on registered nurses, it is important to understand that nursing associates are **not** registered nurses and CQC expects health and care providers to consider this when deploying them.²⁴

There is also growing concern around retention of staff, with a high number of UK nurses and midwives leaving the register. In 2018, the number of leavers was higher

^a The number of vacancies is the number of permanent staff positions (including clinical and non-clinical staff) that are not filled. However, this does not mean that there was an equivalent number of staff missing from the service since trusts try to fill gaps with agency and bank staff.

^b In its written evidence, CQC stated, "Common issues we have identified where there is a shortage of staff relate to inconsistent identification and management of life threatening conditions such as sepsis; incomplete, inconsistent and ineffective audits of key safety priorities and quality improvement projects; poor infection control procedures, including hand hygiene and isolation practices; staff not receiving essential safety training, including appropriate safeguarding training; insufficient record keeping, and poor sharing of information – leading to incomplete care plans and tests and treatments being delayed or repeated unnecessarily. Although these issues are not entirely due to a shortage of nursing staff, the overall impact of staff shortages on a clinical team is that these issues occur all too frequently."

^c The NHS staff survey 2018 showed a decreased by two percentage points of staff saying they were satisfied with the quality of care they gave to patients/service users since 2016. In 2018, 80.7% of staffs said they were satisfied while they were 82.7% in 2016. Source: [National briefing NHS staff survey 2018](#)

than the number entering these professions.^{a, 25} While nurses have described their jobs as rewarding and fulfilling, they have also described feeling a lack of recognition of the value of their work.^b

There are also concerns about the impact that leaving the EU will have on staffing levels within the NHS, with approximately 5.6% of the NHS workforce estimated to be EU/EEA nationals.²⁶

The NHS Long Term Plan aims to reduce the nursing vacancy to 5% by 2028. The forthcoming workforce implementation plan is expected to propose a strategy to meet this objective. In addition, the NHS Long Term Plan has committed to supporting staff with better access to training and skills development as a way to address the issues of retention.

Recruitment of patients in clinical research

A new question was introduced in the questionnaire in 2018 to monitor the extent to which patients were offered the opportunity to take part in clinical research.

Evidence suggests that hospitals supporting high-quality patient-centred research show better healthcare outcomes for patients. As a result, the NHS Long Term plan includes aims to increase the number of people registering to participate in health research to one million, as well as offer whole genome sequencing for research purposes to adults suffering from certain conditions and/or specific cancers.²⁷

Trusts are encouraged to develop clinical trials and to make efforts to recruit patients to take part. CQC is working with the National Institute for Health Research (NIHR) to develop indicators and guidance for inspectors for monitoring access to clinical research as part of our assessment of whether the organisation is effective and well-led.²⁸ Beyond measuring whether trusts effectively offer patients the opportunity to take part in clinical research, this new question will help assess whether different groups of patients are equally offered this opportunity.

^a The Nurse and Midwifery Council annual report shows that 21,931 nurses and midwives joined the profession in 2017-18 while 25,400 left it. Nurse and Midwifery Council, The NMC register, 31 March 2018 (reference in endnote)

^b House of Commons, nursing workforce inquiry report previously cited.

Results from the survey

This section presents key results for the 2018 adult inpatient survey. It highlights statistically significant differences between the results from the most recent survey (2018) and the results from the 2017 survey.^a

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

For each evaluative question, the control-chart displays the percentage of respondents who reported the most positive experience of the service over the years. For example, for Q3 "While you were in the A&E Department, how much information about your condition or treatment was given to you?", the answer considered to reflect the most positive experience is 'the right amount', in comparison to the alternative responses 'not enough' and 'too much'. In this case, the chart will only display the percentage of respondents who answered 'the right amount'.

To allow readers to interpret patterns in the data with greater confidence, the control-chart also displays two lines setting the limits beyond which variations are considered to reflect a "real" change in users' experiences of care rather than changes that could be due to the measurement method or happening by "chance".²⁹

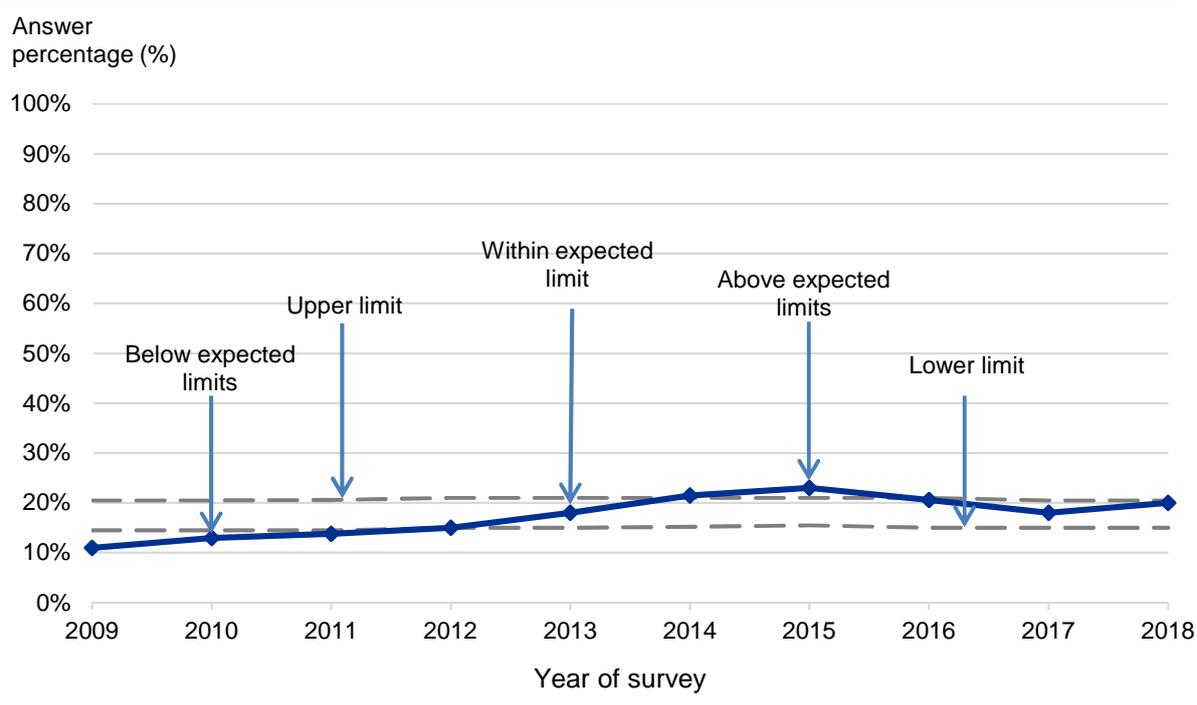
Therefore, it is possible to say that the experience of patients improved for a specific question only if the line plotting the percentage of most positive responses crosses the upper limit line. This suggests there is an underlying phenomenon at play or a real change in behaviour. On the other hand, an increase that would not cross the upper limit line could reflect a change happening by chance, with no underlying pattern in the results.

This method is useful as it allows comparisons between a number of years of data, rather than testing for statistical significance between just two time points. The ability to see trends in survey results over multiple years provides users with greater confidence in interpreting patterns in the data as resulting from real change.

Where control-chart results are not reported in the text of the report, this is because the change over time was not significant (the line of result does not cross the limit lines) or because not enough data points are available to produce reliable results. Figure 3 below is an example of a control-chart that fluctuates from below expected limits in 2009 to above expected limits.

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

Figure 3: 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 scores^a of different subgroups – age, gender, religion, sexual orientation, ethnicity, long-term health conditions, diagnosis ([ICD-10](#) chapter codes – see [Appendix](#)^b), 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, 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)

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

^b 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 question (Q68)

These findings will be presented throughout the report.

Survey results are organised 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**

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

1. Person-centred care

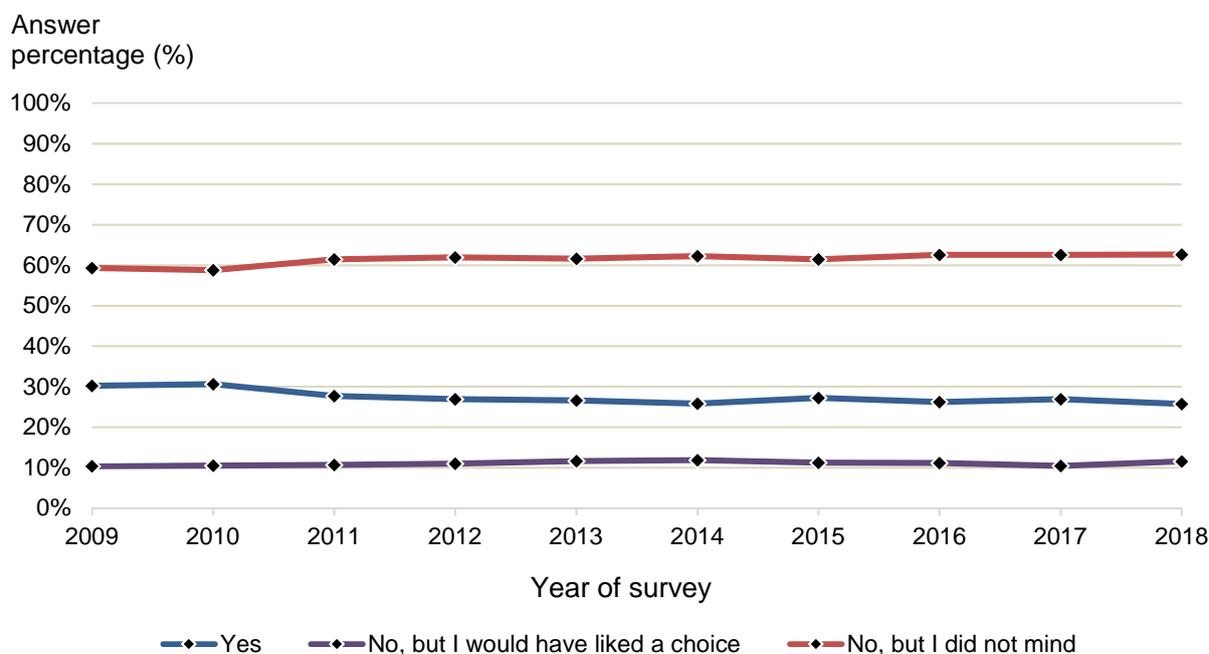
The NHS Long-term plan sets out “a new service model for the 21st century” around five major themes. One of these themes is the renewed commitment to a person-centred approach where “people will get more control over their own health and more personalised care when they need it”.³⁰ Patient choice has been a recurring focus of the NHS, starting with the choice of registration with a GP practice when the NHS was set up seven decades ago, and more recently with patient choice to elective care.

Several questions in the survey measure the extent to which patients considered they were offered a say at different stages of their care. Overall, compared to 2017, the situation has deteriorated, particularly for questions regarding patients’ involvement in the decisions regarding their discharge.

1.1 Patients’ involvement in the choices concerning their care

In England, when patients are referred to see a specialist, they should be offered a choice over where and when to have their first hospital appointment. Not only do patients have the right to choose the provider for their first appointment, but they should be given the opportunity to discuss the choices available with the referring health care professional.³¹ In 2018, only 26% of patients whose admission was planned said they had been offered a choice, a decrease from 2017 (27%). Among those who were not offered a choice, a majority (63%) said they did not care and 12% said they would have liked to be given a choice. This is an increase from 2017 (10%).

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



Note: Answered by all whose most recent admission to hospital was waiting list or planned in advance.

Base: 2009 (26,978), 2018 (23,277).

More than half (54%) of patients said they had “definitely” been involved as much as they wanted to be in decisions about their care and treatment. This proportion decreased from 56% last year, while the proportion of those saying they were involved “to some extent” increased simultaneously (from 34% in 2017 to 35% in 2018). The National Institute for Health and Care Excellence (NICE) published guidance for healthcare professionals on how to improve the experience of care for people using adult NHS services.³² One of the recommendations was to make sure that they communicate in a way that is accessible to patients, for example by avoiding using jargon and confirming understanding by asking questions.

Results show that medical and nursing staff were generally deemed able to answer patients’ questions in a way they understood (66% of respondents said they “always” got answers from doctors in a way they understood when they had important questions and 68% said the same about nurses). However, in both cases, the proportion declined compared to last year (from 68% and 69% respectively) while the proportion of those saying they “sometimes” did increased. In 2017, 26% of respondents said they sometimes got answers from doctors and nurses in a way they understood compared to 27% in 2018.

The same pattern was visible for those who had an operation or procedure regarding whether members of staff provided clear answers when they had questions: 80% of respondents said members of staff answered their questions in a way they could understand “completely” in 2018 compared to 81% in 2017, while 17% said they answered their questions “to some extent” compared to 16% in 2017.

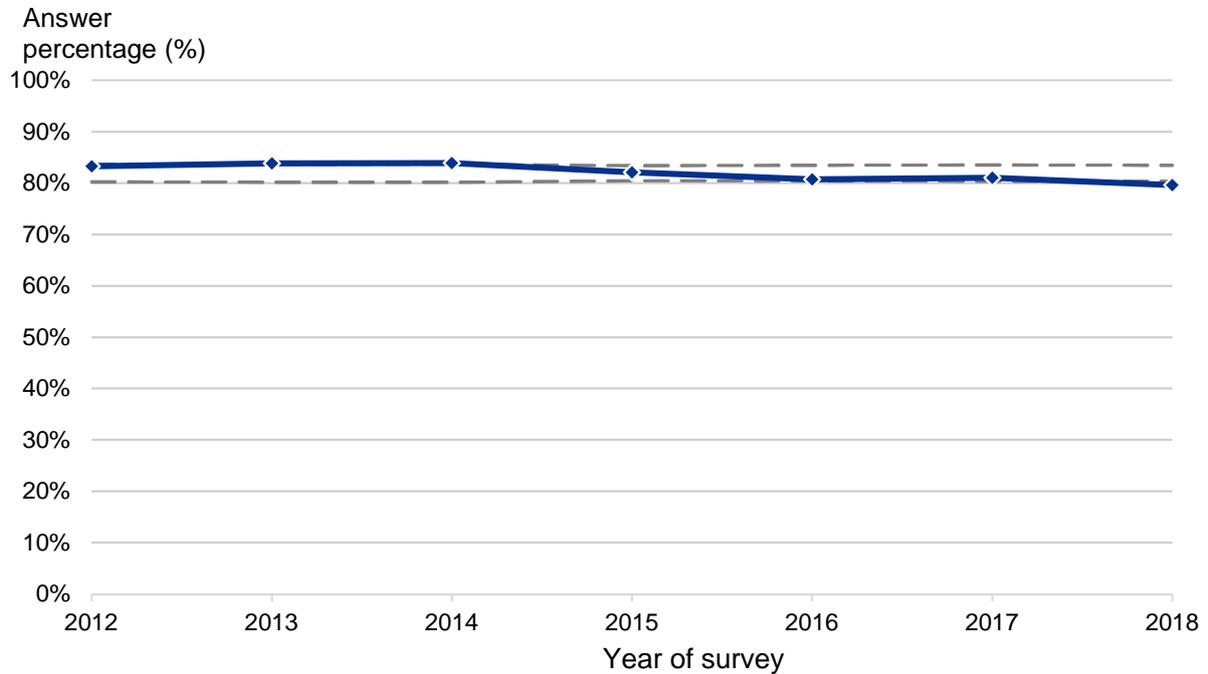
For all these questions, patients were less positive in their responses than last year with the proportion of most positive responses significantly decreasing as compared to 2017.

The analysis of a subset of questions relating to respect for patient-centred values, preferences and expressed needs^a shows that younger patients (aged 16 to 35) reported poorer than average experiences. Patients with dementia or Alzheimer’s, and patients with an ICD-10 code of V (mental and behavioural conditions) reported poorer than average experiences in this area as well.

Patients’ involvement in decisions about their discharge from hospital remains a main area for improvement in patient-centred care. Indeed, 17% of respondents said they did not feel they were involved in decisions about their discharge compared to 16% in 2017. The share of respondents reporting that hospital staff discussed with them whether they might need further health and social care services after leaving the hospital decreased from 81% in 2017 to 80% in 2018. Although this looks like a minor change, it reflects a meaningful decrease over the longer term, as displayed by the control chart below.

^a 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?) and Q48 (Did you feel you were involved in decisions about your discharge from hospital?).

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')



Note: Answered by all
Base: 2012 (32,493), 2018 (39,707).

As discussed further in section 5.1, this could have a further impact on patients' ability to benefit from integrated care once they go back home. This is particularly relevant for older people who could be exposed to further risk of frailty by being unsure of how their care will be continued.

1.2 Emotional support

Beyond ensuring that patients receive accurate and understandable information about their care, other forms of support can help to make sure that patients are fully empowered to make these decisions. The NICE guideline cited previously stipulates that “there should be recognition of the potential need for psychological and emotional support, as well as of the importance of meeting fundamental needs such as nutrition and pain management”.³³ For healthcare professionals, this does not only mean making sure that patients are treated with dignity and respect (see section 4), but also being prepared to “discuss any fears or concerns [...] in a non-judgemental and sensitive manner”. The British Medical Association published a report in 2011 on the psychological and social needs of patients. This went further by recommending that hospitals should have a liaison psychiatry service, also known as a psychological medicine service, to bridge the gap between physical and mental health care.³⁴

In 2018, over a quarter (28%) of respondents said that they did not find someone to talk about their worries and fears during their hospital stay. This is a slight but statistically significant increase from 2017 (27%). Similarly, the proportion of patients saying they did not feel they got enough emotional support from hospital staff during their stay increased from 16% in 2017 to 17% in 2018.

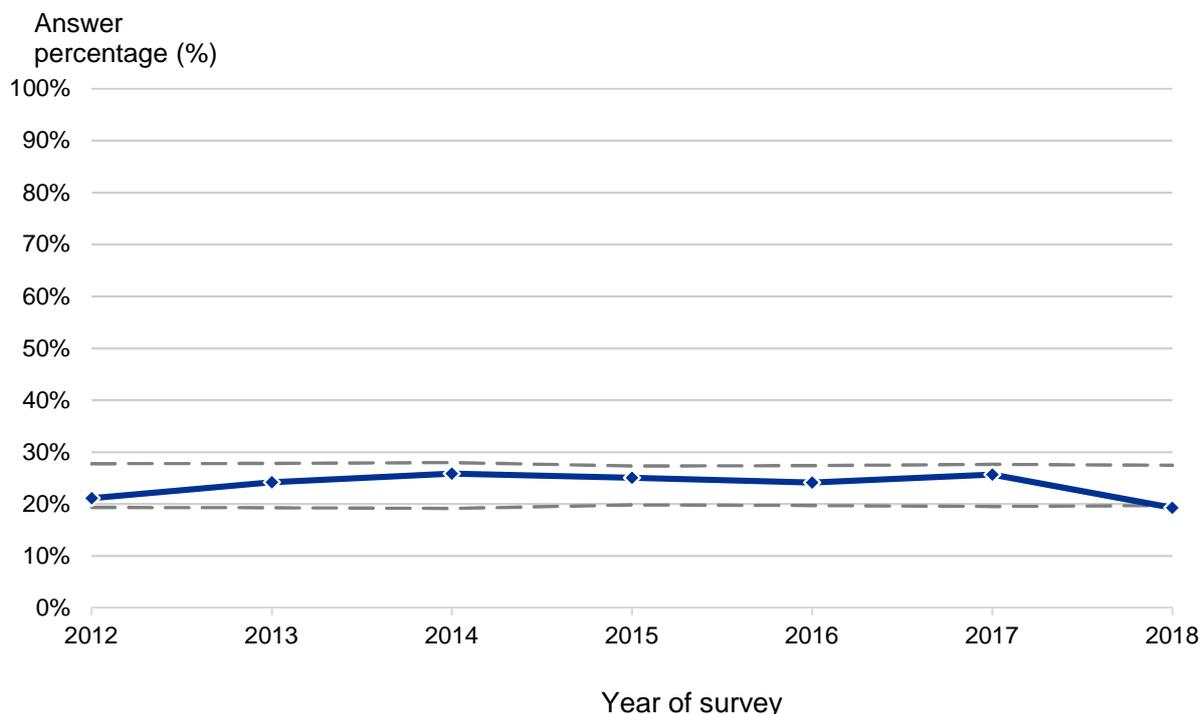
Younger patients (aged 16 to 35) reported poorer than average experience for these questions. It was also the case of patients admitted through emergency who reported poorer experience of emotional support than patients whose admission was planned.

1.3 Collecting patient feedback

In a broader sense, patients’ views on their care can also be sought as a way to improve the delivery of the service. Trusts are encouraged to seek patient feedback and make sure that they are offered an opportunity to report when their care is not appropriate. Domain four of the NHS Constitution is focused on ensuring that people have a positive experience of care.

Results from the survey show a decline in patients’ perceived ability to give their views. Only 15% of respondents said that they had been asked to give their views on the quality of their care during their stay, compared to 20% in 2017. This was also visible in the decrease in the proportion of patients saying they saw or were given information explaining how to complain about the care they had received, from 26% in 2017 to 19% in 2018. This is the lowest since the question was introduced in the adult inpatient survey in 2012 and indicates a meaningful deterioration.

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



Note: Answered by all.
Base: 2012 (50,232), 2018 (58,863).

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

The NHS Constitution pledges that patients “have the right to be given information about the test and treatment options available to [them], what they involve and their risks and benefits”. In particular, the NHS Constitution lays out the right to “informed choice”. This involves not only the right to be involved and take part in decisions about their treatment, but also to receive information in order to make informed decisions about their care. The text of the constitution precisely states that patients should be offered “easily accessible, reliable and relevant information in a form [they] can understand, and support to use it”.

As a result, the provision of spontaneous, rigorous and consistent information to patients about their conditions, treatment and care is an important component of a patient’s experience. However, the information needs to be tailored to be properly understood by non-professionals and it is sometimes challenging for healthcare staff to find appropriate ways to make complex information accessible.^a

^a NICE guideline CG138 provides that healthcare professionals should, “avoid using jargon. Use the words the patient will understand, define unfamiliar words and confirm understanding by asking questions”.

NHS Improvement notes, “Whenever patient and carer experiences are captured and analysed, information always comes up as a big issue. Regardless of how good healthcare staff think the information they give out is, the experience of patients and carers is often that it could be a lot better”.³⁵ It further notes that unclear information can create a great deal of anxiety for patients and carers and have a negative impact on their experience.

Emergency patients had a poorer experience around information and communication than elective ones. Patients with mental and behavioural conditions, older patients (aged 80 and over), and patients with dementia or Alzheimer’s disease also reported below average experiences in this domain.

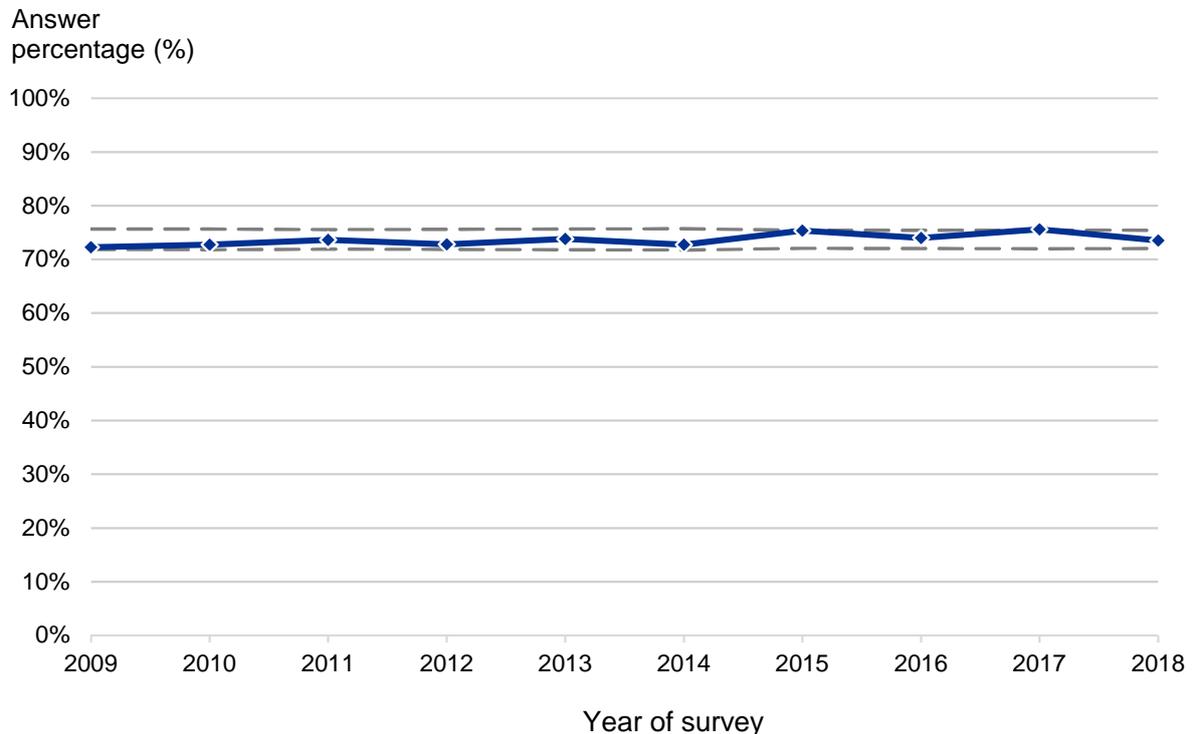
Patients should be provided with sufficient information about their condition and treatment all along their healthcare journey. However, data shows that a small proportion of patients – 4% – reported not being given “any” information about their condition or treatment. This is slightly higher than last year (3% of respondents said they had not been given any information in 2017). The proportion of those saying they did not receive “enough” information also increased compared to last year from 18% to 19%. The proportion of those saying they received the “right amount” of information slightly decreased from 78% in 2017 to 77% in 2018.^a

Results show that the dissatisfaction with the amount of information given is also visible at specific stages of the patient’s healthcare pathway. Respondents who were admitted through an A&E department were asked how much information about their condition and treatment was given to them when in A&E. While we reported an improvement over time in the 2017 adult inpatient survey report, the trend is not sustained this year. In 2018, the percentage of respondents saying they had not been given “any” information about their condition and treatment while in A&E increased to 9% (compared to 8% in 2017). Those who said they had not been given “enough” information also increased (from 15% in 2017 to 17% in 2018). Poor experience of information followed emergency patients beyond the A&E department, at all stage of their hospital stay. Indeed, they reported poorer experience than elective patients in the information, communication and education domain.

The chart below presents the trend of respondents saying that they were given the right amount of information while in A&E over the 10-year period. While the line of most positive responses exceeded the upper limit last year, indicating a genuine improvement, it is back between the control lines in 2018.

^a In 2018, another 1% said they received “too much” information

Q3: While you were in the A&E department, how much information about your condition or treatment was given to you? (Answer: 'Right amount')

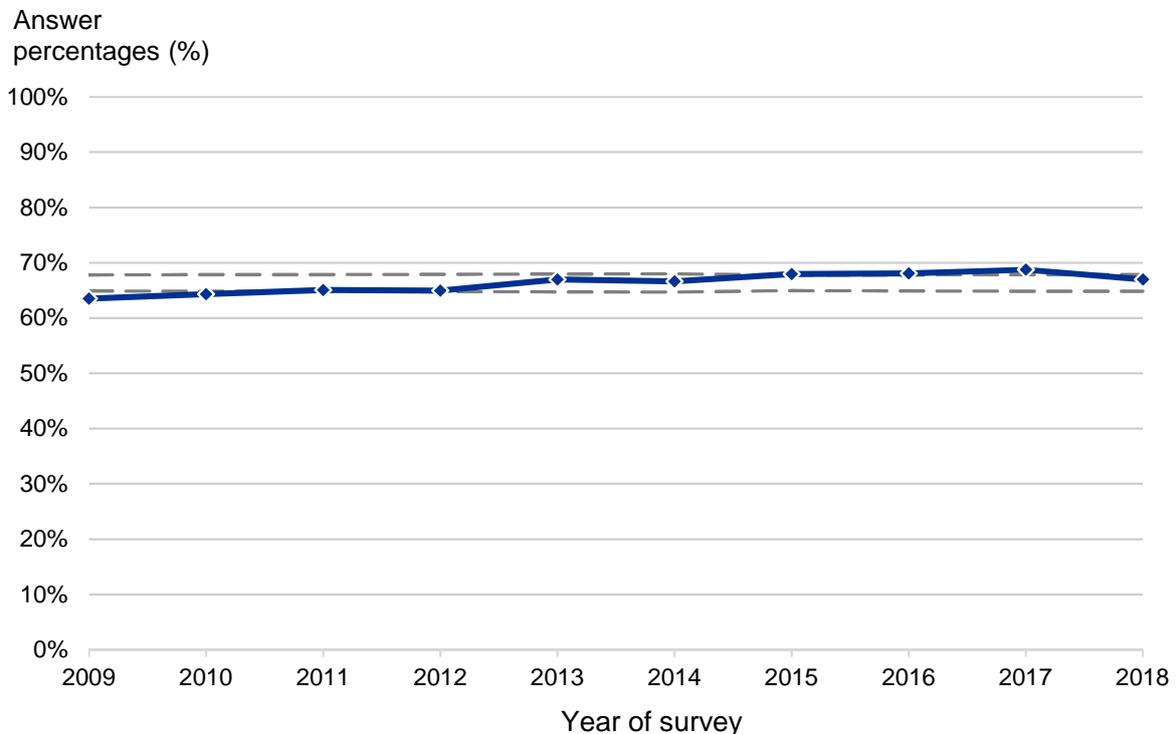


Note: Answered by all who went to the A&E Department.
 Base: 2009 (32,884), 2018 (41,133).

Once admitted to a ward, some patients underwent an operation or procedure. The improvement in the information given before the procedure seen over the years is sustained. In 2018, 61% of patients had been completely told how they could expect to feel after the operation or procedure compared to 55% in 2009. However, a notable proportion of respondents (12%) still said they had not been told how they would feel.

Challenges also remain regarding patients' satisfaction with the information provided after the procedure. The improvement seen over the previous year is not sustained this year. While 69% of patients said it had been explained to them how the operation or procedure had gone in a way they could "completely" understand in 2017, only 67% said this in 2018.

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')



Note: answered by all who had an operation or procedure.
 Base: 2009 (42,600), 2018 (41,061).

1.5 Confidence and trust in people providing care

While the quality and accessibility of the information is key, the information is more likely to be well received and followed by patients if they have confidence in those delivering it.

For all questions relating to confidence and trust in healthcare staff, results are stable over the years and indicate a high level of confidence. However, results also show that respondents are less likely to provide most positive views than in 2017. For example, the proportion of those saying that they “always” had trust in nurses, doctors and other clinical staff slightly decreased from last year while the proportion of those saying they “sometimes” had confidence in them increased slightly.

Overall, 69% of patients said they “always” had confidence in the decisions made about their condition or treatment, a decrease from 71% in 2017.

We found that younger patients (under 50 years old) are less likely to report feeling confident and trusting of staff, the youngest patients (aged 16 to 35) even more so. This was also the case of patients reporting a neurological condition and those with an ICD-10 chapter code of V (mental or behavioural condition).

2. Experience of admission to hospital

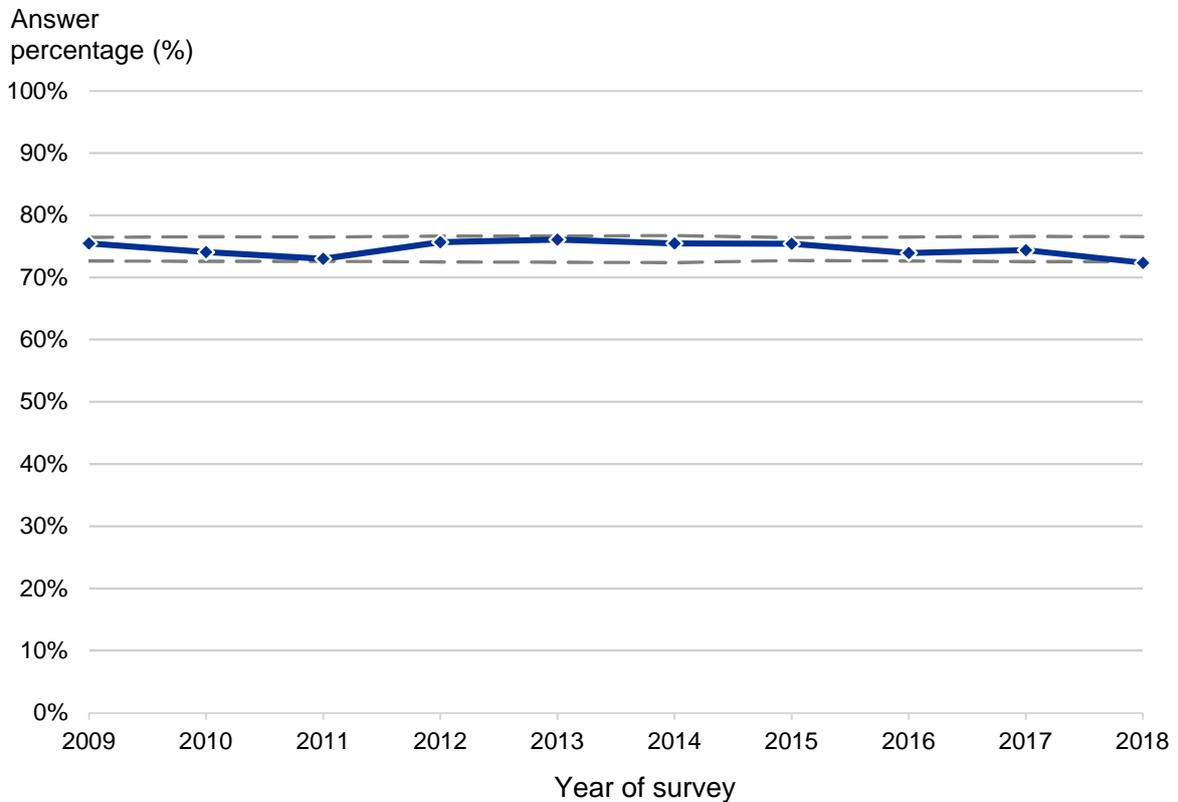
Patients admitted to hospital can either be admitted through the accident and emergency (A&E) department (emergency admission) or through referral (planned admission). In a small number of cases, an admission can be planned but the nature of the patient's condition requires urgent care, in which case the admission is re-categorised as emergency although they are not admitted through A&E. Due to the nature of the service, patients admitted through A&E tend to have a different experience of the beginning of their care to patients whose admission was planned.

The proportion of respondents to the survey admitted through an A&E department has regularly increased over time and reached 69% in 2018 (from 61% in 2009).^a As highlighted previously, emergency patients reported poorer experiences than patients whose admission was planned in four of the nine themes analysed in the subgroup analysis: information, communication and education, emotional support, respect for patient-centred values, preferences and expressed needs, and confidence and trust.

Regarding patients whose admission was planned, results show that 72% of patients considered they had been admitted as soon as they thought was necessary. This proportion is decreasing over time as shown in the chart below and mirrors the increase in patients saying they should have been admitted "a lot" sooner, which passed the threshold of 10% for the first time in 10 years.

^a The adult inpatient survey data is weighted in a way to ensure the views of the patients admitted through A&E are not over-represented. A comprehensive coverage of the experience of accident and emergency patients is published in our Emergency Department Survey.

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’)



Note: Answered by all whose most recent admission to hospital was through waiting list or planned in advance.

Base: 2009 (27,395), 2018 (24,165).

Due to delayed transfers of care, freeing beds for new patients can be difficult and this can be reflected in the time that patients waiting to be admitted have to wait before getting to a bed on a ward. Between July and September 2018, which includes the period during which the majority of respondents were in hospital, the bed occupancy was 89.7%.³⁶ It is suggested that hospitals with a bed-occupancy rate exceeding 85% can expect to face regular bed shortages, periodic bed crises and increased numbers of health care-acquired infections.³⁷

In 2018, 39% of respondents said they had to wait a long time (“definitely”, 16% and “to some extent” 23%) before getting to a bed. The proportion of those satisfied with the time they had to wait has decreased compared to last year (63% in 2017 compared to 61% in 2018).

3. Meeting patients' fundamental needs

In its [guidelines on improving the experience of care for people using adult NHS services](#), NICE states that meeting fundamental needs such as nutrition and pain management are part of the essential requirement of patient care, going beyond the sole clinical treatment of their specific health condition.

3.1 Nutrition and hydration

NICE [guidelines on malnutrition](#) highlight that it is both a cause and an effect of ill health. Among other benefits, nutrition support is deemed to help people to recover from episodes of ill health or following injury and to ensure that people have a positive experience of care.³⁸ CQC's model of regulation on [meeting nutritional and hydration needs](#) states that hospitals must meet inpatients' nutrition or hydration needs, by providing "appetising food" served at an appropriate temperature. It also states that patients should be able to make choices about their diet and that their religious, cultural, moral or ethical beliefs should be fully considered.³⁹

Patients' satisfaction with hospital food has improved over the years, with the proportion of those saying that it was "very good" increasing from 19% in 2009 to 23% in 2018. In 2014, the Department of Health and Social Care recommended a [set of food standards](#) and in 2015 it asked NHS England to review the Council of Europe's [10 key characteristics of good nutrition and hydration care](#). Each trust can choose to either produce food in-house or use the services of a private caterer. Seventy-nine per cent of respondents said they had "always" been offered a choice of food.

We also found that patients who stayed more than one night in hospital reported better experience of food than patients who stayed only one night. Patients with an ICD-10 chapter code VI (diseases of the nervous system) reported poorer than average experience in this area.

CQC's regulation also mentions that people should be encouraged to eat and drink independently but, when needed, should receive support from staff either in the form of encouragement or physically. For older patients, being able to keep eating independently while in hospital can prevent frailty. The final report of the [Mid Staffordshire NHS Foundation Trust Public Inquiry](#) found a lack of patient access to food and drink and the lack of support to consume them was a significant problem. In 2018, 61% of patients said they always got help from staff to eat their meals while 18% said they did not. There was no significant change compared to last year.

A question on hydration measuring whether respondents considered they had enough to drink was added to the questionnaire in 2017. Proper hydration prevents pressure sores, skin conditions, urinary tract infections and constipation, among other conditions.⁴⁰ In turn, poor hydration can lead to salivary dysfunction, which can further affect the patient's capacity to eat by themselves.

Ninety-three per cent of respondents said they were given enough to drink, a proportion similar to last year although the proportion of those saying they were not offered enough drinks increased very slightly.

Patients with dementia or Alzheimer's reported poorer than average experience on the question on hydration. It was also the case for younger patients (aged 16 to 35) and patients of mixed-ethnicity.

3.2 Pain management

Assessment and management of pain are also considered as essential requirements of care (NICE guidelines, note 31).

The General Medical Council (GMC) guidance on good medical practice stresses that in providing clinical care all possible steps must be taken to alleviate pain and distress.⁴¹ The Royal College of Anaesthetists' (RCoA) Good Practice Guide also stresses the duty of care for all healthcare professionals to work together to effectively manage a patient's pain.⁴² In addition to this, delays of more than 30 minutes in providing pain relief is also a "red flag" that can be an indication that nurse staffing levels are not sufficient.

In 2018, more than two thirds (65%) of respondents said they had been in pain during their stay, a proportion stable from 2017. Of those who said they had been in pain, 67% thought that the staff "definitely" did everything they could to control it, a decline from 69% in 2017. Only 8% said that the staff did not do everything to control their pain.

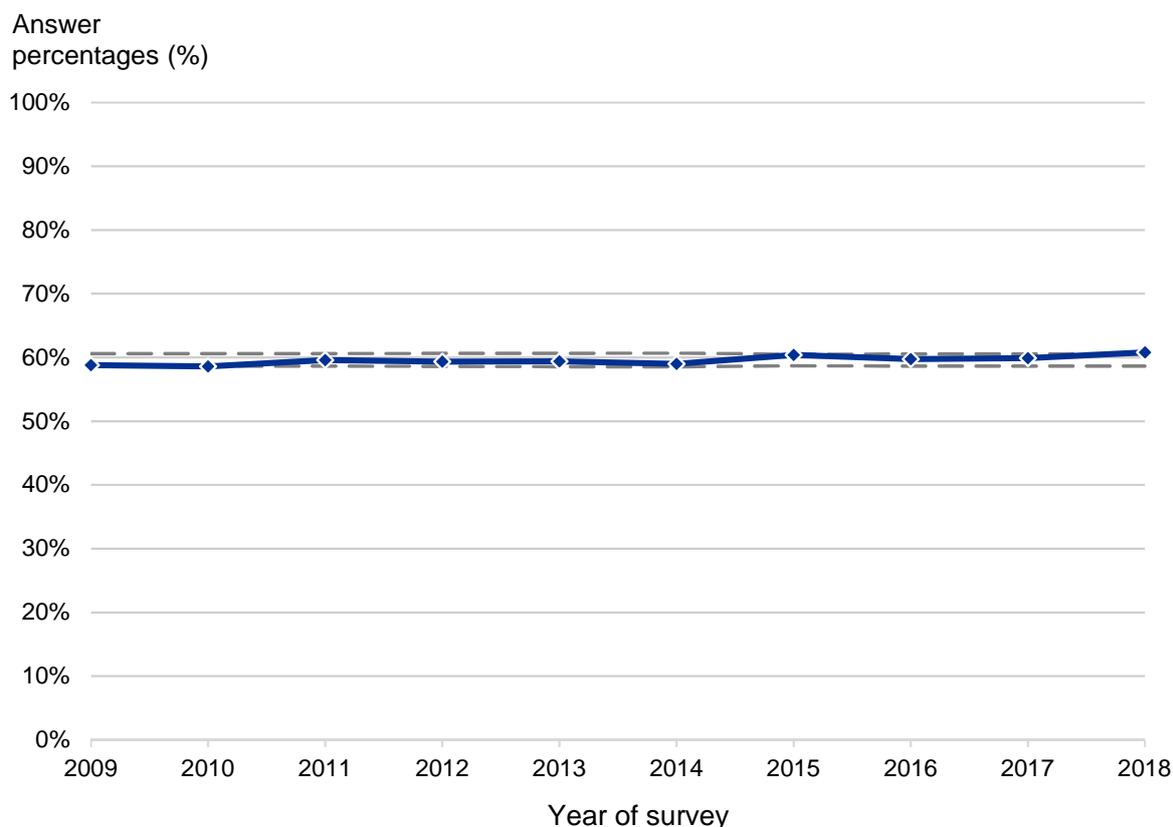
Academic research has shown a correlation between call bell responsiveness and patient satisfaction; patients who are dissatisfied with the length of time it takes to respond to their call tend to be dissatisfied with all other aspects of their care while in hospital.⁴³ In 2018, 59% of respondents said they were able to get help from a member of staff in a reasonable time, a drop from 61% in 2017 (see section 6 below).

3.3 Rest

Sleep is considered to be critical to patient recovery in hospital and evidence suggests that for patients in intensive care, sleep disturbance can have adverse effects on recovery.^{44,45} Factors such as noise, light and clinical care interactions (that is care provided to a patient or monitoring of the patient's vital functions) can reduce the ability for patients to rest and hospitals are encouraged to take measures to limit those during the night time. Efforts have been made across different hospital to reduce noise at night.⁴⁶

In 2018, 61% of respondents said they had not been bothered by noise at night from other patients. This is higher than in 2017 (60%) and also greater than the expected limit on the 10-year trend.

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



Note: answered by all.

Base: 2009 (67,614), 2018 (74,676).

The proportion of those who were not bothered at night by noise from hospital staff (80%) is higher than the expected limit as well showing that meaningful changes have occurred in terms of noise reduction in wards since 2009 (78%).

Moving patients between wards at night will disrupt sleep and is not considered good practice. The report from the Royal College of Physicians '[Hospitals on the edge, the time for action](#)' identified patients being frequently transferred between wards during their stay as a risk to clinical continuity and is an issue especially for older patients with multiple long-term conditions. They noted the effect especially if some of these transfers were happening at night.⁴⁷ The Royal College of Physicians asked trusts to make a commitment not to move patients at night unless it is urgently needed.

Sleep deprivation is known to increase the chances of poor health and wellbeing.⁴⁸ Research on environmental risk factors affecting delirium suggested that while a single ward move did not contribute significantly to the severity of delirium symptoms, multiple room/ward changes did have a cumulative effect.⁴⁹ NICE guidance on delirium also highlighted good sleep patterns as a way of preventing delirium developing and suggested promoting good sleep patterns by avoiding procedures and medication rounds during sleep hours, and by reducing noise to a minimum.⁵⁰ However, there are occasions when it is necessary to move a patient at night for clinical reasons, or because it is felt it will improve a patient's care.

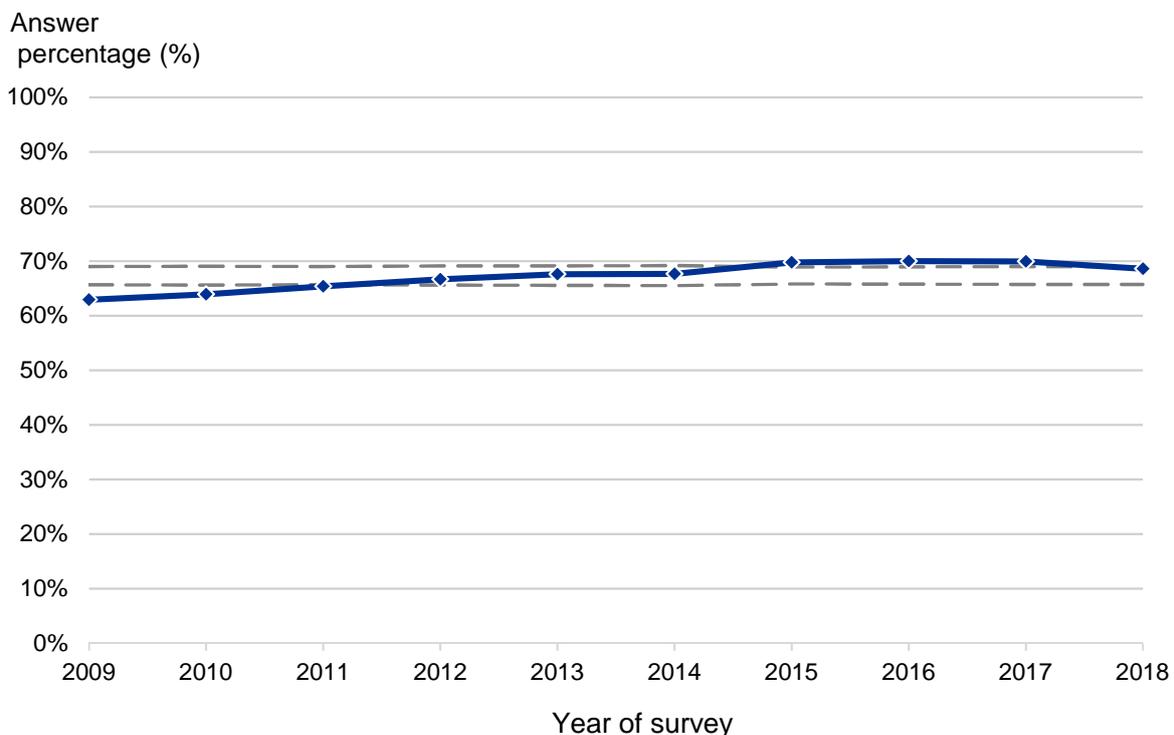
The proportion of patients who changed wards at night while they would have preferred not to has slightly increased since last year. It went from 7% in 2017 to 8% in 2018. Patients who were moved at night also reported they were not always consistently informed of the reason for being moved. Just over half of respondents, 53% said staff “completely” explained the reason for being moved compared to 55% in 2017. In 2018, another 28% said that the reasons were explained to them “to some extent”.

Other factors can also affect patients’ experience in the ward. NHS care providers are expected to eliminate mixed-sex accommodation, except if it in the best interest of the patient or reflective their personal choice. CQC’s inspectors monitor hospitals’ adherence with this recommendation as part of their inspection. Providing patients with same-sex accommodation can be a challenge in the context of bed shortages but is desirable as it is considered to help safeguard a patient’s privacy and dignity.⁵¹

Nine per cent of respondents said they shared a sleeping area with patients of the opposite sex, a proportion slightly higher than in 2017.

Cleanliness of the ward is also considered to improve the experience of beyond the basic need to prevent infection. There has been a trend of improvement in survey results of respondents’ perception of cleanliness of the ward since 2009, but this trend has come to a halt in 2018. In fact, the proportion of those saying the ward was “very clean” decreased from 2017. In 2018, 69% of respondents said that the ward was very clean, down from 70% in 2017. The charts below show the trend of respondents saying the ward was “very clean” over the years.

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



Note: answered by all.
 Base: 2009 (68,276), 2018 (75,333).

4. Dignity and respect

[The Health and Social Care Act 2008 \(Regulated Activities\) Regulations 2014](#), made it a statutory requirement that all people who use services are treated with dignity and respect. This requirement supports CQC's regulation of services and failing to treat people who use services with respect and dignity can trigger regulatory action.⁵² [NICE quality standard 1](#) states that patients should be treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty. Furthermore, the [NHS Constitution](#) states that patients have the right to be treated with respect and dignity, and that the NHS should actively encourage feedback from patients on their care.

In 2018, 80% of respondents said they had "always" been treated with dignity and respect during their stay. This is a slight decrease from 82% in 2017 and it marks a halt to a trend of improvement seen between 2015 and 2017.

Patients aged under 50 reported poorer than average experience when discussing respect and dignity. The youngest patients (aged 16 to 35) were the most negative group. As with most other themes, patients with an ICD-10 code V (mental and behavioural disorder) also had a poorer than average experience.

The proportion of respondents given enough privacy when being examined or treated either in the A&E department or in wards remained high and stable since 2017. In both contexts, only 2% of respondents reported not being given enough privacy.

The percentage of respondents reporting having experienced doctors or nurses talking in front of them as if they were not there dropped slightly compared to 2017, but remains above the upper control limit, indicating that the situation is better when compared to the 10-year period.

5. Patient discharge from hospital and integrated care

With the roll-out of integrated care, the expectation is to reduce the need for patients to use acute healthcare services by providing better services outside of hospitals, and to prevent hospital admissions by enabling patients to receive the same care in a different setting. The roll-out of integrated care is also an opportunity to improve coordination between acute services, primary and community services at the point of a patient's discharge from hospital. It would effectively make sure that patients being discharged because they no longer need acute treatment will be able to find the support they need in the community. As the lack of coordination around discharge can cause delayed transfers of care and prevent new patients accessing acute care, this is a key area of focus for the NHS. However, as previously mentioned, a noticeable proportion of patients stated that they had not felt involved in the decisions about their discharge (see section 1.1). Results also show a deterioration of reported experience of being discharged from hospital as well as ongoing challenges around delays when being discharged.

5.1 Coordination of care at hospital discharge

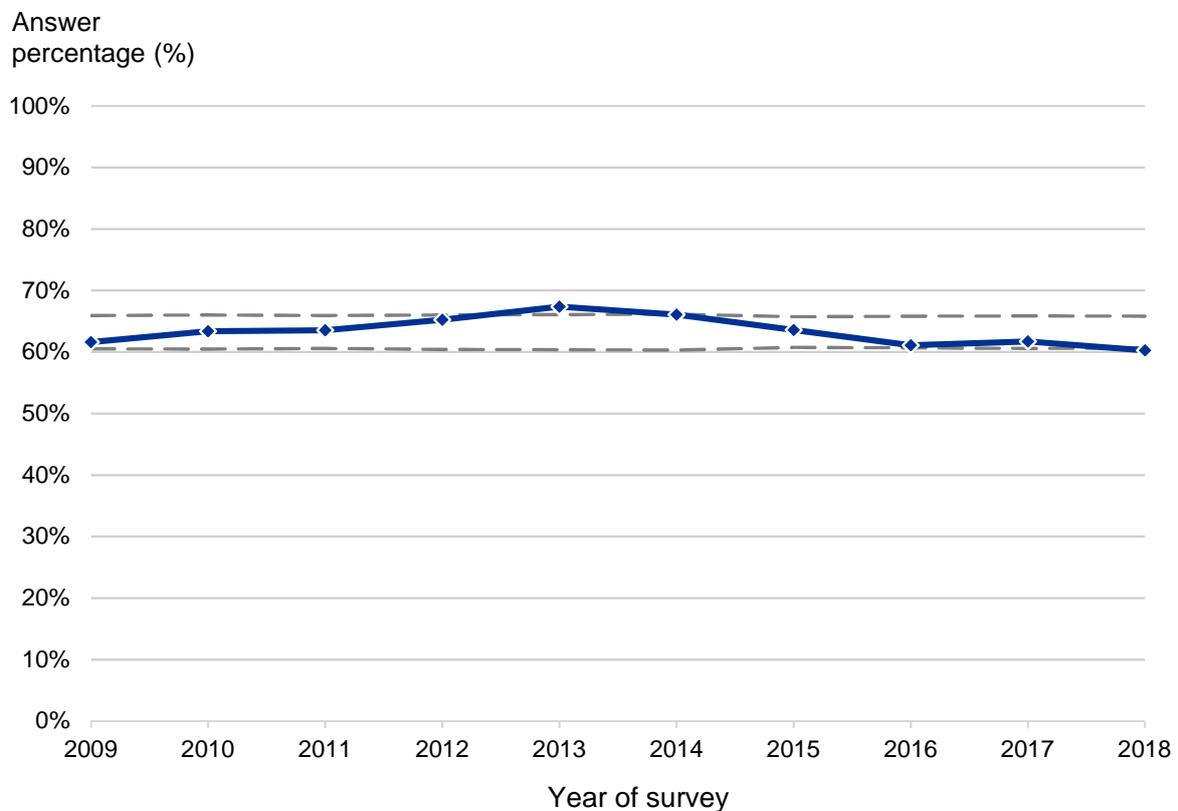
In 2018, responses to questions relating to the coordination of care when being discharged from hospitals were consistently more negative than in 2017.

Data shows that at the time of being discharged, significant proportions of patients were not sufficiently informed of their discharge plans. Fifteen per cent of respondents said they did not receive enough notice about when they were going to be discharged and 18% said they did not know what would happen next with their care when they left the hospital. The situation has been deteriorating slightly but significantly since 2017.

The NHS Constitution mentions that all patients should have easy access to reliable and relevant information about their condition, care and support plan in a form they can understand, but no specific pledge is made about discharge. Each hospital has its own discharge policy and patients can approach the Patient Advice and Liaison Service (PALS) to access it. Discharge should nevertheless be part of the treatment plan agreed with the medical team and should be planned as early as possible.⁵³ NICE recommends that discharge planning should start at the time of admission for a medical emergency.⁵⁴

Survey data also indicates that information given to patients to deal with their condition on their own might not always be sufficient. Forty per cent of respondents said that they were not given written or printed information about what they should or should not do after leaving the hospital, an increase from 38% in 2017, and which falls below the expected limits.

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



Note: answered by all.

Base: 2009 (66,804), 2018 (73,738).

In addition, 37% of respondents said they were not told by members of staff about danger signals to watch for after they went home, an increase from 36% in 2017. One out of four respondents (25%) also said they were not told who they could contact if they were worried about their condition or treatment after they left the hospital – an increase from 24% in 2017.

At the time of discharge, patients go through a discharge assessment that aims to determine whether they need more care after they leave the hospital. If the patient does not need more care after leaving hospital, the discharge is said to be “minimal”.

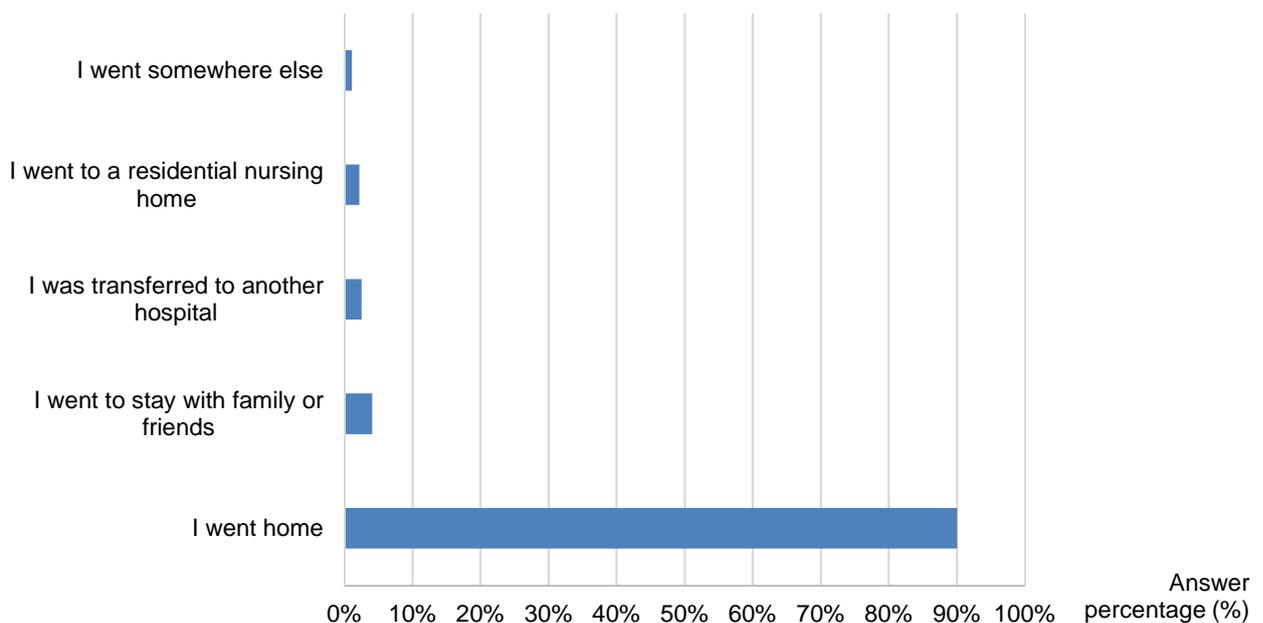
The NHS advises patients to organise for a friend or family member to collect them from hospital.⁵⁵ However, having the support of a family member is not always an option and the previous housing situation of the patient may no longer be suitable. One out of five respondents (20%) said their family or home situation was not considered when planning their discharge. This proportion is stable over time. Among those who had family, friends or carers involved, more than a quarter (26%) felt that they were not given all the necessary information to care for them.

The discharge assessment can also conclude that the patient still needs support after leaving the hospital, in which case the discharge is considered “complex” and measures need to be implemented to ensure continuity of care. Healthcare

professionals should seek the views of patients in the discharge assessment. The number of respondents saying that their needs around further health and social care services were discussed with them has decreased from 81% in 2017 to 80% in 2018. As detailed in section 1.1, this falls below the expected limits, showing a longer trend since 2012.

The vast majority of respondents indicated that they went home after being discharged (90%), while 4% said they went to stay with family or friend, 3% were transferred to another hospital and 2% went to a residential nursing home.^a

Q53: Where did you go after leaving the hospital (2018)



Note: answered by all.
Base: 74,647.

Patients who went home or to stay with family or friends following their discharge from hospital were asked whether they considered they got enough support from health or social care professionals to help them recover and manage their condition. Almost one in four (24%) said they did not but that it would have been useful. This is an increase from 22% in 2017.

As health and social care is provided by local health and social care systems and not solely by the NHS itself, such services require additional coordination among multiple actors. Local health and social care systems need to work together with acute NHS trusts to make sure that people receive continuity of care between hospital and home. Guidance on [managing transfers of care between hospital and home](#) was published by the Local Government Association, the Department for Health and Social Care, NHS England and the Association of Directors of Adult Social Services in 2015.⁵⁶ A new question was added to the adult inpatient survey questionnaire in 2018 asking patients whether the care and support they expected

^a The remaining 1% said they went “somewhere else”.

was effectively available when they needed it. Results show that 19% of respondents said it was not.

Along with younger patients (aged 16 to 50), patients with an ICD-10 chapter code XIV (diseases of the genitourinary system) reported poorer than average experience around coordination of care.

5.2 Discharge delays

The proportion of respondents saying that their discharge was delayed remained high (41%) and similar to 2017, despite the data showing that the number of DToC decreased when comparing July 2018 and July 2017.^a However, data used by the NHS to measure DToC is based on a monthly average of days, while the data from the adult inpatient survey reflect patient's perception of delay.

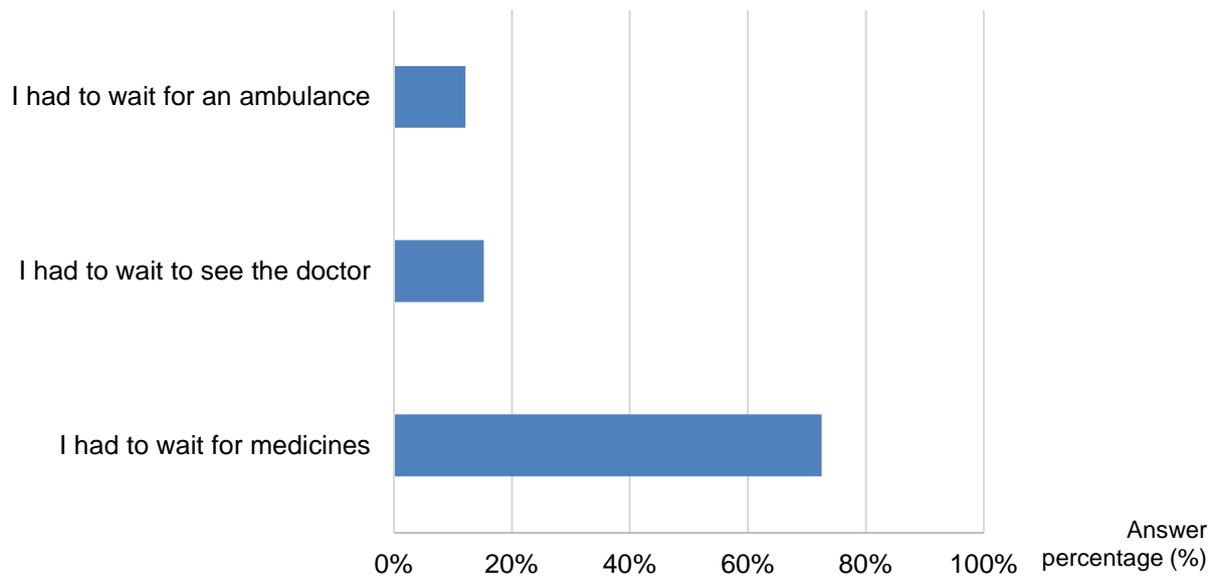
Discharge delays can negatively impact health outcomes, especially older patients whose long-term mobility can be reduced as a result of not being active during prolonged hospital stays. Other negative outcomes include a higher risk of infection and decline in a person's ability to undertake key daily activities.⁵⁷

In addition, patient care in hospital incurs much higher costs than in other settings, such as a care home, or in the patient's own home. Data on DToC is collected monthly by NHS England to monitor trends and identify the reasons for such delays. While this data looks at both NHS and social care related reasons, the adult inpatient survey accounts only for delays owing to the NHS acute trusts.

Almost three patients out of four (73%) whose discharge had been delayed said that the main reason was that they had had to wait for medicines. The remaining quarter of respondents indicated they had to wait for an ambulance (12%) or for a doctor assessment (15%).

^a At the time of the survey, in July 2018, there was an average of 4,528 beds per day occupied by patients who could have been discharged. The situation had improved from previous years. There were 5,867 delayed transfer of care beds in 2017 and this number had reached 5,954 in July 2016. NHS England, [Delayed transfer of care time series](#), Delayed Transfers of Care Data 2018-19, March 2019.

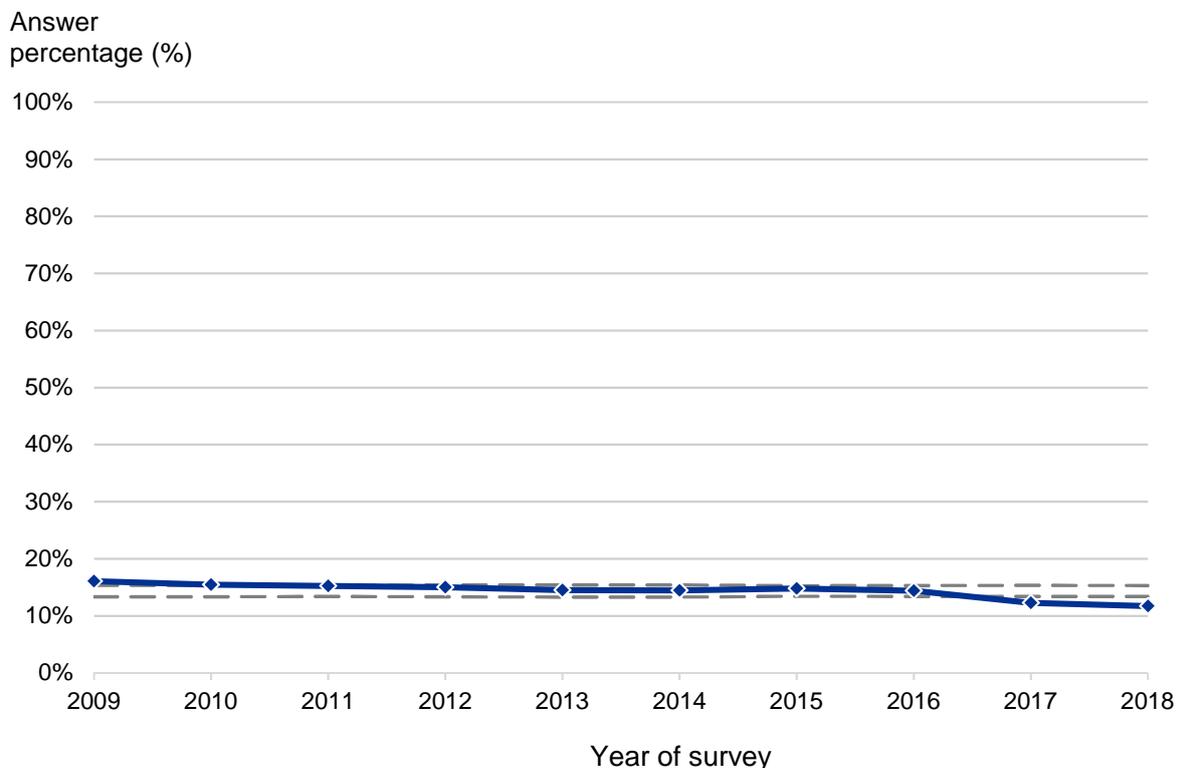
Q51: What was the main reason for the delay (2018)



Note: Answered by all whose discharge was delayed.
Base: 24,805.

Over the last 10 years, the amount of time spent waiting for discharge has increased. In 2018, 12% of respondents whose discharge was delayed said they waited less than an hour compared to 16% in 2009. As shown in the chart below, this indicates a meaningful change in trend data.

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



Note: Answered by all whose discharge was delayed.
Base: 2009 (27,339), 2018 (30,127).

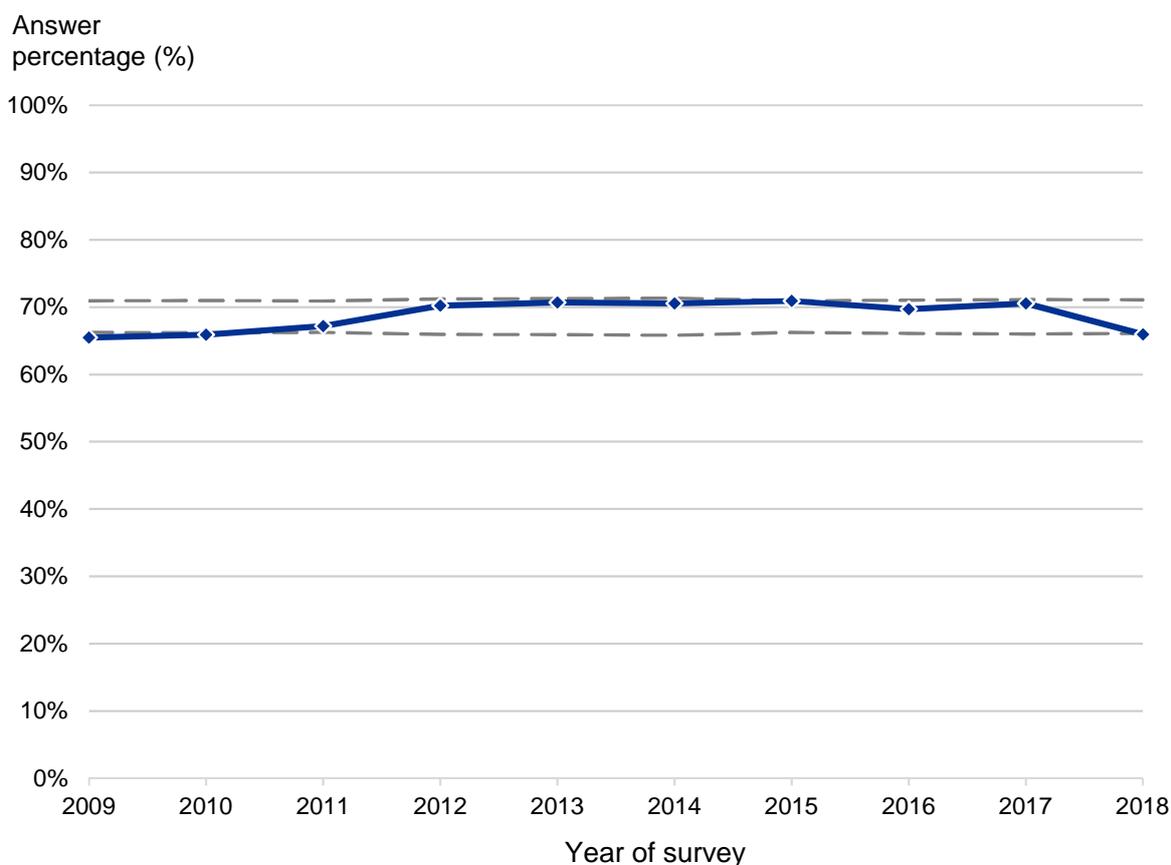
The proportion of respondents reporting waiting more than four hours increased since last year (24% in 2017 compared with 26% in 2018).

5.3 Information about medicines when leaving the hospital

While section 5.2 reported gaps in information when leaving the hospital, this section looks more specifically at the handling of medicines. The most common reason reported by patients to explain the delay in their discharge is that they were waiting for medicines.

Other results from the survey seem to indicate that the handling of the dispatch of medicines at discharge represents a challenge for trusts. Patients' satisfaction with the information given on medicines when discharged has decreased since last year. Fifteen per cent of respondents who were given medicines to take home said they had not been given clear written or printed information about it. This was 13% in 2017. The proportion of those saying that they had been completely given information about their medicine dropped to a level not seen since 2010. The chart below illustrates this break from previous years.

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



Note: Answered by all who had medicines.
Base: 2009 (55,292), 2018 (49,628).

In addition, 44% of respondents reported not being told about medication side effects to watch for when they went home. This is higher than the proportion of those who

said they had been “completely” told about them (37%). Nine per cent of respondents reported that the purpose of the medicines they were to take at home had not been explained to them in a way they could understand. This proportion has remained stable over time.

Research shows that the risk of medicine-related harm following discharge is high for older patients due to multiple factors including poor provision of information about possible side effects, lack of communication between secondary and primary care and heightened physiological stress for patients. Evidence from a study conducted in England between 2013 and 2015 suggests that medication-related harm affects one in three older adults following hospital discharge and that non-adherence (the fact that patients do not take the medication as prescribed or agreed) is implicated in one quarter of cases. This has a negative impact on patients’ health outcomes and recovery and can lead to re-admission to hospital. In addition to the individual harm to patients, this puts additional pressure on the NHS and result in extra cost for stay and treatments that could have been avoided.⁵⁸

6. Availability of staff

With a vacancy rate of 8.7% between July and September 2018, the NHS workforce is considered at stretch and CQC has raised concerns about the impact of staffing levels on the ability of service to deliver safe care.⁵⁹ 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]".⁶⁰ While data regularly collected by NHS England allows for monitoring the evolution of vacancies, data from the NHS patient survey programme gives information on how this impacts care from the patient's perspective.

About one in eight patients (12%) said there were "rarely" or "never" enough nurses to care for them in hospital. This percentage has remained stable over the years. Just over half of respondents (58%) said there were "always" or "nearly always" enough nurses.

Further, just under half (49%) of respondents said they "always" knew which nurse was in charge of looking after them. Another 31% said they knew this "sometimes". This question was introduced in 2016 and after a slight increase in 2017 (up by one percentage point to 50%), the share of those saying "yes always" is back to its level of 2016. In 2013, the [National Quality Board](#) (NQB) published *How to ensure the right people, with the right skills, are in the right place at the right time*, a guide to nursing, midwifery and care staffing capacity and capability. This advises that information about the nurses, midwives and care staff should be presented clearly on each ward, as well as what their roles are.⁶¹ Identifying members of staff can help patients who need attention to get help more quickly. In 2018, 59% of respondents said they were able to get help from a member of staff in a reasonable time, a decrease from 61% in 2017.

Organising the right mix of different professionals in the ward has also been pointed out as key to maximising the skills of each individual. The updated guidelines from the NQB states that staff should work as multi-professional teams to, "avoid placing demands solely on any one profession and support improvements in quality and productivity".⁶² In addition, agency and bank staff who work in the ward temporarily also need to be integrated in the permanent team. The adult inpatient survey monitors patients' experiences of whether members of staff work well together. In 2018, 74% of respondents said that members of staff "always" did and another 21% said they "sometimes" did. The proportion of those saying that they did not think members of staff worked well together increased from 4% in 2017 to 5% in 2018.

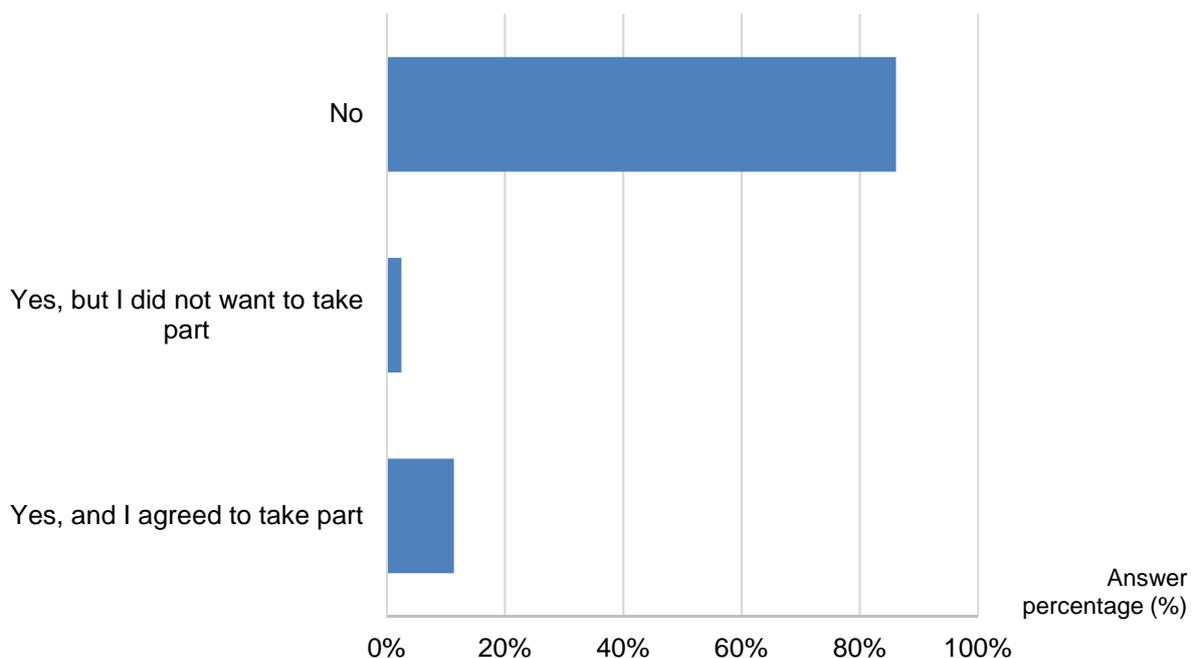
In addition to nursing and medical staff, such as doctors, nurses and healthcare assistants, many other professionals are involved in a patient's stay. These include cleaners, porters or catering staff. A high proportion of respondents (82%) said they "always" felt well looked after by the non-clinical staff and an additional 15% said they "sometimes" did. The proportion of those saying they "did not" increased from 2% in 2017 to 3% in 2018.

7. Recruiting patients to participate in research

In 2018, a new question was added to the survey asking patients if anyone discussed with them whether they would like to take part in a research study. The NHS Long Term Plan aims to increase the number of people registering to participate in health research to one million by 2023/24. Although this objective concerns the broader population, there is a need to specifically engage current inpatients whose conditions are known and diagnosed. The NHS Long Term Plan also proposes to offer patients suffering from certain rare conditions or specific cancer with whole genome sequencing as part of genomic research.

The extent of the challenge to recruit patients to take part in clinical research is visible in the results of the survey: in 2018, 86% respondents said no one discussed with them whether they would like to take part in a research study. However, the potential to recruit more patients seems to exist as only 2% of respondents said they discussed this but did not want to take part.

Q69: During this hospital stay, did anyone discuss with you whether you would like to take part in a research study? (2018)

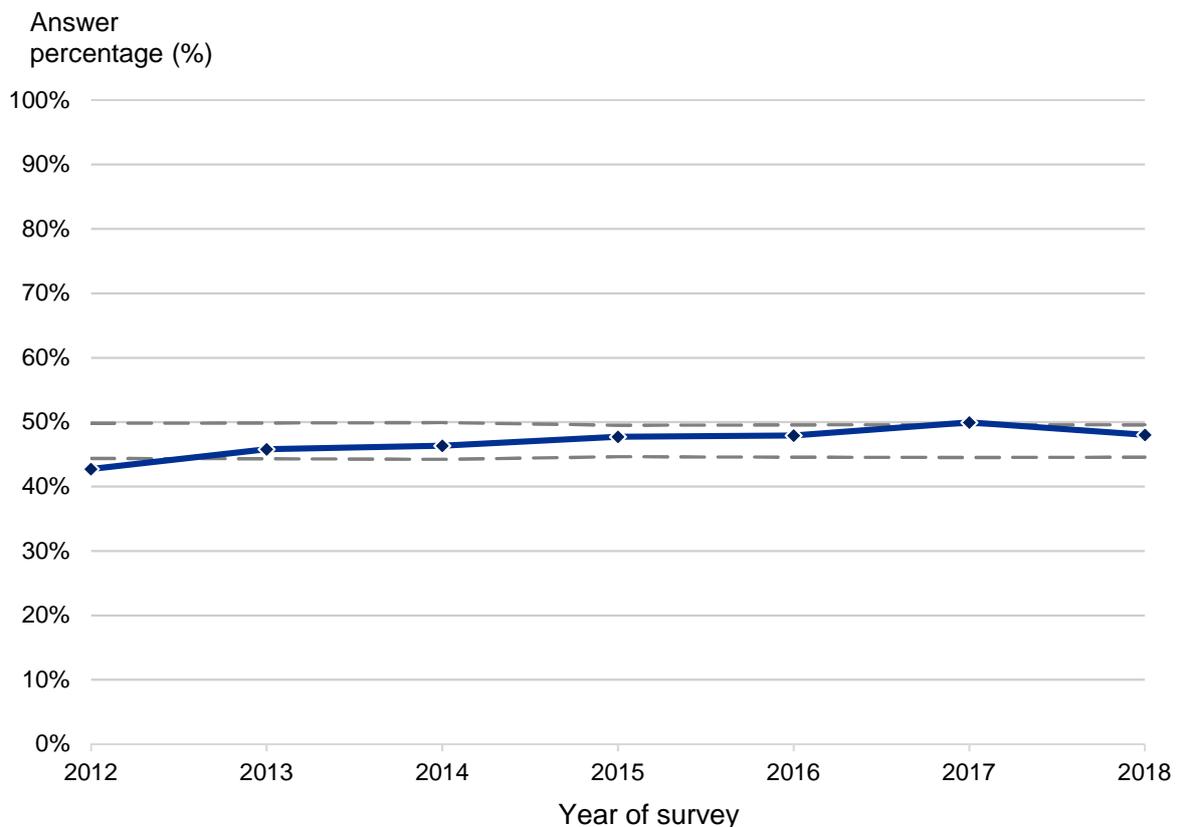


Note: Answered by all
Base: 63,712.

8. Overall experience

In many areas of the adult inpatient survey, results remained stable compared to 2017. However, some trends of improvement seen in previous years appear to be slowing. Overall 48% of patients scored their experience very positively (giving it a score of 9 or 10 out of 10). This is a small decrease from 50% in 2017 when it went above the upper control line and showed a genuine change from 2012. The proportion of those scoring their experience very poorly (0, 1 or 2 out of 10) remained similar as in previous year.

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



Note: answered by all.
Base: 2012 (61,379), 2018 (72,319).

There was large age divide for this question, with younger patients (aged 16 to 35) reporting poorer than average experience while older patients (aged over 66) reported higher than average experiences.

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 in line with 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 2018 questionnaire was kept as similar as possible to that used in 2017 to enable comparisons. We added two new questions and removed one question. One of the new questions related to availability of care following discharge from hospital and the other aimed to measure to what extent patients are invited to take part in research. A minor layout change was also made to the printed questionnaire to make instructions more visible.

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

2. Comparability with previous years

The adult inpatient survey first ran in 2002 and multiple changes to the questionnaire have occurred over the years. The survey results for 2018 are comparable with results from 2009 onward unless stated otherwise, and the statistical test for comparisons is based on a 10-year period.

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, leaflet offering guidance on multi-language options for completing the questionnaire, and a flyer outlining the value of the data to CQC. This was followed by a reminder to all non-respondents, then a final reminder containing another survey pack. 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 the following mailing.

Fieldwork for the survey (the time during which questionnaires were sent out and returned) took place between August 2018 and January 2019. The length of fieldwork varied from trust to trust depending on the date of approval of their sample.

One trust was excluded from analysis because of mailing errors.

4. Sampling

All patients aged 16 years or over at the time of their hospital stay were invited to take part if they were treated in the trust. Trusts drew a sample from their records of the sampling period (July 2018). 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 during July 2018
- 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](#).

All trusts providing inpatient services were eligible to take part in the survey. However, due to a mailing error, one trust's data was excluded from the results.

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 aims to 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 way 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 and filter questions. The demographic questions are presented without weights applied, as it is more appropriate to present the real percentages of respondents to describe the profile of respondents, rather than adjust figures.

Rounding

The tables present percentage figures rounded to the nearest whole number, so the values given for any question will not always add up to 100%. Please note that rounding up or down may make differences between survey years appear bigger or smaller than they actually are.

Statistical significance

Statistical tests were carried out on the data to determine whether there had been any statistically significant changes in the results for 2018 compared with 2017.

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 in 'expected limits of variation'. Results outside these expected limits would suggest underlying behavioural or real change.

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

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

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

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

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 differences between groups observed in the results could have arisen from a population where there were no actual differences. They relate to the demographic factor as a whole rather than to compare between specific categories in the factor. Variables were also checked for multicollinearity to ensure co-efficient estimates were not being influenced by additional factors.

Differences that are equivalent to at least 0.1 standard deviations from the overall mean of the target variable are treated as being noteworthy in this report. Composites were created with questions about NHS patient experience framework. See [Appendix H](#) for the charts.

Appendix B: Demographic tables

The tables below show the demographic characteristics of respondents to the 2018 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	66%
No	34%
Number of respondents	63,917

Answered by all

Q75: Do you have any of the following long-standing conditions?	
Breathing problem, such as asthma	29%
Blindness or partial sight	7%
Cancer in the last 5 years	20%
Dementia or Alzheimer's disease	5%
Deafness or hearing loss	23%
Diabetes	22%
Heart problem, such as angina	29%
Joint problem, such as arthritis	48%
Kidney or liver disease	11%
Learning disability	2%
Mental health condition	10%
Neurological condition	9%
Another long-term condition	26%
Total	50,620

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	50,007

Answered by those with a long-standing condition

Proportions responding to the survey by sex	
Male	48%
Female	52%
Number of respondents	76,668

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	23%
66-80	41%
>80	23%
Number of respondents	76,668

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

Q79: What is your religion?	
No religion	18%
Buddhist	0%
Christian (including Church of England, Catholic, Protestant, and other Christian denominations)	75%
Hindu	1%
Jewish	0%
Muslim	2%
Sikh	0%
Other	1%
I would prefer not to say	2%
Number of respondents	73,260

Answered by all

Q80: Which of the following best describes how you think of yourself?	
Heterosexual / straight	94%
Gay / lesbian	1%
Bisexual	0%
Other	1%
I would prefer not to say	4%
Number of respondents	70,621

Answered by all

Q81: What is your ethnic group?	
White	94%
Mixed	1%
Asian or Asian British	3%
Black or Black British	2%
Arab or other ethnic group	0%
Number of respondents	72,417

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 previous 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. 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, similar to England's results, most people responded positively.

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

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

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

New Zealand

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

The 20 items/questions cover four key domains of patient experience: communication, partnership, co-ordination, and physical and emotional need. Many of the questions are the same as those in the adult inpatient survey 2018.

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

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

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

Further questions

This summary has been produced by CQC's Survey Team and reflects the findings of the adult inpatient survey 2018. 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 all feedback on the findings of the survey and the way we have reported the results – particularly from people using services, their representatives, and those providing services. If you have any views, comments or suggestions on how we could improve this publication, please contact 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.



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

Appendix 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 been reviewing the use of all survey data to identify who uses it. We would like to hear from anyone interested in, or already using the data to contact us with feedback or recommendations at: patient.survey@cqc.org.uk.

NHS trusts and commissioners

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

Patients, their supporters and representative groups

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

Care Quality Commission (CQC)

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

NHS England

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

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

Department of Health

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

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

NHS Improvement

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

For more Information see <https://improvement.nhs.uk/> and <http://www.ntda.nhs.uk/>.

Appendix F: Changes to the questionnaire

The 2018 Adult Inpatient Survey has remained largely the same as the 2017 survey. The changes to questions are described below.

Two new questions were added.

Q66 Was the care and support you expected available **when** you needed it?

Q69 During this hospital stay, did anyone discuss with you whether you would like to take part in a research study?

One question was removed:

Q59 Were you told how to **take** your medication in a way you could understand?

The formatting of one page of the printed questionnaire was modified:

The formatting of page 10 of the printed questionnaire was modified to make a reminder paragraph more visible. This paragraph is placed before the section including the demographic questions and reminds respondents that if answered by proxy, the responses should strictly reflect the views of the patient. While the paragraph appeared at the bottom of the left column in the 2017 questionnaire, it was moved to the top of the right column in the 2018 one so that there would not be a column break between the reminder and the block of questions to which it applies.

Find more details about changes to this year's questionnaire in our development report for the NHS adult inpatient survey 2018 on the NHS Surveys website, <http://nhssurveys.org/survey/2117>.

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 14 quality statements about patient experience. The standard aims to provide the NHS with clear commissioning guidance on the components of a good patient experience. The quality standard gives evidence-based statements for commissioners that provide the foundation for an 'NHS cultural shift' to a patient-centred service. For further information on the NICE quality standard, please see:

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

Appendix 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^a 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
- **ICD 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:** Patient, Friend or relative, Patient and friend / relative, Patient with help of professional

The themes and composite questions are:

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

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

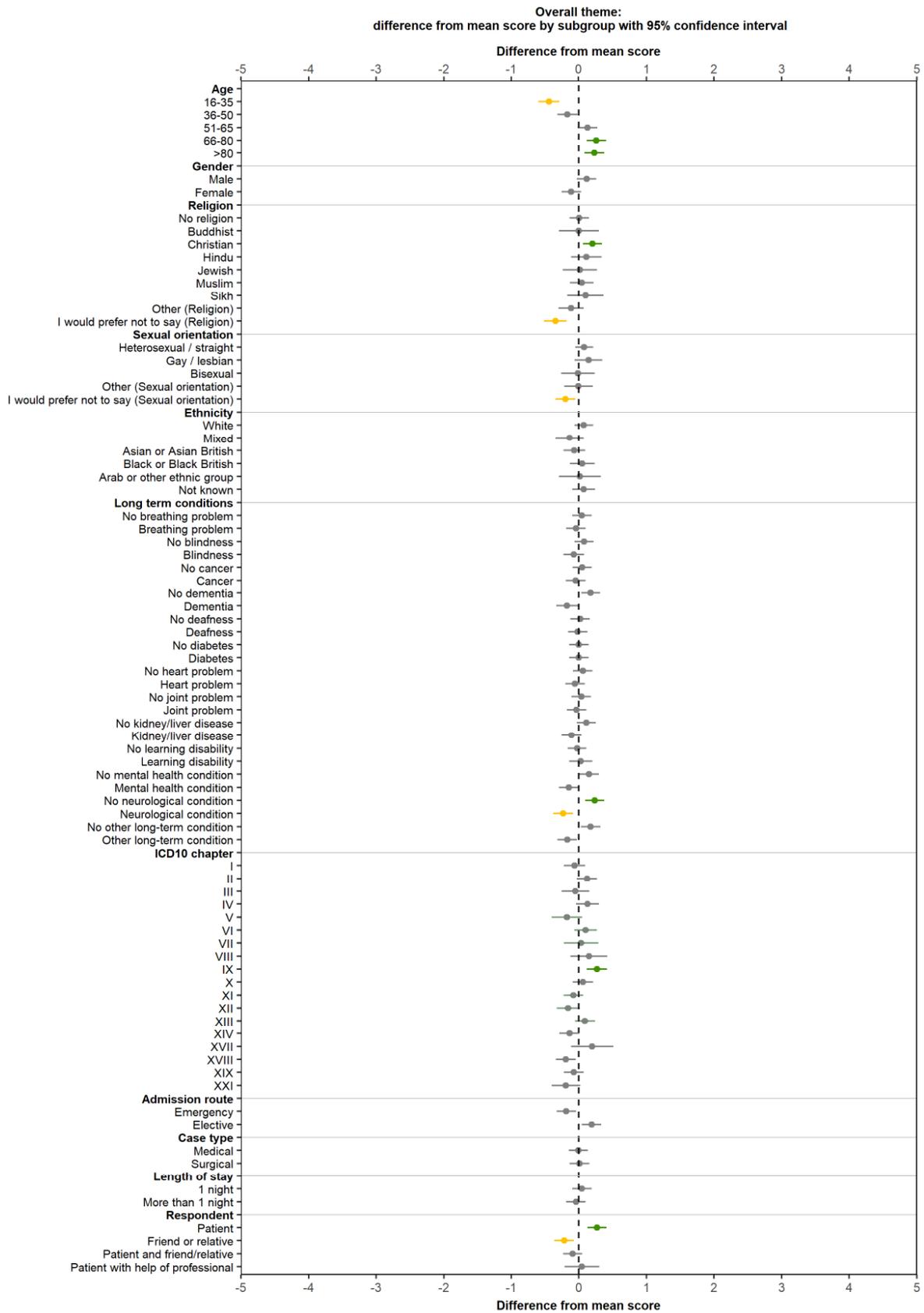
- **Q68:** Overall... (Please circle a number)

Interpreting the charts

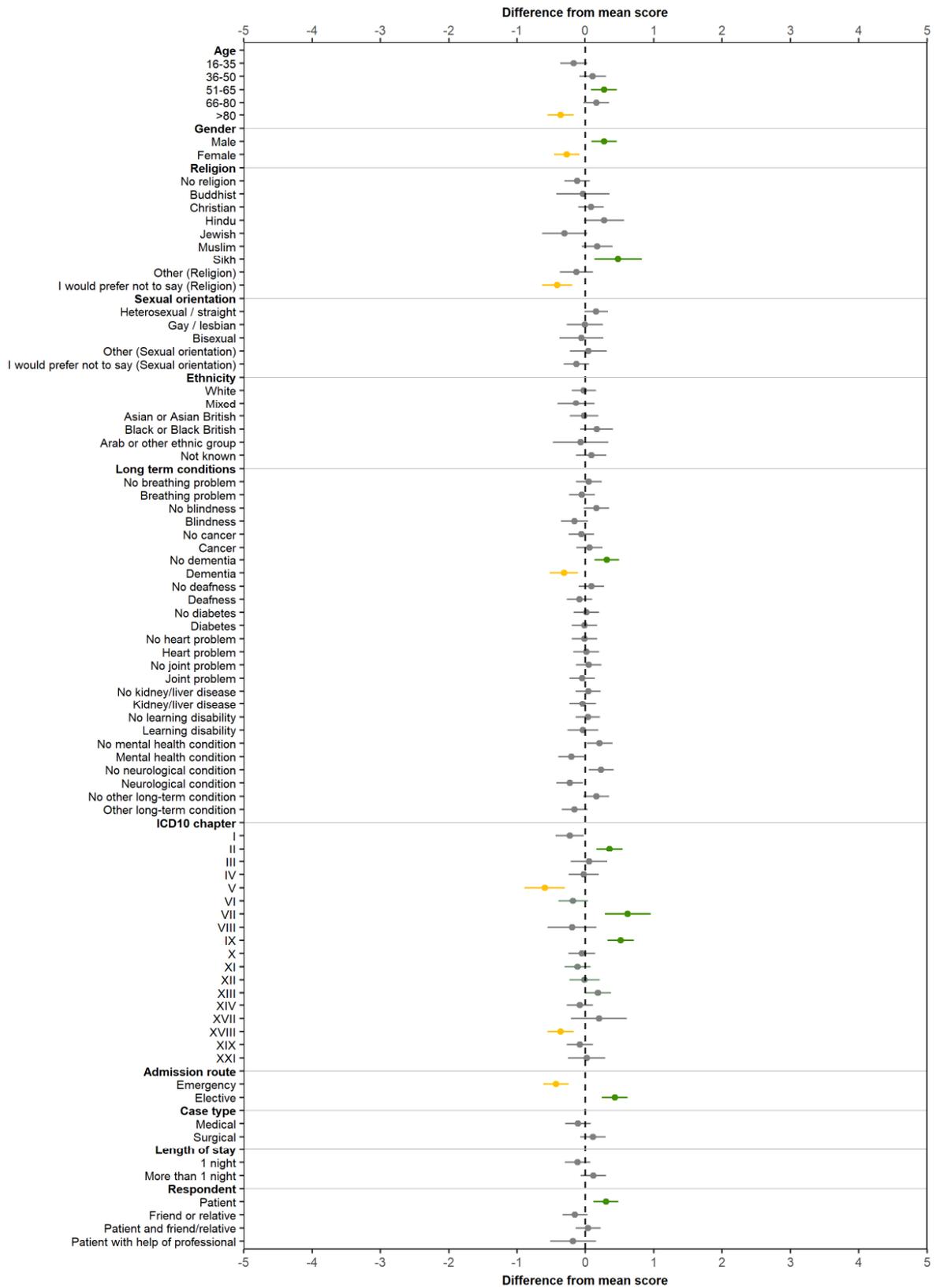
In this report, differences that are equivalent to at least 0.1 standard deviations from the overall mean of the target variable are treated as being noteworthy, provided that the confidence interval does not overlap the mean line.

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

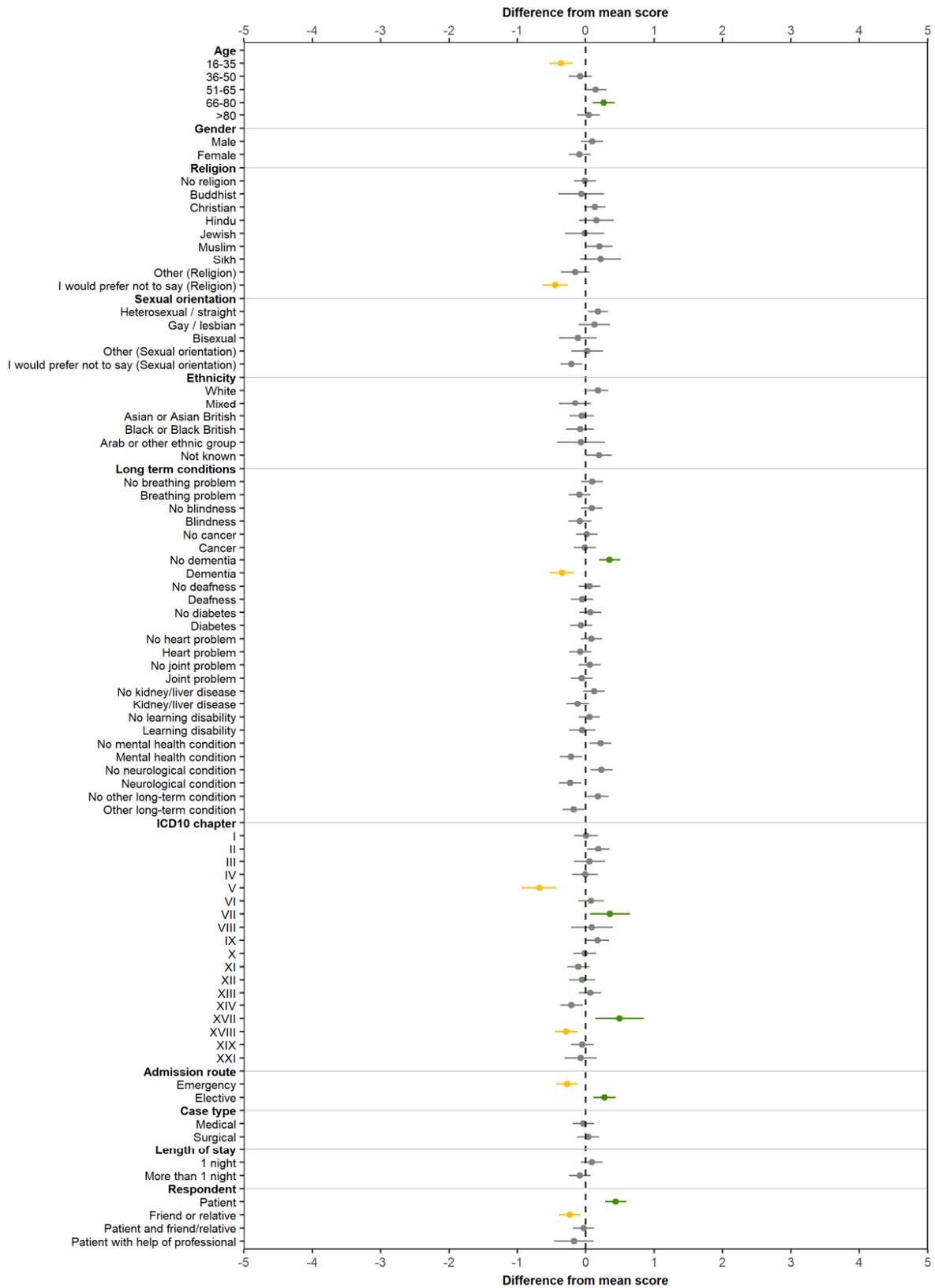
The graphs in this section highlight better than average experiences that are significant in green. Significantly worse than average experiences are highlighted in yellow.

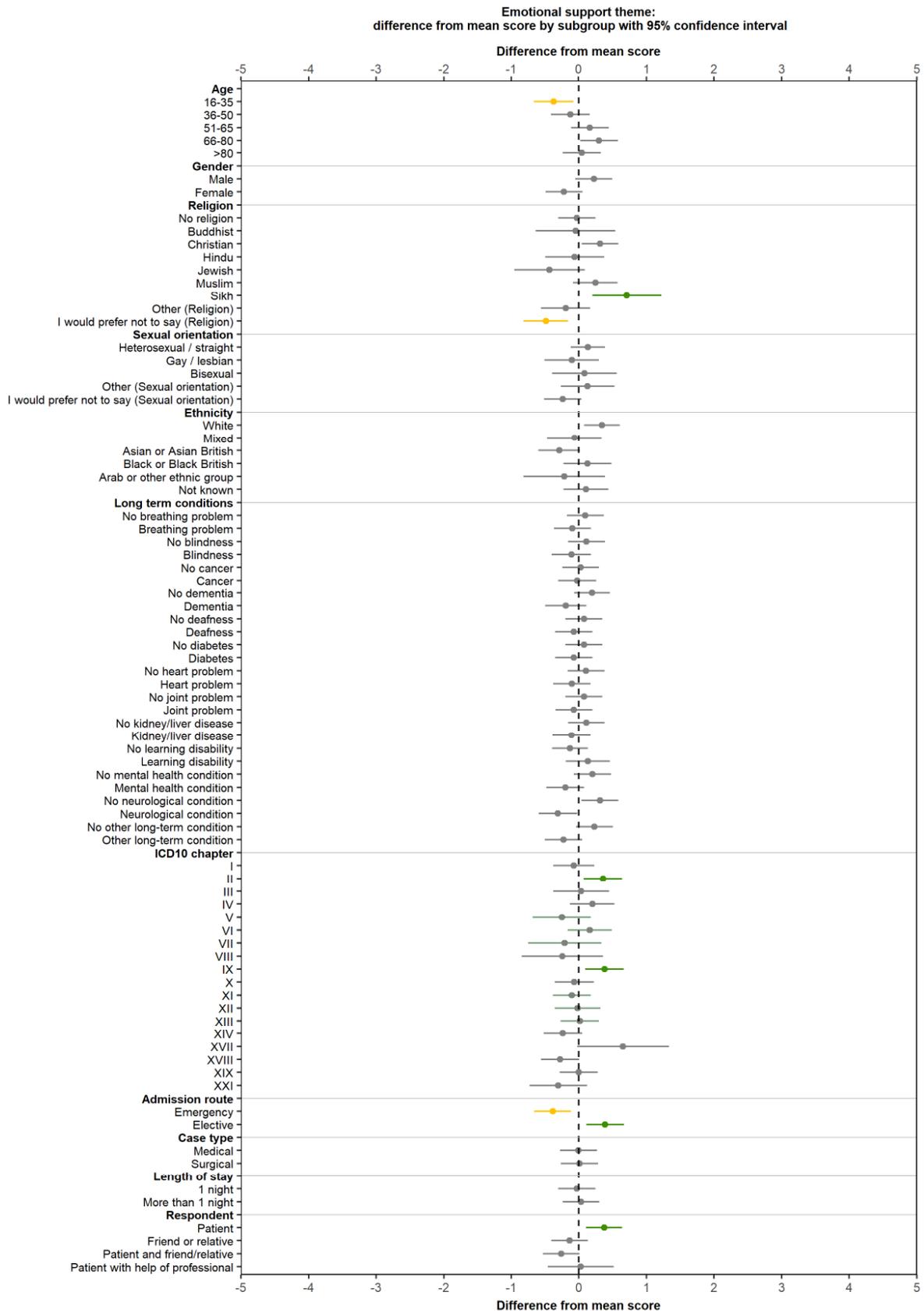


Information, communication and education theme:
 difference from mean score by subgroup with 95% confidence interval

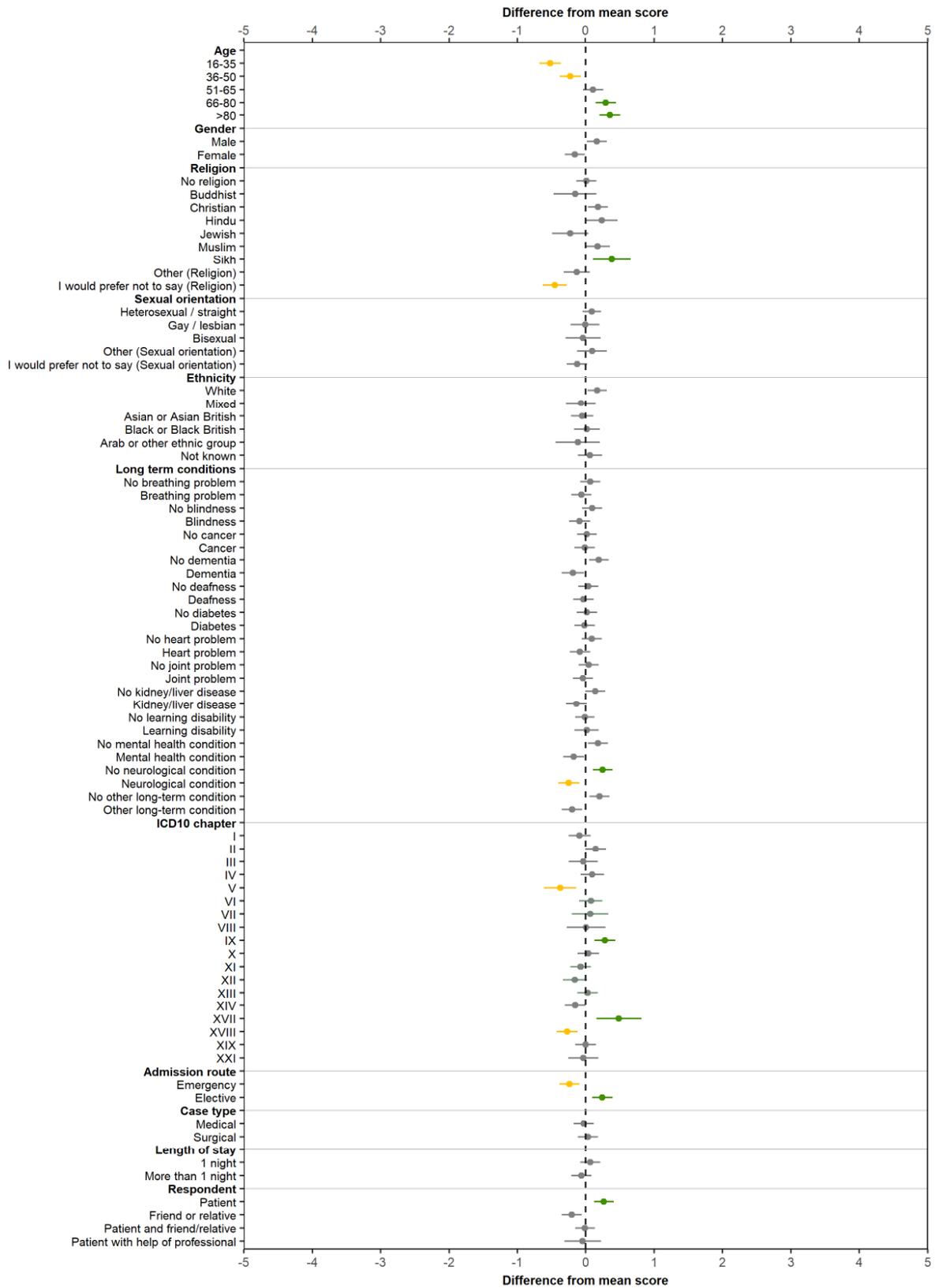


Respect for patient-centred values, preferences, and expressed needs theme:
 difference from mean score by subgroup with 95% confidence interval

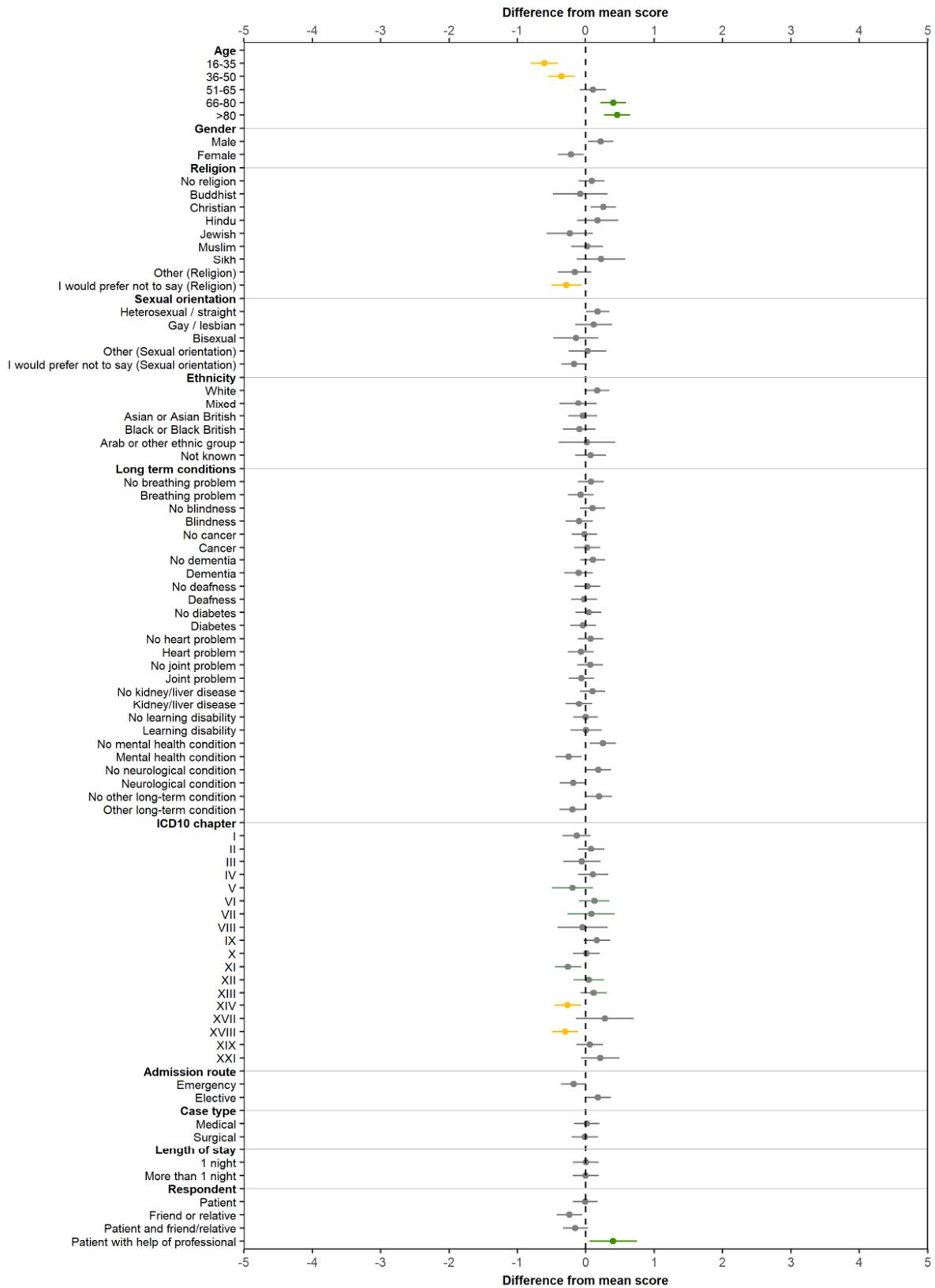


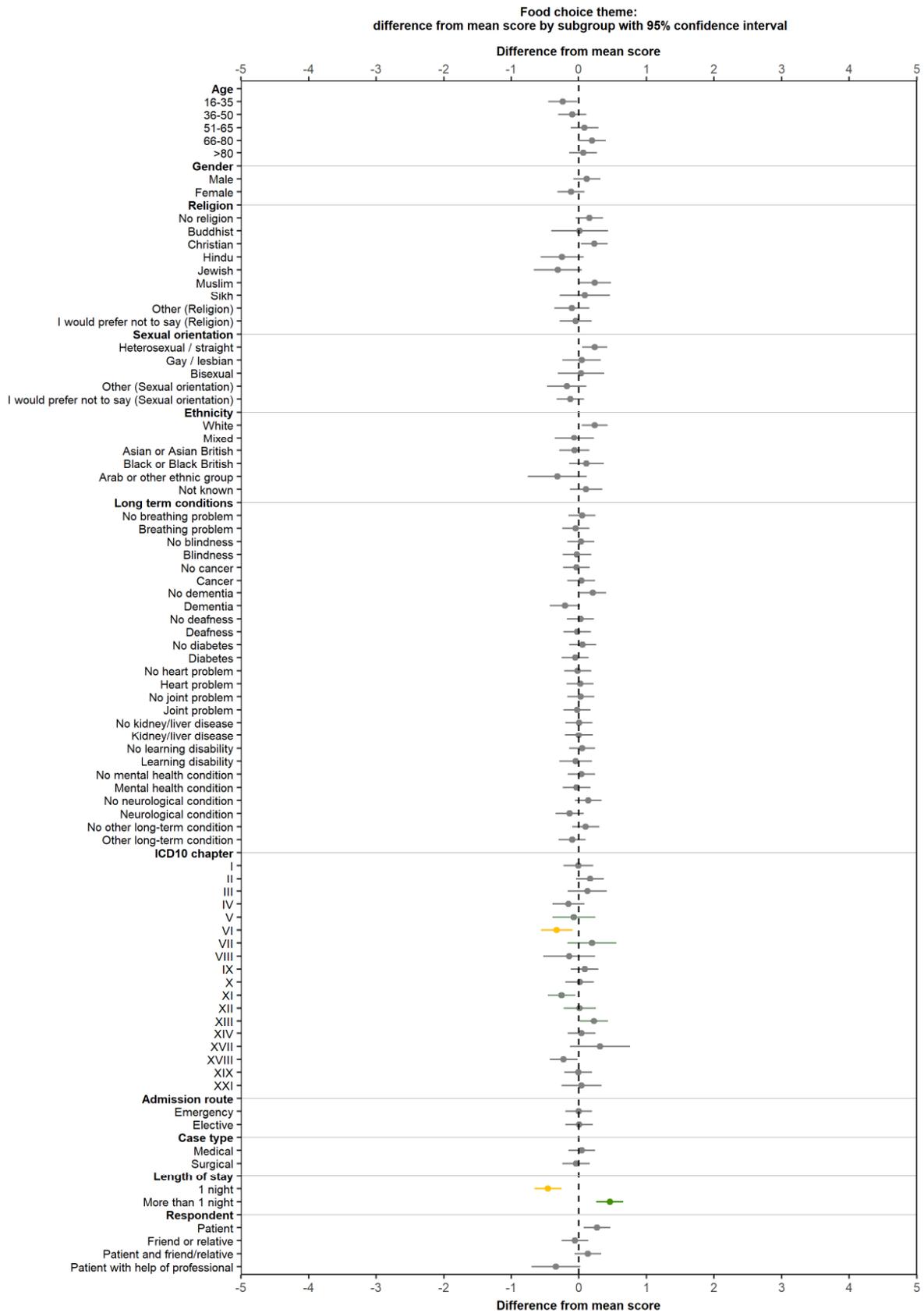


Confidence and trust theme:
 difference from mean score by subgroup with 95% confidence interval

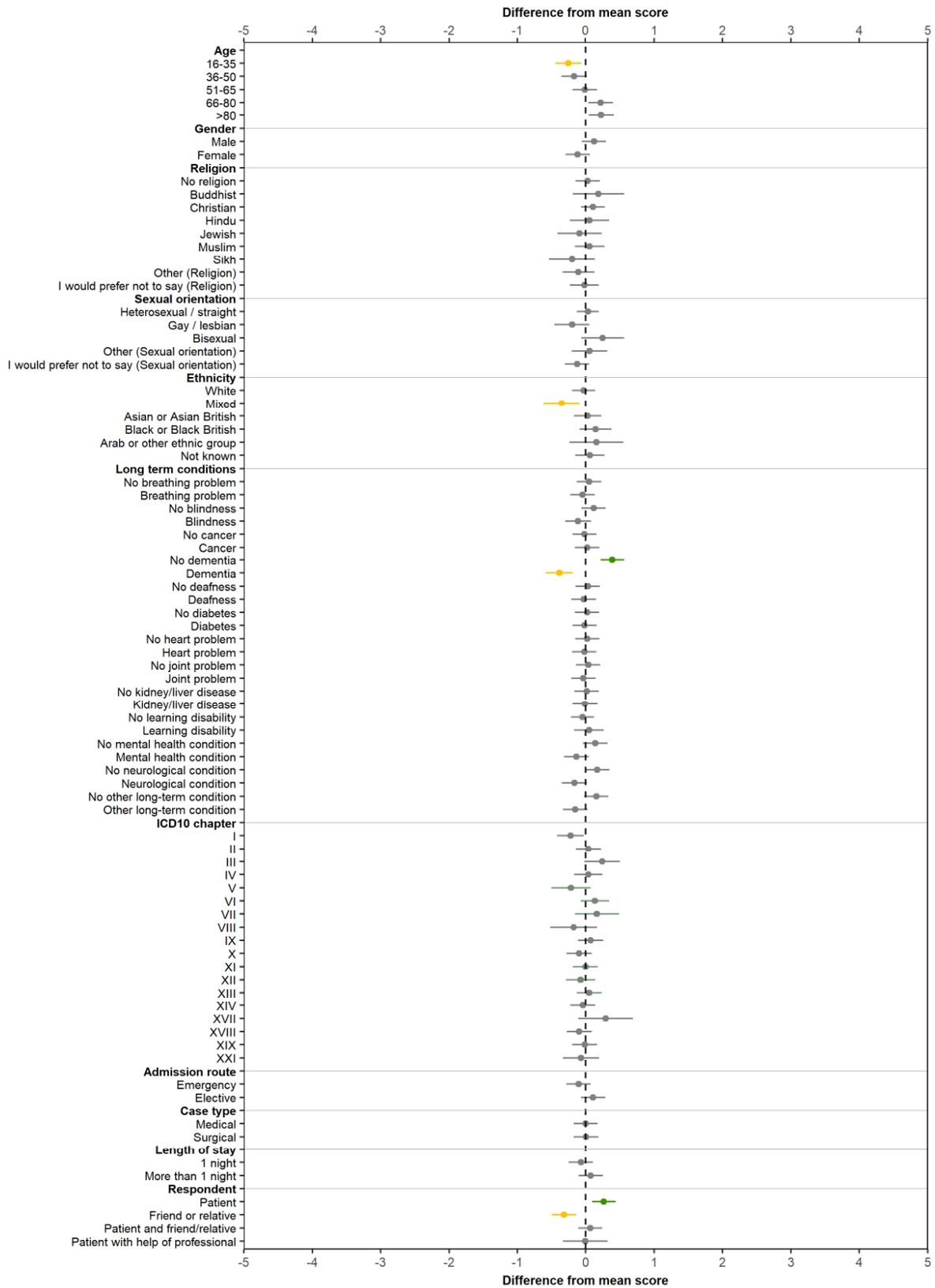


Coordination and integration of care theme:
 difference from mean score by subgroup with 95% confidence interval

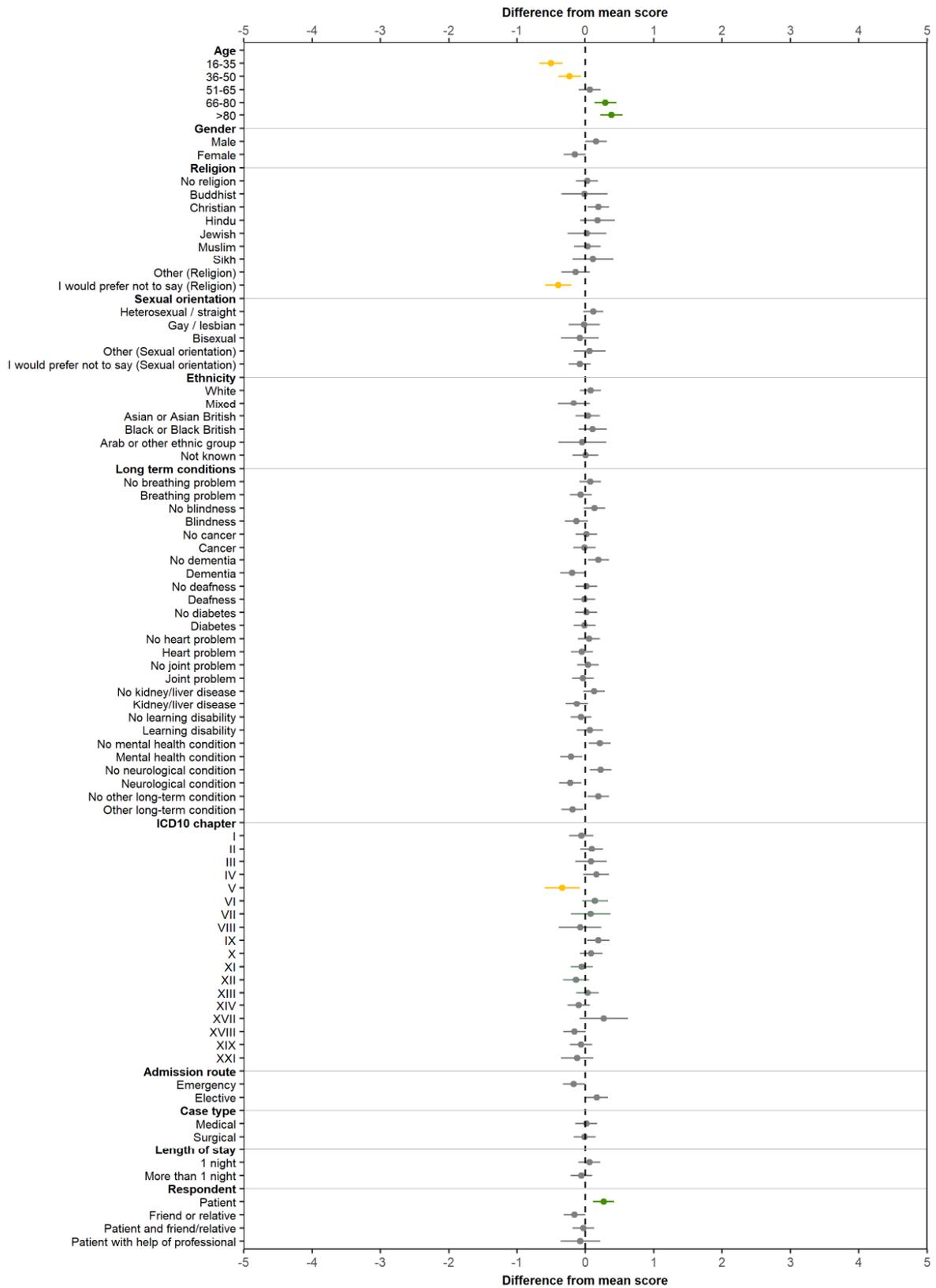




Hydration theme:
difference from mean score by subgroup with 95% confidence interval



Respect and Dignity theme:
 difference from 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 2018, 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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