Acknowledgements

This report was prepared by Sophie Crawley, Francesca Duffield and Chloë Hood.

We would like to thank Elena Baker-Glenn, Jacob Crawford and Alan Quirk for their contribution to this report.

We would also like to thank Chris Dyer, Nicky Hayes, Russell Hogarth, Rob Stewart, Helen McCormack, Caroline Rogers, Peter Crome, Roland Valori and Dawne Garrett for their input and support.

Finally, thanks to all participating wards for working with us.

Table of Contents

Quality Mark for Elder-Friendly Hospital Wards

Executive Summary

Background

Previous reports have highlighted failings in basic care standards for older people. Based on this, the Quality Mark for Elder-Friendly Hospital Wards (Quality Mark) was developed. The Quality Mark is a Quality Improvement programme for individual hospital wards that admit patients aged 65 and over. Wards participating in the Quality Mark sign up to commit to a continuous focus on the care provided for elder patients made by the hospital, the ward and the staff to achieve a consistently good quality of care for older people.

The Quality Mark Process

There are two stages involving a set amount of data collection from patients, staff, ward manager, lead consultant, multi-disciplinary team, review of the environment, and governors. These sources contribute to an overall picture of the ward experience for older patients and whether the quality of care is sustainable.

At the end of the second stage, the ward must receive a pre-determined level of positive feedback demonstrated by the overall ward level scores or ratings, before an Award Committee to consider whether the ward should be awarded the Quality Mark.

This report

This is the first National Report for the Quality Mark for Elder-Friendly Hospital Wards. It focuses on feedback collected from staff on 55 participating wards which completed both stages. Patients and staff ratings are explored at each stage of the Quality Mark, to measure any improvements are made between the two stages. The report also focuses on whether there are any differences between wards that did achieve the award and wards that did not.

Method

The data included are from 50 Acute Hospital wards and five Community Hospital wards across 26 Hospitals and 21 Trusts from wards who completed both stages of the Quality Mark between September 2016 and January 2018.

Patient and staff questionnaires are completed anonymously. Patients are eligible if they are over the age of 65 and stay on the ward for at least two nights. Clinical or support staff are eligible to complete the online staff questionnaire.

Results

A total of 2358 Patient Questionnaires were returned at Stage I, and 2533 returned at Stage II. A total of 1088 Staff Questionnaires were returned at Stage I, and 1018 returned at Stage II.

Various analyses have been carried out on the results to identify any themes, key findings and recommendations.

Key findings

Findings suggest that the Quality Mark programme is associated with discernible improvements in patient and staff ratings of care provided to elderly people. Some of the main findings are:

- Wards who participate show an increase in patient experience scores across 2 stages of data collection
- Wards with a higher frequency of positive comments are more likely to achieve QM and wards with a higher frequency of negative comments are less likely to achieve QM
- By Stage II, all staff questionnaire domains had significantly improved
- If feedback from the first stage of the QM was shared amongst staff, wards were significantly more likely to achieve the award
- Staff training and development is a significant factor in achieving QM
- Action planning and quality improvement activity is sustained beyond achievement of QM
- Some aspects of patient experience score less positively at both stages – food, temperature, social interaction and privacy need more focus to achieve quality improvement

Recommendations

- Wards should collect and respond to feedback from patients and staff, with a focus on older patients
- Quality improvement aims should enable quality improvement in patient centred care by putting the patient's views first and focus on themes that emerge from feedback subthemes can be reported and acted on when gathering detailed feedback unique to ward. Repeat data collection should be planned to measure progress
- Share all positive and negative comments and suggestions to staff on the ward
- Involve leadership in patient centred care
- To quickly address some concerns commonly reported by older patients, wards should focus on noise levels, temperature, meal times and privacy, as these aspects were scored lower at both stages of measurement.

Introduction

Background

Over several years, reports have identified failings in basic care standards for older people, and statistics demonstrated a continuing rise in admissions to hospital of people aged 60 and over. A King's Fund report (Oliver et al, 2014) highlighted that older patients tend to experience longer hospital admissions and delayed discharges, while emergency readmission within one month is also common.

When in hospital, older people can suffer cognitive decline and loss of mobility resulting in impairment of daily living skills, and risking other adverse outcomes such as continence problems, pressure sores, malnourishment and dehydration. Provision of the highest quality of care possible is essential to address the complexity of care needs and avoid such adverse outcomes. It is therefore important that healthcare professionals who work in these settings have the skills, support and confidence to provide the best patient-centred care possible (Aiken et al, 2012).

Dignity in Practice, an NIHR study carried out in 2011, reported an "almost unanimous" view amongst hospital staff interviewed, that an acute hospital is not the 'right place' for older patients and acute wards are not 'fit for purpose' for the treatment of older patients (Tadd *et al.* 2011). The 2014 HSJ/ Serco Commission report on hospital care for frail older people reiterated this and stressed that this patient group are particularly vulnerable to receiving a poor service. The Care Quality Commission's Dignity and Nutrition Inspection Programme (2011) observed staff speaking to older patients in a condescending or dismissive way which failed to acknowledge their needs. The inspection also revealed that 20% of a sample of more than 100 hospitals failed to meet standards for basic nutrition and dignity of older patients. High variation in quality of care provided within and between wards in the same hospital was reported by these studies, and also the National Audit of Dementia (RCPsych 2011) and the Francis Report (Mid Staffordshire NHS Foundation Trust enquiry 2013). In 2015, the Parliamentary and Health Service Ombudsman reported that older people and their family members found it difficult to complain about hospital care or treatment. This finding emphasises the importance of gathering data about the quality of care on wards.

The Quality Mark programme was developed in 2012 by the Royal College of Psychiatrists as a quality improvement programme for individual acute hospital wards that admit patients aged 65 and over. The Quality Mark is managed by the Royal College of Psychiatrists and supported by Age UK, the British Geriatrics Society, the Royal Colleges of Nursing and Physicians, and other professional bodies.

Quality Mark for Elder-Friendly Hospital Wards

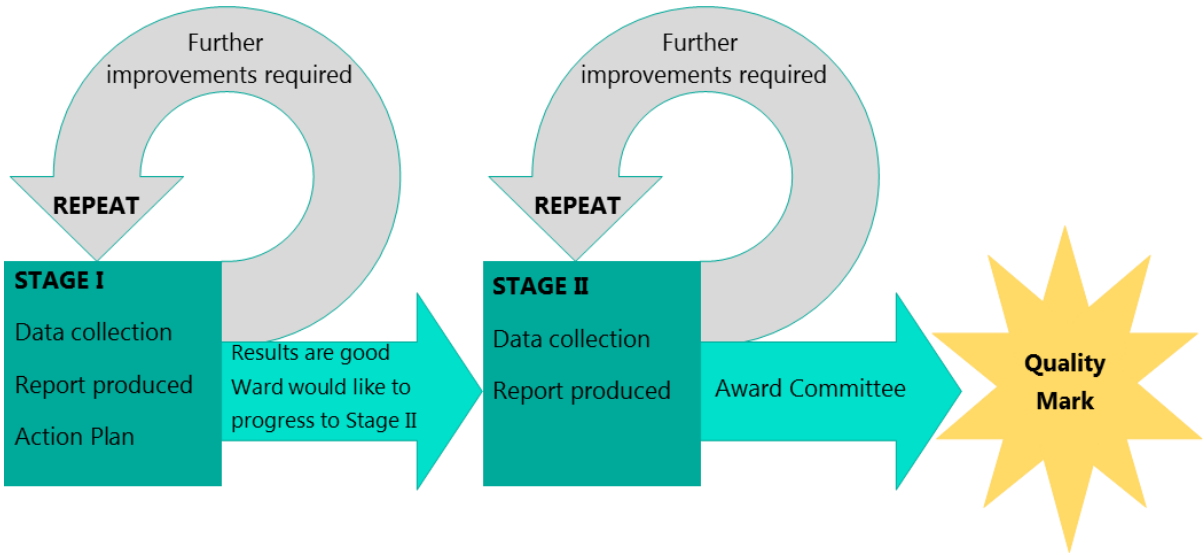
The Quality Mark Process

Wards participating in the Quality Mark sign up to ensure a continuous focus on the care provided for people aged 65+ and demonstrate the commitment made by the hospital, the ward and the staff to achieve a consistently good quality of care for older people.

Each ward undertakes two stages of data collection, involving patients, staff and a range of other sources (see below). The questionnaires use statements about care quality which can be mapped to components of dignified care, (for example, see Help the Aged (2008),) such as support to make choices in care, control over individual preferences in decision making, courteous and respectful interactions, and facilities that are appropriate and clean.

At the end of Stage II, the ward must receive a pre-determined level of positive feedback, demonstrated by the overall ward level scores or ratings, before their Stage II report is considered by the Quality Mark Advisory Committee (AC). The AC includes services users and carers, nurses, physicians and allied healthcare professionals. The AC considers all feedback and the ward's ratings before recommending to the Chair of the Combined Committee for Accreditation whether the Quality Mark should be awarded. The Quality Mark process is summarised in the Figure 1. See Appendix A for further details and for further information about the development of the programme, see Dicks et al (2013).

Figure I: Quality Mark Process Model



Data sources

Participation in the Quality Mark involves data collection from several sources contributing to an overall picture of the ward experience for older patients and whether the quality of care is sustainable. This includes:

- Feedback from the Ward Manager and a Lead Consultant about support and resources provided to them and their team,
- Multidisciplinary team feedback about team dynamics, skills and coverage, and understanding of care approaches,
- Review of the environment by the Ward Manager and hospital Governors,
- Governors' rating of the ward, following a visit at mealtime.

These elements all receive separate scores which can be compared with the patient and staff scores. Further important contextual information is provided by observations of care carried out on the ward and a Hospital Management Questionnaire evidencing leadership at highest management level with respect to the care for older people. Details of all data collection requirements can be found at Appendix E and scores for all hospitals who have participated in both Stages at Appendix H.

This Report

This is the first National Report for the Quality Mark for Elder Friendly Hospital Wards. The report focusses on the feedback collected from older patients and from staff on 55 participating wards. We explore the ratings from patients and staff at each data collection stage, to measure whether any improvements are made between the two stages. We have also looked at differences between the wards who achieved the award and those who did not. The results highlight that participating in the Quality Mark has a positive effect on the quality of acute care received by older patients.

The report includes feedback from wards that have completed an interim review (this is required 18 months after the ward achieves the Quality Mark, to ensure the wards continue to meet award requirements and review progress and any significant changes on the ward).

Method

Sample and eligibility:

The data included in this report came from 50 Acute Hospital wards and five Community Hospital wards across 26 Hospitals and 21 Trusts, from wards who had completed both stages of the Quality Mark between September 2012 and January 2018.

Where wards had more than one attempt at Stage I or Stage II data collection, their latest data sets are included and earlier attempts excluded; partial reassessment data is excluded from this analysis. (12/55 wards have some data which has been excluded. Reasons for reassessment at both Stage I and Stage II include lower scores across the measures and incomplete data sets).

Measures:

Patients were eligible to complete the questionnaire if they were over the age of 65 and had stayed on the ward for at least two nights. The patient questionnaires were completed anonymously and by hand, and returned to the Quality Mark team in pre-paid envelopes. Clinical and support staff were eligible to complete the online staff questionnaire. Staff responses were anonymised. Individual responses were not made available to wards with the exception of anonymised comments provided by patients.

The patient and staff questionnaires consist of statements relating to the quality of care. Participants rate their level of agreement using a five-point Likert scale: Strongly Agree (SA), Agree (A), Neither Agree nor Disagree (NAND), Disagree (D), Strongly Disagree (SD). Responses are recoded numerically, so that SA = 5 and SD = 0. This produces a score from the total questionnaire responses of 0-100, with a benchmark of at least 75 indicating that most patients/staff have agreed or strongly agreed with most statements.

Statements in the staff training domain are an exception, as binary responses (Yes/No) are used. Both questionnaires are split into five separate domains that relate to different aspects of patient care (the Staff Questionnaire has an extra domain about responding to feedback at Stage II).

Patient Questionnaire domains:

The patient questionnaire contains 23 statements at Stage I and 24 at Stage II, split across the five domains. Example statements from each of the domains are shown below

- **Comfort on the Ward**: e.g. *"The ward is quiet at night-time"*
- **Eating & Drinking:** e.g. *"The food is excellent"*
- **Staff Attitude:** e.g. *"Staff let me know that they have time for me"*
- **Getting Help:** e.g. *"I can always get help from staff when I need it for: Using the toilet facilities "*
- **Privacy & Dignity:** e.g. *"I always receive care that is considerate and avoids embarrassment"*

Staff Questionnaire domains:

The staff questionnaire contains 25 statements at Stage I and 32 at Stage II split between five/six domains. Example statements from each of the domains are shown below:

- **Morale, Leadership & Teamwork**: e.g. *"There is always a colleague to turn to if I need support"*
- **Time to Care:** e.g. *"I have enough time to provide patients with reassurance when they need it"*
- **Skills to Care:** e.g. *"The training and supervision I have received enables me to: Understand how dementia affects patients in hospital"*
- **Access to Support**: e.g. *"The ward team has easy access to: Walking aids"*
- **Training**: e.g. *"Safeguarding vulnerable adults"*
- **Responding to feedback (Stage II only):** e.g. *"If I am approached with a concern or a complaint I am able to inform patients about who will discuss their concern/ complaint with them/ when this discussion will be"*

Results

Statistical analysis:

As both patient and staff data were not normally distributed, Mann-Whitney U-Tests were used to determine whether there were any significant differences between the scores at Stage I and II. Statistical significance was set at $p<.001$, and data was analysed using IBM SPSS version 21.

Sample Characteristics:

Tables 1 and 2 display an overview of the sample characteristics. A total of 4891 Patient Questionnaires and 2096 Staff Questionnaires were included in the analysis for this report. Forty-four of the 55 participating wards included in this report achieved the Quality Mark Award (33 at their first Stage II assessment, six after partial reassessment, two following a full reassessment, three following both a full reassessment and a partial reassessment). An overall response rate cannot be calculated because the exact number of patient questionnaires distributed was not returned for every ward.

Table 1: Patient sample characteristics

Patients	Stage I	Stage II
Number returned, n Average per ward	2358 43	2533 46
Female, n (%)	1305 (61.6%)	1381 (59.4%)
Male, n (%)	815 (38.4%)	944 (4061%)
Aged 65-74, n (%)	563 (25.5)	643 (26.2%)
Aged 75-84, n (%)	867 (39.2%)	933 (38.0%)
Aged 85-94, n (%)	697 (31.6%)	773 (31.5%)
Aged 95+, n (%)	82 (3.7%)	105 (4.3%)
White British, n (%)	1971 (90.2%)	2115 (89.8%)
White other, n (%)	92 (4.2%)	104 (4.4%)
Black or Black British, n (%)	45 (2.1%)	58 (2.5%)
Mixed race, n (%)	13 (0.6%)	6 (0.3%)
Asian or Asian British, n (%)	47 (2.0%)	43 (1.8%)
Chinese, n (%)	1 (0.1%)	6 (0.3%)
Other, n (%)	17 (0.8%)	24 (1.2%)
Completed questionnaire without assistance, n (%)	932 (43.2%)	1058 (45.6%)
Completed questionnaire with friend/ relative, n (%)	715 (33.2%)	696 (30.0%)
Questionnaire completed by friend/ relative on behalf of patient, n (%)	509 (23.6)	567 (24.4%)

Table 2: Staff sample characteristics		
Staff	Stage I	Stage II
Number returned, n Average per ward	1078 20	1018 19
Registered Nurse (general), n (%)	506 (46.9%)	481 (47.2%)
Healthcare Assistant/ Clinical Support worker, n (%)	456 (42.3%)	425 (41.7%)
Doctor	44 (4.1%)	31 (3.0%)
Other	72 (6.7%)	81 (803%)

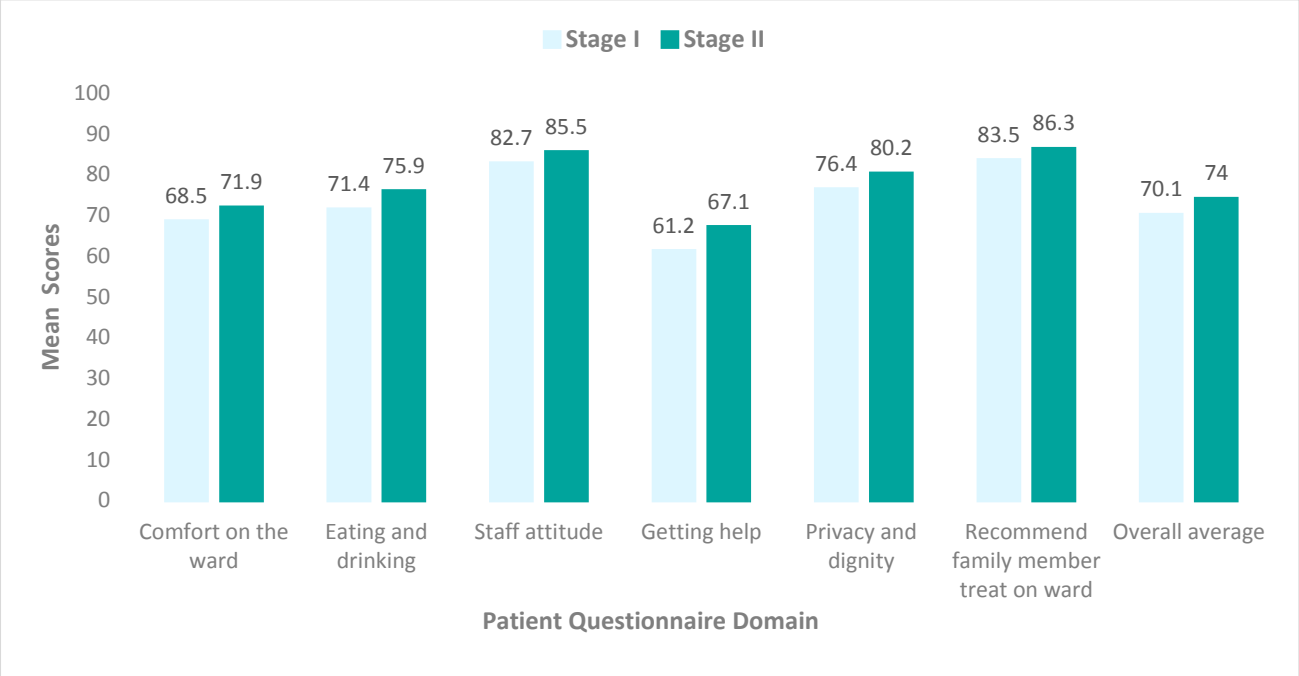
Section 1: Patient experience

Comparing Stages I and II – does patient feedback improve?

At Stage I of the Quality Mark, *Assessing Quality*, the ward collects data over a set period (see Appendix E for details of assessment tools) and the Project Team compile the data collected into a detailed local report collating and summarising the ward's results. This highlights areas for action planning and the ward then develops and submits an action plan to identify its top priority actions. At Stage II, *Achieving the Quality Mark,* the ward repeats the assessments, but has a higher minimum target of patient questionnaire return. The ward receives a second report, comparing their summary results between the two stages of data collection.

Figure 1 shows the mean ward scores for the Patient Questionnaire, derived from all questionnaires returned at Stage I and Stage II, broken down by domain. Patient feedback stage comparisons showed modest improvements in all 5 domains; 'comfort on the ward', 'eating and drinking', 'staff attitude', 'getting help', and 'privacy and dignity'. The overall average patient questionnaire score shows a statistically significant improvement at Stage II.

Figure 1: Improvement in patient experience domain scores between stages (Stage 1 N = 2358, Stage II N = 2533)



At both stages, the area where patients reported the most positive experience was "Staff attitude", whilst the area with the least positive responses was "Getting help when needed".

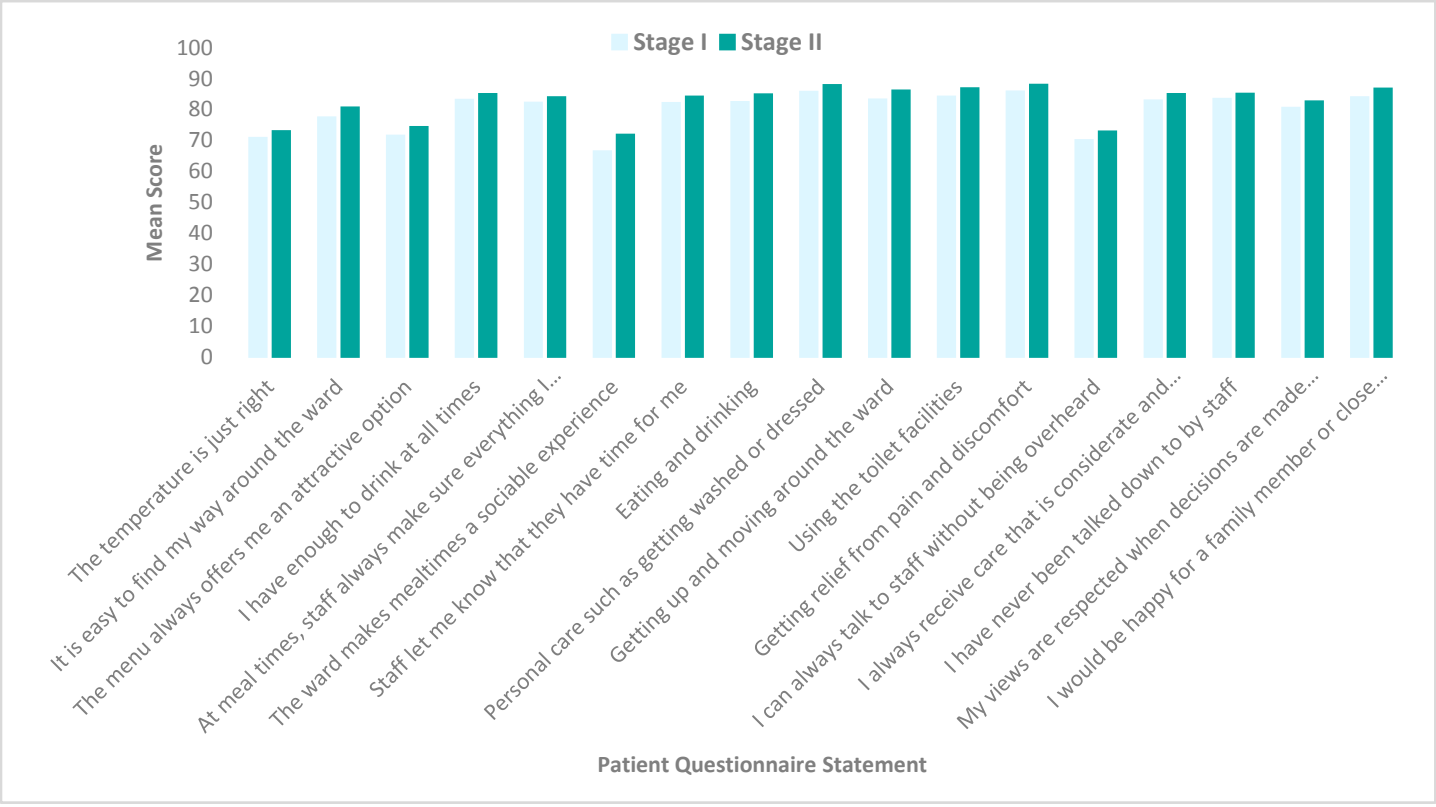
A significant difference between Stage I and Stage II was found across the five domains in the Patient Questionnaire (Comfort on the ward, Eating and Drinking, Getting help, Privacy and Dignity, and the Recommendation) for the wards which achieved the Quality Mark. In comparison, although improvement was shown, there was no significant improvement from Stage I to Stage II across the five domains for the wards which did not achieve the Quality Mark.

Aspects of patient experiences that improved

All 23 statements that make up the patient questionnaire were scored higher by patients at Stage II than at Stage I (Appendix F2); 17/23 statements were shown to have improved significantly **(Figure 2).** The statements where patients scored most positively were *"staff always seem caring", "[I can always get help with…] getting relief from pain and discomfort" "[I can always get help with…] personal care such as washing and getting dressed",* and this was consistent at both stages.

Similarly, the lowest scoring statements were the same at both stages, albeit in a slightly different order (*'the ward makes mealtimes a sociable experience', 'the ward is quiet at night time', 'the ward is quiet throughout the day', 'the food is excellent').*

Figure 2: Aspects of patient experience that improved significantly (17/23 statements)



Comparing wards with an award of the Quality Mark with wards which did not achieve it

After Stage II data collection, wards achieving scores above the benchmark of 75 are considered for award of the Quality Mark. We compared the scoring of individual statements in the patient questionnaire between wards who achieved award of the Quality Mark and those who did not. All 23 of the statements demonstrated significant differences (**Figure 3**).

Figure 3: Patient Questionnaire Statement Scores at Stage II – Award versus No Award

Stage II additional question

The Patient Questionnaire at Stage II includes an additional question. The total number of Stage II questionnaires submitted was 2533. A significant difference was found between those with QM and those without QM. Table 3 shows the difference in those patients that responded Strongly Agree and Agree across wards with and without an award.

Table 3: Stage II additional question – Patient Questionnaire

	Wards with QM (44)	Wards without QM (11)
Statement	Strongly Agree/ Agree	Strongly Agree/ Agree
Staff respond to any concerns or complaints about my care	**89.7% (n=1890/2046)**	**85.5% (n=360/406)**

Similarly, the Staff Questionnaire at Stage II includes an additional domain, "Responding to patient feedback", which is made up of eight statements. A significant difference was found between those with QM and those without QM across the seven statements **highlighted in bold** in Table 4 below.

Table 4: Stage II additional domain – Staff Questionnaire

	Wards with QM (44)	Wards without QM (11)
Statement	Strongly Agree/ Agree	Strongly Agree/ Agree
I am able to inform patients of who will discuss their concern/complaint about them	**95.7% (n=774/796)**	**94.7% (n=198/207)**
I am able to inform patients of when this discussion will be	**82.1% (n=664/767)**	**73.2% (n=153/195)**
I am supported and encouraged to apologise when something has gone wrong, on behalf of the ward	**91.9% (n=744/788)**	**82.9% (n=173/201)**
I can direct patients/relatives to a person or service in the hospital who will assist them further	**95.7% (n=774/797)**	**89.4% (n=187/200)**
I can obtain a complaints form if requested	82.3% (n=666/785)	78.4% (n=164/199)
Compliments, concerns and complaints are shared with me on a regular basis	**87.2% (n=706/778)**	**77% (n=161/199)**
Positive and negative feedback raised by patients in SI of QM was shared with me	**78% (n=631/773)**	**64.6% (n=135/192)**
Details of the SI report and ward action plan were shared with me	**74.7% (n=604/765)**	**62.7% (n=131/194)**

Patient Comments

The role of patient comments

The patient questionnaire allows free text comments. These comments are collated and considered within the ward's report by the Award Committee. The comments provide valuable context to the scores on aspects of the patient experience. The free text comments give the patients the opportunity to share their opinions, which they may not consider doing otherwise. Given previous research suggesting that older patients are often reluctant to share their opinions[1], it is a very valuable element of the Quality Mark.

Comments are also considered when decisions by the Award Committee are made on whether to award the ward or not. Either a series of negative comments (e.g. about problems in staff attitude), or a single negative comment about a serious breakdown in care provision (e.g. not being given drinks; left in soiled sheets; told off when requesting toileting help) may provide sufficient grounds to withhold QM and for further assessment to take place, despite score levels.

Content of patient comments

Patients are invited to comment on their experience of the ward, including positive comments, negative comments and suggestions for how the ward could improve. The occurrence of the number of positive or number of negative comments shows a difference between the wards who deliver consistently high-quality care and those who are not performing as well (as demonstrated by scores).

Negative patient comments

Across both Stages, there were 639 negative comments across the 44 wards which achieved QM (average 14.5) and 178 for the remaining 11 wards without QM (average 16.1). If the negative comment included more than one theme, these were treated as separate comments in the following analysis. This has increased the total negative comments to 770 for wards with QM (average 17.5) and 248 for wards without QM (average 22.5). Wards that do not achieve the QM award have on average twice as many negative comments about staff attitude. This is a very important component of patients experience and clearly has an effect on overall scores from staff and patients on care quality, and thus an impact on the information on which the Award Committee base their decision.

[1] *Breaking down the barriers: older people and complaints about health care*. PHSO 2015

Figure 4: Negative patient comments broken down by theme between wards with Award and No Award

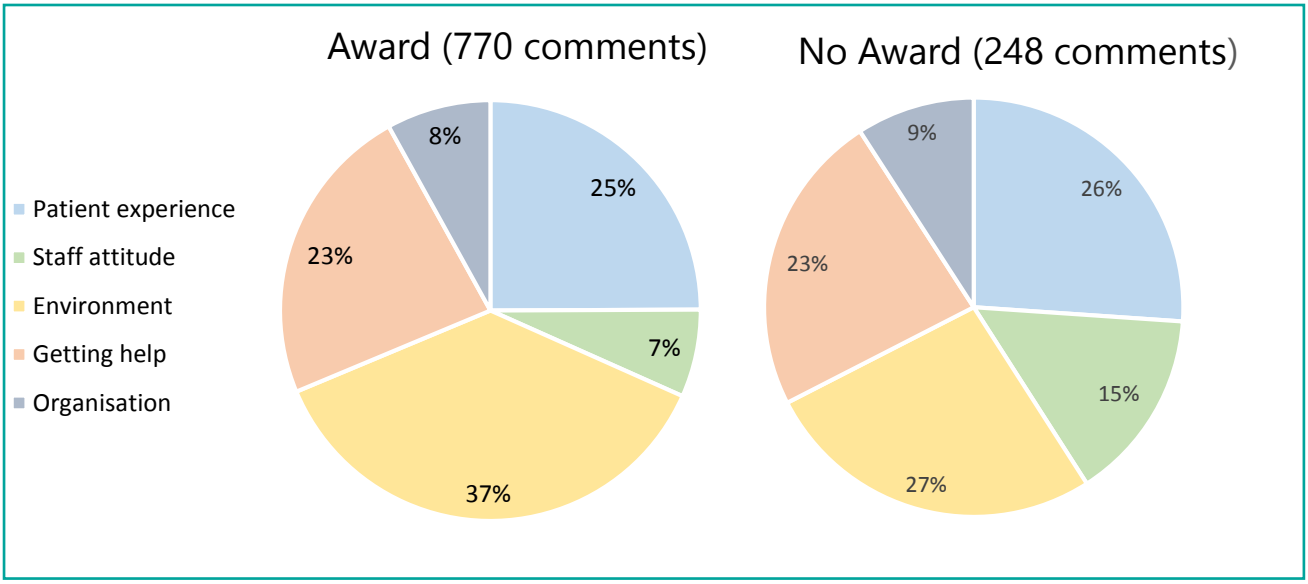
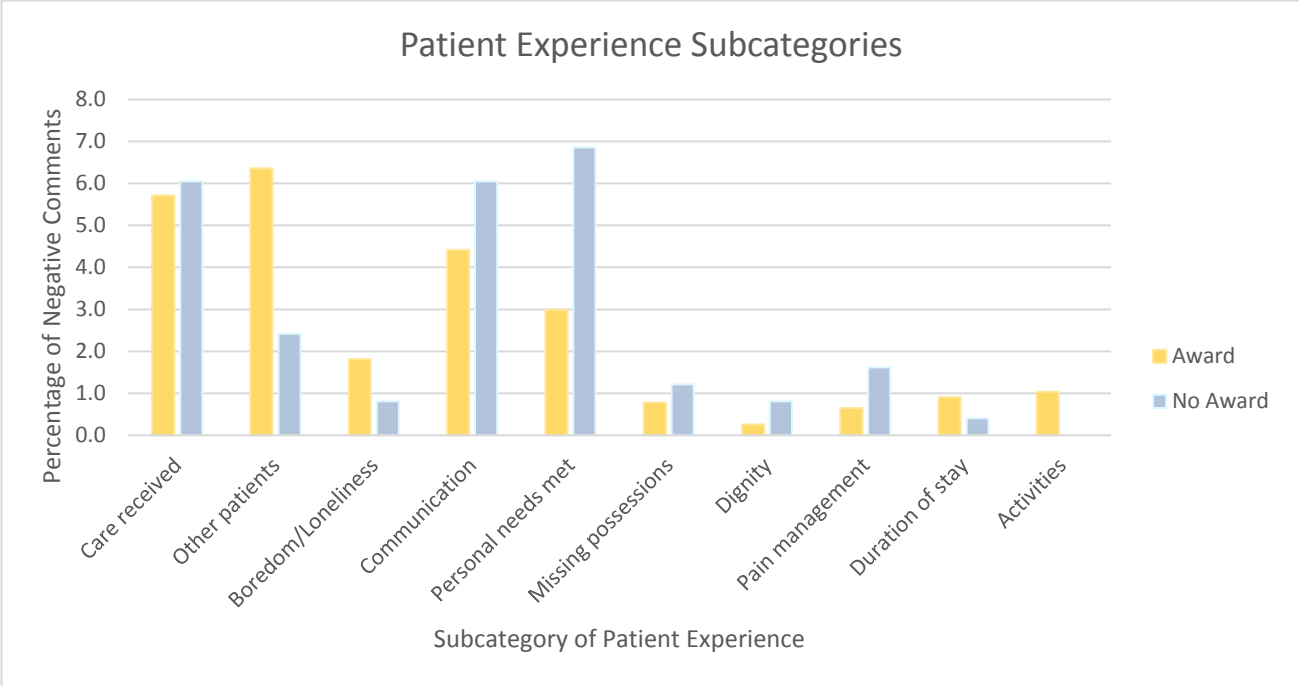


Figure 5: Patient Experience Subcategories



When looking at the subcategories of the 'patient experience' theme, the wards who did not achieve the Quality Mark had more than double the negative comments about patient's personal needs being met compared to those wards who did achieve the award. The most frequent Patient Experience Subcategory for wards that achieved the award were about other patients. For wards that achieved the award, the most frequent negative patient experience comments were regarding other patients.

Positive patient comments

At both stages, patients returned more positive comments than negative comments about their experience (893 at Stage I and 1042 at Stage II). Positive comments were frequently about the running or atmosphere of the ward, or the attitude or behaviour of staff:

"The wards are kept very clean"

"Excellent care"

"Friendly, helpful staff"

Wards achieving the award had an average of 20 positive comments from patients (884/44) compared to wards without the award with an average of 14 (158/11).

Patient comments in relation to patient ratings (scores)

Like other sections of the questionnaire, the comments are voluntary. Patient comments are treated as contextual and illustrative within the QM award process. The frequency (number) of positive patient comments, and the percentage of positive comments within a ward's total comments, do appear to relate to their overall scores and performance:

- The ten wards with the most positive comments achieved the award.
- Nine of the ten wards with the highest overall percentage of positive comments also achieved the Award.
- Six wards out of the top ten scoring wards (overall patient questionnaire mean) were also within the top ten with regards to overall percentage of positive comments.
- Out of the ten wards with the biggest reduction in their percentage of negative comments from Stage I to Stage II, eight had achieved the award.
- Nine of the ten wards with the lowest overall percentage of negative comments achieved the award.
- Six of the wards out of the top ten scoring wards (overall patient questionnaire mean) also had the lowest frequency of negative patient comments.
- Out of the ten wards with the lowest percentage of negative comments, nine obtained QM, and four of these wards were within the top five scoring wards (overall mean of patient scores).

Patients' suggestions for improving their experience

Patients were invited to suggest improvements to the patient experience on the ward. In total, from the 55 wards, 961 comments were returned across both stages. The suggestions were categorised into five themes: Patient Experience (19%), Staff Attitude (6%), Environment (31%), Getting Help (22%) and Organisation (7%). 13% (120/961) commented that no improvements were required and 2% (23/961) made suggestions categorised as "other".

Patient Experience

19% of suggestions reported in the Patient Questionnaires related to Patient Experience (175/961)

10% suggested that they needed more **engagement** with activities or people;

- *"TVs or radios in each bay or more conversation with people."*
- *"Patients getting together more on the ward."*

5.1% suggested they needed more or better **communication** from staff in the hospital;

- *"The updates on patient progress, although appreciate lack of time for this."*
- *"Clearer communication about my treatment. Received a lot of mixed messages."*

Staff Attitude

6% of suggestions reported in the Patient Questionnaires related to Staff Attitude (62/961)

3.1% suggested better **care** is needed from staff at the hospital:

- "To treat the patients with more care and compassion."
- "Some members of staff are unsympathetic."

Ward Environment

31% of suggestions reported in the Patient Questionnaires related to Ward Environment (295/961)

10.1% suggested that the **food or drink** needed improving;

- *"Meals could be more varied and more appealing."*
- *"Improve the food as it was very poor."*

9.7% suggested that improvements needed to be made to the ward **environment**;

- *"The day room is very plain."*
- *"It would be good to have efficient reading lamps at each bed."*

Getting Help

22% of suggestions reported in the Patient Questionnaires related to Getting help (212/961)

15% suggested that the ward needed **more staff**;

- *"Staff seem stressed and pushed too much, need more staff."*
- *"More staff, mostly very nice but do not have enough time to respond to patient's needs."*

*3.1% suggested that they didn't get enough **time** with staff*

- *"More one to one time with staff, to feel less secluded."*
- *"Nurses having more time to help on shower and bathroom duties."*

Organisation

7% of suggestions reported in the Patient Questionnaires related to Organisation (67/961)

3.4% suggested that the ward should be better organised

- *"Make equipment repairs quicker."*
- *"Better organisation of meals. Tea trolley was not brought round some days. Too long between hot drinks."*

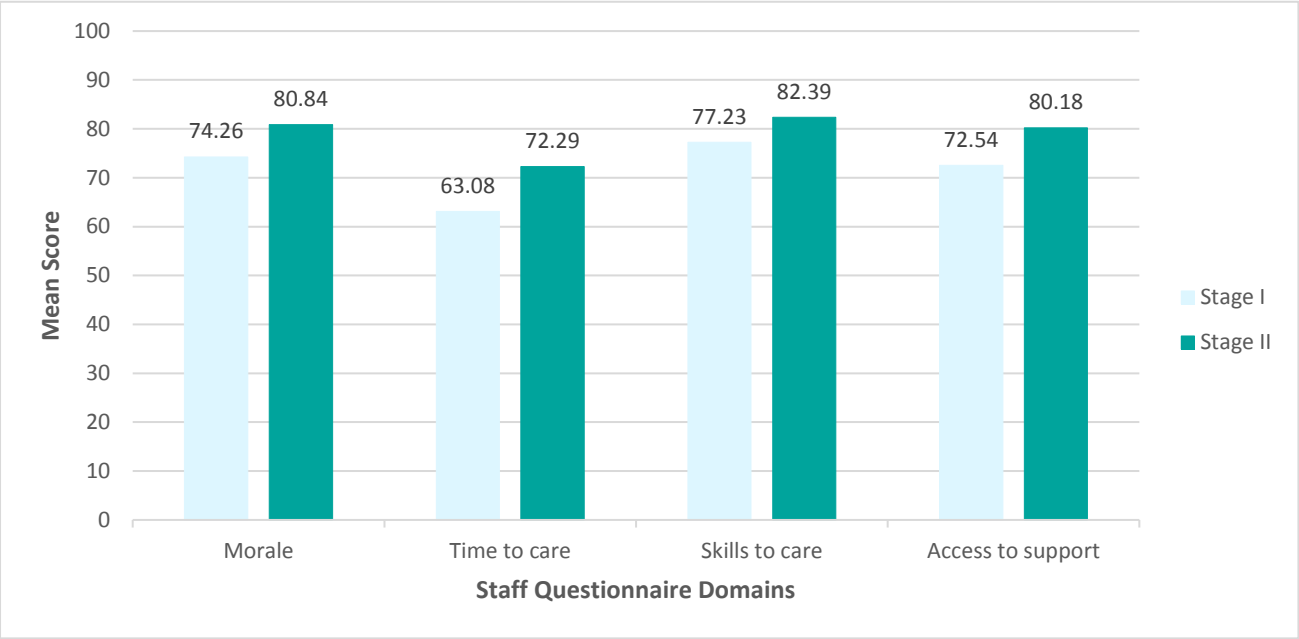
Other frequent suggestions included temperature of the ward being too hot or cold, and to decrease noise from equipment and other patients.

Section 2: Staff experience

Comparing Stages I and II – does staff feedback improve?

Staff responses were more positive at Stage II across all questionnaire domains: Morale, Leadership & Teamwork, Time to Care, Skills to Care and Access to Support (Appendix G2) and all improvements were found to be significant. The domain that achieved the most positive scores for both stages was found to be Skills to Care, whilst the lowest scoring area for both stages was found to be Time to Care.

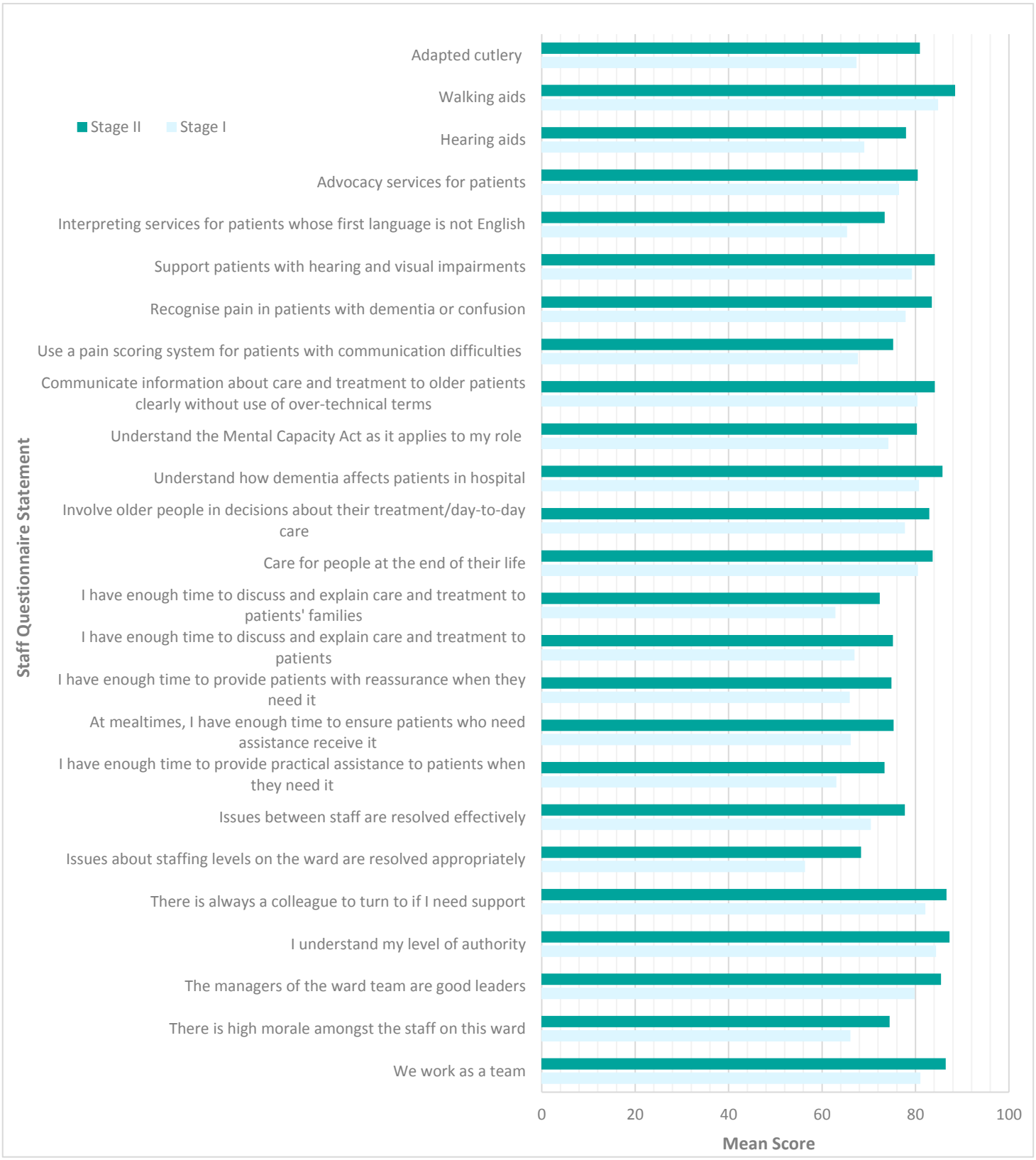
Figure 5: Improvement in Staff Questionnaire Domain Scores between Stage I and Stage II - all wards (Stage I N= 1078, Stage II N=1018)



Aspects of staff experience that improved

Scores for all individual statements in the staff questionnaire were higher at Stage II than at Stage I, and 25/25 of these were shown to have improved significantly (see Figure 6). The most positively scored statements were the same at both stages, *"access to walking aids", "I understand my level of authority", and "there is always a colleague to turn to if I need support".* The three lowest scoring statements were the same at both stages, *"Issues about staffing levels are resolved appropriately", "I have enough time to discuss and explain care and treatment to patient's families", and "I have enough time to provide practical assistance to patients when they need it".* (Appendix G2).

Figure 6: Improvements in Staff Experience between Stage I and Stage II - all wards



Comparing percentage increases between stages for the staff statement ratings, the most improved were 'access to adapted cutlery' (13.55% improved), 'issues about staffing levels on the ward are resolved appropriately' (12.01%) and 'I have enough time to provide patients with practical assistance when they need it' (10.33%). When measuring the increase of 'Strongly agree' or 'agree' ratings, the largest percentage increase was for 'I have enough time to discuss and explain care and treatment to patients' (21.10%). Staff morale rating improved by 14.7%, with Stage II scores reflecting that 76.8% of staff either strongly agreed or agreed that "there is high morale amongst the staff" (Appendix G4).

Comparing wards with an award of the Quality Mark with wards who did not achieve it

A significant difference between Stage I and Stage II scores was found across all 4 domains in the staff questionnaire (Morale, Leadership & Teamwork, Time to Care, Skills to Care and Access to Support) for the Wards who achieved QM. In comparison, although improvement was shown, there were no significant differences found in staff scores between stages for the wards who did not achieve the Award (Appendix G3).

Staff Training

Staff were asked whether they had attended training across 12 areas relevant to providing quality essential care to older patients. For all 12 training modules, staff attendance was higher at Stage II compared to Stage I, for wards with and without the Quality Mark Award. On average, there was an 8.7% increase in staff attending training at Stage II. The biggest improvements in training provision were 'symptoms of delirium' (13.5%), 'person-centred care approaches' (12.7%), 'risks associated with the use of sedation and restraint' (11.1%) and 'communication and discussing issues relating to end of life care and decisions consistent with the National End of Life Care Programme' (10.8%).

Table 5: Staff training attendance

Training	Stage I Training attendance (n= 1088)	Stage II Training attendance (n=1018)	Difference
Symptoms of delirium	67.6% (n=729)	81.1% (n=826)	13.5%
Person-centred care approaches	75.3% (n=812)	88% (n=896)	12.7%
Risks associated with the use of sedation and restraint	53.6% (n=578)	64.7% (n=659)	11.1%
Communication and discussing issues relating to end of life care and decisions consistent with the National End of Life Care Programme	66.3% (n=715)	77.1% (n=785)	10.8%
Distraction and calming (de-escalation) techniques for the management of patients who are displaying behaviour that challenges/are aggressive/are agitated	66.3% (n=715)	76.8% (n=782)	10.5%
Types of dementia	80.8% (n=871)	90.9% (n=925)	10.1%
Cultural competence and diversity	74.2% (n=800)	82.7% (n=842)	8.5%
Continence care	82.4% (n=888)	89.5% (n=911)	7.1%
Symptoms of dementia	85.8% (n=925)	92.9% (n=946)	7.1%
Encouraging food and fluid intake	89.6% (n=966)	94.4% (n=961)	4.8%
Recognising situations in which patients may be at risk of falling	91.5% (n=986)	95.5% (n=972)	4%
Safeguarding vulnerable adults	92.1% (n=993)	95.9% (n=976)	3.8%
Total	77.1%	85.8%	8.7%

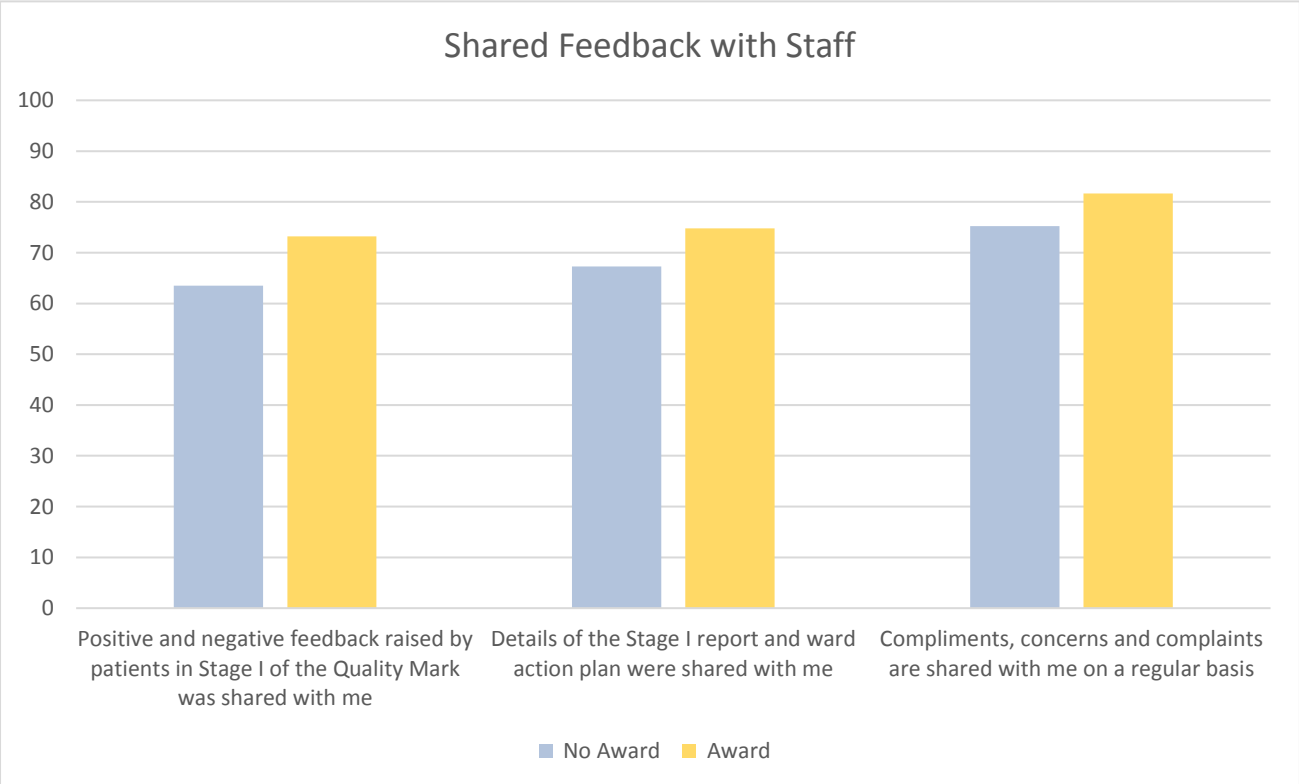
Staff Training, Award versus no Award

Whilst all wards showed an increase in staff attendance at training, a bigger improvement was found for wards who achieved the award. On average, those with the award showed an improvement of 9.3%, whilst wards who did not achieve the award showed an improvement of 6.6%. Whilst for the wards who achieved the award, training around 'Communication on and discussing issues relating to end of life care and decisions consistent with the National End of Life Care Programme' and 'Risks associated with the use of sedation and restraint' indicated 13.3% and 13% improvements respectively, wards without the award demonstrated a smaller improvement of 1.1% and 4.3% respectively. It is also apparent from the data that, for the majority of staff training, attendance was already higher for the wards who achieved the Award at Stage I than for the wards who did not go on to achieve the Quality Mark (Appendix tables G4 and 5).

Sharing results with staff

The Stage II staff questionnaire asks staff whether they agree that the findings of Stage I (ward report and action plan) were shared with them. If feedback from the first stage of the QM was shared amongst staff, wards were significantly more likely to achieve the award.

Figure 7: Sharing Feedback with Staff – Award versus No Award



Section 3: Interim Reviews after 18 months

Twenty three of the wards who achieved the Quality Mark Award have undertaken interim reviews. This helps ensure wards continue to meet award requirements and helps them review progress and any significant changes on the ward. Twelve wards withdrew at the Interim Review point, usually due to the ward or organisation's priorities changing at the midpoint of their award. The Interim Review includes asking wards to detail improvements that have been made *since* they achieved the Award. The feedback from these 23 wards indicates ongoing improvements made across patient experience, environment, and staff experience.

In Stage I and Stage II, patient comments, as well as Governor comments and detailed Person, Interaction and Environment observations, provide a level of insight into patient experience and capture information and experiences that questionnaires alone may not reach. These comments can provide meaningful data for wards, and often help wards to identify actions and improvements for the essential care experience of older people. This improvement is particularly evident in the connection between the patient suggestions at Stage II, and the interim review self-reported improvements which have taken place.

In addition to the reported improvements at interim review detailed below, 2.5% (3/118) were categorised as "other".

Environment

33.9% of improvements reported in the Interim Reviews related to improvements in the environment (40/118)

- 22% made changes to make the ward environment more user/dementia friendly, ***"Environmental changes to be more dementia friendly; contrast between floors/walls/doors and signage/ toilet raisers".***
- 11.9% made changes to improvement the general environment of the ward, ***"Additional storage, developed MDT room".***

Getting help

20.3% of improvements reported in the Interim Reviews were around getting help (24/118)

- 14.4% have made changes to improve staffing levels, ***"Increase in minimum staffing levels".***
- 5.9% of changes were around improving staff availability, ***"Main bays now have desks to allow staff members to be present at all times".***

Organisation

28% of improvements reported in the Interim Reviews were about the organisation of the ward (33/781)

- 15.3% made improvements around staff training/ awareness;
  "Now have a practice development nurse; educational programme now embedded into ward practice. Older people's unit regular MDT teaching".
- 12.7% made general changes to the organisation of the ward,
  "Development of Trust vision- Elderly Care Village- having all services and therapies on one site."

Patient Experience

15.3% of improvements reported in the Interim Reviews were about patient experience (18/118)

- 7.6% made improvements to patient engagement,
  "Now have TV, DVDs, CDs, twiddlemitts and a therapy cat, regular visits from therapy dog".
- 5.1% implemented changes to improve the patient experience in general, ***"Involved in pilot of open visiting and hope to improve patient and carer experience".***
- 1.7% made changes to improve the discharge process,
  "Week day early shift, 4th RN takes on role of ward co-ordinator. Supports junior staff and can plan discharge/ transfers".
- 0.8% reported changes made to improve communication between staff,
  "Risk boards by patient beds"

Conclusion

This report set out to show how the Quality Mark process affects the quality of care delivered to older people on acute hospital wards. We focussed on the key elements of patient and staff feedback.

The data collected were from multiple hospitals with a variety of ward types admitting older patients as the majority of their patients. Results were based on large sample sizes and minimum target responses were set for each ward based on patient throughput and whole-time equivalent staffing.

Wards who participate show an increase in patient experience scores across 2 stages of data collection

Patient experience showed modest improvements from Stage I to Stage II in all five of the domains: Comfort, Eating and Drinking, Staff Attitude, Getting Help and Privacy and Dignity. The overall Patient Questionnaire score also significantly improved, indicating benefit for patients from their ward having participated in the Quality Mark. The focus on aspects of essential care and action planning for improvement between the two stages helped the wards to achieve and maintain higher standards of care. The domain that increased the most was "Getting Help" and the domain that increased the least was "Staff Attitude", which was consistently high at both.

Aspects of patient experience was significantly higher at Stage II in wards which achieved the Quality Mark compared to those which did not. This demonstrates the value of having a two-stage process incorporating both evaluation and quality improvement, and a continual focus on the quality of care.

Wards with a higher frequency of positive comments are more likely to achieve QM and wards with a higher frequency of negative comments are less likely to achieve QM

This difference suggests that the patient questionnaire and derived score are well aligned to patient experience and can be used to discriminate between high quality and poor-quality care. Negative comments to do with staff attitude were more prevalent among wards who did not achieve the QM. The patient questionnaire is a useful and important aspect of the QM, providing in-depth and valuable feedback to the wards.

By Stage II, all staff questionnaire domains had significantly improved

The greatest changes were related to staff having better access to adapted cutlery, the ward responding to staffing levels and the staff having enough time to provide practical assistance. The staff scores in the 'time to care' domain were the lowest in both stages, but did make a substantial improvement.

If feedback from the first stage of the QM was shared amongst staff, wards were significantly more likely to achieve the award

This result highlights how important sharing feedback from patients is, to achieve better standards of care and meet the needs of patients to improve their experience.

Staff training and development is a significant factor in achieving QM

Wards who achieved QM had greater improvements in numbers of staff who agreed that they had received training, particularly related to dementia.

Action planning and quality improvement activity is sustained beyond achievement of QM

Qualitative feedback from interim reviews show a range of improvements in place, some directly related to patient feedback and others to other aspects of data collected for Quality Mark such as improvements to the environment. This suggests that the interim review and on-going membership of the QM provide a useful focus for sustaining quality improvement and achieving high quality patient experience.

Some aspects of patient experience score less positively at both stages

The quality of food, ward temperature, mealtimes made a focus of social activity, and ability to talk privately to staff are the lowest scoring patient statements across both stages. High numbers of negative comments were received about food, staffing levels, and waiting to get help. Problems with these aspects of patient experience are likely to be experienced across acute settings, and not confined to wards participating in the Quality Mark, as demonstrated by initiatives such as the Campaign for Better Hospital Food, and continuing media reports on the impact of shortfalls or reductions in hospital staffing.

Overall

Findings suggest that the QM programme is associated with discernible improvements in patient and staff ratings of care provided to elderly people. The project aims to provide a means of focus on the quality of care experienced and the support given to staff to provide this, which then leads to measurable improvement in patient experience. Compiled results from wards participating fully show that improvements are achieved. QM is an accessible quality improvement method for wards and gives useful measurements of experience, which can be translated into action.

Recommendations

This report has focussed on results generated by two questionnaires which are part of the Quality Mark programme. The benefits associated with participating (see Conclusion above), may also be derived from any similar systematic approaches to collecting feedback from different perspectives in order to target improvement at the patient experience. Based on the report's conclusions, we would recommend:

- Wards should collect and respond to feedback from patients and their staff. Gathering feedback and measuring patient's views is important as it identifies areas of care and experience that can be improved, equipping the ward to make positive effects on the quality of care provided to older patients.
- Quality Improvement feedback should be collected from older patient's wards, as this is the group of patients least likely to provide feedback. Gathering feedback by using methods such as the Quality Mark help wards to identify and focus on areas of improvement to meet the needs of elderly patients.
- Quality Improvement programmes should focus on the patient experience and factors contributing to it to ensure improvement and action plans are focussed on this. Wards should use the feedback from patients and staff to identify themes in aspects of care that need improving on their ward, to create an action plan and make effective and accurate improvements to the quality of care that the ward provides.
- Wards should ensure that QI programmes incorporate repeat data collection and feedback to check on progress into any care quality improvement strategy.
- It is important to feedback all positive comments, negative comments and suggestions to staff on the ward. This should help to increase morale among the ward when achievements are shared and allows staff to learn from and reflect on patient's views. It is an integral way to increase emphasis and place the ward's focus on improving patient experience. When details from the Quality Mark were shared with the staff, this improved quality of patient care as staff and the MDT learn from feedback to change their care delivery. A process should be in place to celebrate achievements and work as a team on areas to improve.
- Ward based quality improvement programmes should aim to include hospital leaders such as Consultants, Ward Managers, Senior hospital management and Hospital Governors so that the understanding of patient's experience can be increased. This could result in further care quality improvement. The improvements demonstrated in this report can also be attributed to other Quality Mark measurements derived from participation of hospital leaders (Appendix E).

- Areas of patient care quality which scored lower at both stages and were common to many wards were temperature, meal times, noise on the ward and privacy. These are issues that all wards could focus on improving to achieve a higher quality care experience. Food quality, access to appropriate food (such as finger food) and assistance at mealtimes are key aspects of nutrition for older patients, highlighted by the Care Quality Commission as part of their Nutrition and Dignity inspections. Promoting mealtimes as a time of sociable activity can also help to improve nutritional intake and morale. Provision of support at mealtimes including volunteer support, allowing family carers to visit, seating patients together to eat are all initiatives which have helped improve nutrition in the ward setting (see http://www.wardipedia.org/56-mealtimes-made-special for examples).

Appendix A

The Quality Mark: aims, objectives and process

The Quality Mark process aims to support wards to focus on delivery of good-quality, essential care for older people by:

- Engaging patients, ward staff, hospital management and governors in assessing the quality of care provided
- Providing training to ward staff in Person, Interaction and Environment observations of care
- Producing a detailed local report that identifies areas of achievement and areas for improvement, enabling targeted action planning
- Encouraging the ward team to reflect on their ability to provide elder-friendly care with the training and resources they have available to them
- Awarding and recognising the achievement of elder-friendly wards
- Encouraging a focus on a continuous improvement through iterative data collection

The Quality Mark process

Stage I

Assessing Quality. At the point of signing up to the Quality Mark programme, the ward submits contextual data and starts working towards the achievement of the Quality Mark by completing a full set of assessment tools, over a three-month period. A minimum number of patient questionnaires and staff questionnaires is specified. Feedback in the form of a detailed local report collating and summarising the ward's results is produced by month 5, highlighting areas for action planning. The ward then develops and submits an action plan which identifies its top priority actions. The ward has up to 12 months from completing Stage I to begin implementing their action plan and to initiate a second round of assessment. If the report suggests that the ward is not performing at the level required to achieve the Quality Mark, wards will repeat Stage I. If results from Stage I suggest that the ward can achieve the criteria for award of the Quality Mark, the ward will be asked to confirm that they wish to proceed to Stage II.

Stage II

Achieving the Quality Mark. Stage II repeats the assessments used for Stage I, requiring a higher level of patient questionnaire return. In addition, feedback confirming a consistent high standard of care delivery is sought from patients discharged from the ward and ward staff. Within two months of completion, the ward receives a report detailing their performance which also compares their summary results with those from the previous round of data collection and information obtained from additional feedback.

Award

After the Stage II assessment, ward reports are considered by the Quality Mark Awards and Advisory Committee (AC). Recommendations of the AC are subject to scrutiny by the Royal College of Psychiatrists' Special Committee for Professional Practice and Ethics, who ratify awards and ensure all decisions are in line with the agreed process.

Recommendations of award

1. Award – if a decision is taken that the ward has fulfilled requirements and demonstrated a good and consistent quality of care, a recommendation of award will be made.

2. Further Stage II assessment – if it appears that requirements for Stage II have not been fulfilled, the committee may recommend further assessment. Depending on the issues outstanding, this may either be further feedback collected from patients and/ or staff, repeat of the environmental assessment, or a repeat of the full data collection stage.

3. Further Stage I assessment – in the case of a ward failing to fulfil the majority of requirements at Stage II, the committee will recommend that the ward returns to the baseline stage of assessment.

If the ward is unsuccessful, they will be able to complete another action plan and continue to make improvements before attempting Stage II again. If successful, the ward will hold the Quality Mark for up to three years, subject to terms and conditions including data sharing and interim review.

Appendix B

Interim Review

This is a short form review at the midpoint of the award period to confirm that the ward continues to meet award requirements. An interim review includes:

- A short form interim review questionnaire completed by the Ward Manager and Lead Consultant regarding any significant changes in the ward leadership and environment.
- A repeat of the patient questionnaire data collection over 6-8 weeks with a target of 15 questionnaires.

Self-reporting

The ward agrees to alert the Project Team to significant changes on the ward, including changes to ward leadership input, ward designation or the environment, or the closure or merger of the ward.

Appendix C

Measurement in the Quality Mark

Measurements in the Quality Mark derive from broad indicators relating to patient experience of care. These are

- Autonomy
- Practical Assistance/ Personal Care
- Nutrition
- Pain recognition
- Personal Hygiene
- Environment
- Social Inclusion
- Privacy
- Communication Management

Questions/ criteria based on these indicators are divided between tools (questionnaires and checklists) measuring

- The experience of older patients
- Observation and reflection on the quality of care interactions
- The experience of ward staff
- The experience of ward leaders
- Feedback from the multidisciplinary team
- Staffing on the ward
- The quality of the physical environment as it relates to older people
- The perspective of visitors to the ward (hospital governors, recognised patient representatives or equivalent)
- The wider organisational context

Responses and ratings from each tool are fed back to the ward as:

- Overall weighted scores, representing positive responses from each group or tool (e.g. patients, staff, environmental checklist)
- Section scores within tools (e.g. comfort on the ward, food on the ward)
- Detailed breakdown of responses within each tool
- Compilations of responses from each tool by domain, for overview and action planning

More detail about measurement can be seen at www.qualitymark.org.uk

Appendix D

Status of Quality Mark members

Membership of the Quality Mark is open to hospital wards in England admitting a high proportion of patients aged 65 and over. This includes general medical, orthopaedic and rehabilitation wards, as well as specialist care of the elderly wards.

As of August 2018, 136 wards have participated in the Quality Mark and 44 wards have achieved the QM. The status of all wards who have participated in the Quality Mark are displayed below.

1) Member status

Status	Number of wards
Current members	40
Quality Mark Award - Current members	24
Quality Mark Award - Withdrew	20
Withdrew after completing Stage II	9
Withdrew after completing Stage I	70
Incomplete data set at either stage	20

2) Wards who have achieved the award of the Quality Mark and who have submitted Interim Reviews

Ward	Interim Review data collection	Ward	Interim Review data collection
Hindhead	Autumn 2015	Ewhurst	Autumn 2016
Ward 46 MRI	Autumn 2015	ward 52 DMH	Autumn 2016
Ward 2b RLI	Autumn 2015	Ward 44 DMH	Autumn 2016
Ward 2x RLI	Autumn 2015	Eashing ward	Autumn 2016
Ward 2y RLI	Autumn 2015	Ward 45 MRI	Autumn 2016
Ward 19 STH	Autumn 2015	Combe Ward	Spring 2017
Lindhurst	Autumn 2015	Ward C5	Spring 2017
Ward 21 RPH	Autumn 2015	Elizabeth Ward	Autumn 2017
Barton ward	Autumn 2015	Harpur Ward	Autumn 2017
Rookwood A	Autumn 2015	Lister Ward	Autumn 2017
Rookwood B	Autumn 2015	Heberden Ward	Autumn 2017
		Waterhouse Ward	Autumn 2017

Appendix E
Quality Mark data collection requirements at Stage I and II

Patient Questionnaire	Wards must return a minimum of 25 Patient Questionnaires, but are set a recommended target of achieving 40% of the predicted total number of patients aged over the age of 65. This target is based on the actual number of patients over the age of 65 discharged from the ward over a 4 week period immediately preceding data collection.
Staff Questionnaire	Wards must return a number equivalent to at least 50% of the ward's nursing establishment (this may include feedback from doctors, nurses, healthcare assistants and members of the multidisciplinary team).
Multidisciplinary Team Questionnaire	This questionnaire is completed collectively by members of the multidisciplinary team working on the ward. In order to achieve a quorum, this meeting includes at least two Registered Nurses, two Healthcare Assistants/ Clinical Support Workers, two Doctors (including a consultant), and one member of any other discipline working on this ward.
Ward Management Toolkit	This comprises: • 1 Ward Manager's Questionnaire • 1 Lead Consultant's Questionnaire • 1 Off-Duty Staffing Matrix , covering a four week period • 1 Ward Leaders' Environmental Checklist, completed by the Ward Manager and Lead Consultant together
Governors' Toolkit	This comprises: • 1 Governors' Environment Checklist, completed collectively by at least 2 Governors • Governors' Ward Rating, completed by 2-3 Governors individually
PIE observations	1 feedback form based on two 2-hour observations carried out on a neighbouring ward. The ward will also have observations carried out on their ward by two members of staff from a neighbouring ward. This module requires two members of staff from each ward to attend a one day training workshop.
Hospital Management Questionnaire	This is completed by a member of the senior management team for the **hospital** (applicable to all wards from the hospital participating at that time)

Action plan
This is a requirement of the process and must be submitted following the receipt of the local ward report showing the results of data return. The ward has then completed Stage I (Assessing Quality).

Stage II
Data collection requirements are as for Stage I (see above), with the addition of:

- **Increased minimum Patient Questionnaire target –** a minimum of 30 Patient Questionnaires must be returned per ward (as opposed to 25 in Stage I).

- **Additional questions relating to listening and responding to feedback and complaints –** questions related to this will be included in the patient, staff, ward manager and MDT questionnaire.

Qualitative feedback (comments) are presented to the Award and Advisory Committee (AC) for consideration along with the collated results of the main data collection phase.

Appendix F

Patient experience data

1) Patient experience, domain comparison.

	Stage I		Stage II		Statistics		
Patient Q domain	**n**	**Mean**	**n**	**Mean**	**z**	**p**	**r**
Comfort on the Ward	2322	68.50	2507	71.90	-4.960	<0.001*	0.0714
Eating & Drinking	2305	71.40	2494	75.90	-6.520	<0.001*	0.0941
Staff Attitude	2324	82.70	2456	85.50	-3.640	<0.001*	0.0526
Getting Help	2175	61.20	2340	67.10	-5.667	<0.001*	0.0843
Privacy & Dignity	2321	76.40	2501	80.20	-5.469	<0.001*	0.0788
Recommendation	2278	83.50	2462	86.30	-5.017	<0.001*	0.0729
Overall	2358	70.10	2533	74	-7.833	<0.001*	0.1120

Notes r= Effect size
*=p<0.01

2) Patient experience, individual statements

	Stage I		Stage II		Statistics		
Statement	**n**	**mean**	**n**	**mean**	**z**	**p**	**r**
The temperature is just right	2296	70.85	2479	73.04	-3.374	.000*	0.0571
The ward is quiet throughout the day	2275	66.91	2465	68.65	-2.246	0.25	0.0573
The ward is quiet at night-time	2265	68.68	2441	70.25	-2.195	0.28	0.0377
The toilets are clean	2130	82.70	2338	83.77	-2.210	0.27	0.0452
It is easy to find my way around the ward	2073	77.46	2269	80.72	-5.515	.000*	0.0890
The food is excellent	2264	69.37	2459	71.02	-2.337	0.19	0.0282
The menu always offers me an attractive option	2253	71.59	2446	74.40	-3.941	.000*	0.0662
I have enough to drink at all times	2282	83.22	2471	85.03	-3.682	.000*	0.0553
At meal times, staff always make sure everything I need is in reach	2269	82.21	2457	83.98	-3.365	0.001	0.0508
The ward makes mealtimes a sociable experience	2193	66.50	2413	71.89	-6.432	.000*	0.1041
Staff always seem caring	2314	87	2501	88.44	-2.348	0.19	0.0343

Statement	Stage I		Stage II		Statistics		
	n	mean	n	mean	z	p	r
Staff let me know that they have time for me	2299	82.11	2491	84.23	-3.350	.000*	0.0457
Staff welcome visits from my family and friends	2282	85.42	2482	86.15	-1.386	0.166	0.0169
Eating and drinking	1449	82.44	1517	84.90	-3.316	0.001	0.0434
Personal care such as getting washed or dressed	1875	85.73	1987	87.95	-3.822	.000*	0.0536
Getting up and moving around the ward	1605	83.22	1679	86.14	-4.303	.000*	0.0755
Using the toilet facilities	1654	84.17	1749	86.86	-4.034	.000*	0.0723
Getting relief from pain and discomfort	1968	85.87	2108	88	-3.776	.000*	0.0549
I can always talk to staff without being overheard	2268	70.07	2463	72.81	-3.844	.000*	0.0553
I always receive care that is considerate and avoids embarrassment	2280	82.92	2475	85.06	-4.360	.000*	0.0649
I have never been talked down to by staff	2288	83.47	2468	85.15	-2.615	0.009	0.0489
My views are respected when decisions are made about my care	2259	80.58	2440	82.65	-4.177	.000*	0.0608
I would be happy for a family member or close friend to be treated on this ward	2263	84.03	2446	86.84	-5.072	.000*	0.0632

3) Patient experience; domain means at Stage I and II comparing wards with an award of the Quality Mark with who wards who did not achieve it

Stage I	Award				No Award				Statistics			
Statement	**Mean**	**N**	**SD**	**Med**	**Mean**	**N**	**SD**	**Med**	**U**	**Z**	**P**	**R**
Comfort	69.25	1894	19.66	60.00	65.35	428	21.05	70.00	361315.5	-3.530	.000	-0.0733
Eating and drinking	71.60	1880	20.91	75.00	70.41	425	21.14	75.00	388037	-.930	.352	-0.0194
Support from staff	83.34	1896	18.98	83.00	80.16	428	21.90	83.00	376066	-2.457	.014	-0.0510
Getting help	60.75	1758	30.85	70.00	62.95	417	28.11	70.00	359078	-.651	.515	-0.0140
Privacy & dignity	76.65	1892	20.26	75.00	75.35	429	21.30	75.00	394723.5	-.898	.369	-0.0186
Recommend	83.87	1852	19.48	75.00	81.75	426	21.89	75.00	378689.5	-1.427	.154	-0.0299
Overall average	70.37	1920	16.15	72.00	68.87	438	15.87	70.46	396412	-1.872	.061	-0.0385

Stage II	Award				No Award				Statistics			
Statement	**Mean**	**N**	**SD**	**Med**	**Mean**	**N**	**SD**	**Med**	**U**	**Z**	**P**	**R**
Comfort	73.11	2089	17.63	75.00	65.60	418	18.18	65.00	329418	-7.972	.000	-0.1592
Eating and drinking	76.70	2078	16.90	75.00	71.96	416	17.69	75.00	363628	-5.152	.000	-0.1032
Support from staff	86.17	2054	15.47	92.00	82.30	402	16.47	83.00	352676	-4.850	.000	-0.0979
Getting help	67.40	1932	26.32	75.00	65.96	408	24.37	72.00	374637.5	-1.583	.113	-0.0327
Privacy & dignity	81.01	2088	16.69	81.00	75.80	413	18.46	75.00	362881	-5.170	.000	-0.1034
Recommend	87.16	2056	17.30	100.00	81.77	406	21.81	75.00	362536.5	-4.753	.000	-0.0958
Overall average	74.67	2112	14.54	75.00	70.62	421	14.31	72.00	372453	-5.264	.000	-0.1046

Appendix G

Staff experience data

1) Staff experience domain comparison

	Stage I		Stage II		Statistics		
Staff Q domain	**n**	**Mean**	**n**	**Mean**	**z**	**p**	**r**
Morale	1078	74.26	1018	80.84	-8.990	<0.001*	0.1964
Time to care	1078	63.08	1018	72.29	-10.421	<0.001*	0.2276
Skills to care	1078	77.23	1018	82.39	-7.944	<0.001*	0.1735
Access to support	1078	72.54	1018	80.18	-10.902	<0.001*	0.2381

Notes r= Effect size
*=p<0.01

2) Staff experience, individual statement

	Stage I		Stage II		Statistics		
Statement	**n**	**mean**	**n**	**mean**	**z**	**p**	**r**
We work as a team	1078	80.98	1018	86.39	-6.235	<.001*	0.1361
There is high morale amongst the staff on this ward	1078	66	1018	74.39	-7.0.85	<.001*	0.1548
The managers of the ward team are good leaders	1078	79.78	1018	85.39	-5.245	<.001*	0.1146
I understand my level of authority, i.e. the decisions I can make without seeking approval	1078	84.35	1018	87.21	-3.786	<.001*	0.0827
There is always a colleague to turn to if I need support	1078	82.05	1018	86.57	-4.433	<.001*	0.0968
Issues about staffing levels on the ward are resolved appropriately	1078	56.26	1018	68.27	-9.766	<.001*	0.2133
Issues between staff are resolved effectively	1078	70.38	1018	77.65	-7.231	<.001*	0.1579
I have enough time to provide practical assistance to patients when they need it, e.g. support walking to the toilet	1078	62.97	1018	73.30	-8.436	<.001*	0.1843
At mealtimes, I have enough time to ensure patients who need assistance receive it	1078	66.07	970	75.24	-7.403	<.001*	0.1617
I have enough time to provide patients with reassurance when they need it	1020	65.84	940	74.78	-8.487	<.001*	0.1903
I have enough time to discuss and explain care and treatment to patients	985	66.86	1018	75.10	-8.351	<.001*	0.1903
I have enough time to discuss and explain care and treatment to patients' families	1078	62.78	1018	72.27	-9.581	<.001*	0.2093
Care for people at the end of their life	1078	80.45	1018	83.60	-3.485	<.001*	0.0761
Involve older people in decisions about their treatment/ day-to-day care	1078	77.69	1018	82.88	-6.135	<.001*	0.1340
Understand how dementia affects patients in hospital	1078	80.66	1018	85.71	-5.761	<.001*	0.1258

Statement	Stage I		Stage II		Statistics		
	n	mean	n	mean	z	p	r
Understand the Mental Capacity Act as it applies to my role	1078	74.10	1018	80.23	-6.694	<.001*	0.1462
Communicate information about care and treatment to older patients clearly without use of over-technical terms	1078	80.36	1018	84.06	-4.806	<.001*	0.1050
Use a pain scoring system for patients with communication difficulties e.g. Abbey Pain Scale, Dolopus 2, etc.	1078	67.63	1018	75.15	-6.592	<.001*	0.1440
Recognise pain in patients with dementia or confusion	1078	77.83	1018	83.42	-6.512	<.001*	0.1422
Support patients with hearing and visual impairments	1078	79.15	1018	84.06	-5.830	<.001*	0.1273
Interpreting services for patients whose first language is not English	1078	65.28	1018	73.33	-7.724	<.001*	0.1687
Advocacy services for its patients (e.g. PALS, ICAS, etc.)	1078	76.39	1018	80.40	-4.702	<.001*	0.1027
Hearing aids (e.g. hearing loops, spare batteries for personal aids, amplifiers, communicators)	1078	68.95	1018	77.90	-8.550	<.001*	0.1868
Walking aids	1078	84.76	1018	88.41	-4.615	<.001*	0.1008
Adapted cutlery	1078	67.32	1018	80.87	-11.651	<.001*	0.2545

3) Staff experience; domain means at Stage I and II comparing wards with an award of the Quality Mark with who wards who did not achieve it.

Award	Statistics				
Staff Q domain	n	Mean	z	p	r
Morale	1684	77.920	-10.126	<.001*	-.247
Time to care	1684	68.360	-11.259	<.001*	-.274
Skills to care	1684	80.440	-8.441	<.001*	-.206
Access to support	1684	77.330	-11.723	<.001*	-.286

No Award	Statistics				
Staff Q domain	n	Mean	z	p	r
Morale	412	75.56	-.226	.821	-.011
Time to care	412	64.27	-1.111	.267	-.055
Skills to care	412	76.84	-1.093	.274	-.054
Access to support	412	71.86	-1.024	-.054	-.050

4) Staff experience: improvement in agreement statements between Stages I and II

Strongly agree or agree					
	Stage I		Stage II		Improvement
Statement	n	%	n	%	%
There is high morale amongst the staff on this ward	669	62.1	782	76.8	14.7
Involve older people in decisions about their treatment/ day-to-day care	896	83.1	938	92.2	9.1
I have enough time to discuss and explain care and treatment to patients	705	65.4	840	82.5	17.1
I have enough time to discuss and explain care and treatment to patients' families	595	55.2	777	76.3	21.1
Understand how dementia affects patients in hospital	965	89.5	878	96	6.5

5) Staff training attendance, wards who achieved the award of the Quality Mark

Staff training, wards with Award	**Stage I**		**Stage II**		**Difference (%)**
	% YES	**N =875**	**% YES**	**N = 809**	
Cultural competence and diversity	75.3	659	85	688	9.7
Communication and discussing issues relating to end of life care and decisions consistent with the National End of Life Care Programme	67	586	80.3	650	13.3
Recognising situations in which patients may be at risk of falling	92.3	808	96	777	3.7
Risks associated with the use of sedation and restraint	54.9	480	67.9	549	13
Distraction and calming (de-escalation) techniques for the management of patients who are displaying behaviour that challenges/are aggressive/are agitated	67.3	589	78.7	637	11.4
Encouraging food and fluid intake	89.8	786	95.3	771	5.5
Safeguarding vulnerable adults	92.6	810	96.3	779	3.7
Symptoms of dementia	86.6	758	93.7	758	7.1
Types of dementia	81.8	716	91.8	743	10
Symptoms of delirium	69.9	612	83.9	679	14
Person-centred care approaches	76.2	667	88.8	718	12.6
Continence care	82.3	720	89.7	726	7.4
Totals	**78**		**87.3**		**9.3**

6) Staff training attendance, wards without the award of the Quality Mark

Staff training, wards without Award	Stage I		Stage II		Difference (%)
	% YES	n=203	% YES	n=209	
Cultural competence and diversity	69.5	141	73.7	154	4.2
Communication and discussing issues relating to end of life care and decisions consistent with the National End of Life Care Programme	63.5	129	64.6	135	1.1
Recognising situations in which patients may be at risk of falling	87.7	178	93.3	195	5.6
Risks associated with the use of sedation and restraint	48.3	98	52.6	110	4.3
Distraction and calming (de-escalation) techniques for the management of patients who are displaying behaviour that challenges/are aggressive/are agitated	62.1	126	69.4	145	7.3
Encouraging food and fluid intake	88.7	180	90.9	190	2.2
Safeguarding vulnerable adults	90.1	183	94.3	197	4.2
Symptoms of dementia	82.3	167	90	188	7.7
Types of dementia	76.4	155	87.1	182	10.7
Symptoms of delirium	57.6	117	70.3	147	12.7
Person-centred care approaches	71.4	145	85.2	178	13.8
Continence care	82.8	168	88.5	185	5.7
Totals	**73.4**		**80**		**6.5**

Appendix H

All measures for all wards who completed both stages of the Quality Mark by January 2018.

Ward name	PQ SI	PQSII	SQ SI	SQSII	MDT SI	MDT II	WM SI	WM SII	LC SI	LC SII	EQ SI	EQ SII	GQ SI	GQ SII	HMQ SI	HMQ SII
Ward GRU	81.4	77.5	82.3	78.7	83.6	90.6	90.7	93.4	59.8	51.8	66.7	97	72.3	94.2	44.2	64.2
Stroke Unit IOW	77.5	74.6	79.9	71	57.8	90.6	79.5	64.3	78.8	87.9	76.8	96.2	44.2	64.2	31	31
Ward 45	77.3	79.3	60.5	74.3	58.6	85.9	75	78.1	82.1	78.1	93.9	83.3	93.8	86.5	74.2	95
Wisley (now Hindhead)	74.2	78.9	74.9	76.9	87.9	91.4	75	80.1	79.5	86.6	87.1	86.4	91.1	100	60	63.3
ward 46 MRI	88.9	92.8	86.5	89.6	90.5	86.9	74.3	95.4	75.9	80.4	90.9	90.9	88.4	90.4	74.2	68.3
2B RLI	79.4	76.8	71.6	82.4	86.2	96.9	94.2	96.4	76.8	77.7	57.6	66.7	92	98.1	96.7	57.5
2x RLI	76.8	86.9	60.7	85.4	100	98.4	95.9	94.9	93.8	95.5	63.6	87.9	94	89.4	96.7	57.5
2Y RLI	84.7	79.8	90.2	76.7	94.8	96.1	86.6	81.6	99.1	98.2	83.3	80.3	96.4	100	96.7	57.5
Steepholm	82.1	82.7	67.3	83.2	69	90.6	65.1	73	67.9	88.4	78.8	83.3	95.5	92.9	50.8	75
Ewhurst	78.1	78.7	78.2	80.3	81	86.7	89.5	95.9	46.4	63.4	89.4	87.9	76.8	100	60	63.3
Gresley Unit	82	72.7	68.9	64.4	94.4	92.2	72.1	75.5	75.9	76.8	89.4	92.4	87.2	91.7	79.2	98.3
Ward 1 & 3 DRI	78.9	83.6	71.9	67.4	91.9	96.9	72.7	84.2	59.8	86.6	72.7	87.7	82.7	94.2	71.2	77.5
Ward C5 (prev B8) RBL	83.2	84.1	74.9	80.4	83.1	96.9	80.8	85.7	88.4	83.9	87.9	97	78.8	80.8	58.3	55.8
Ward B22 RBH	78.6	77.5	70	70	52.4	65.6	65.7	60.7	68.8	74.1	90.9	87.9	79.5	83.3	58.3	96.7
Ward 52 DMH	63.4	77.1	67.8	78.4	83.9	97.7	51.7	76	92	73.2	87.9	95.5	96.2	100	58.3	64.2
Ward 44 DMH	78.2	77.9	75.6	85	88.7	86.7	76.7	100	63.4	70.5	68.2	97	90.4	97.1	58.3	64.2
Michael Bates Ward	76.2	75	74.9	77.7	79	90.6	74.4	88.8	78.6	75	77.3	95.5	72.4	86.5	52.5	71.7
Ward 19 STH	86.1	82.2	89.3	81.6	100	100	90.1	97.4	92.9	89.3	75.8	98.5	91.3	94.2	90.8	92.5
Ward 32 LRI	75.6	81.6	68.3	69.7	79	92.2	65.7	88.8	69.6	94.6	59.1	81.8	85.6	90.4	88.3	94.2
Ward 39 LRI	61.2	85.1	60.9	87.8	68.5	89.1	62.2	89.3	66.1	88.4	75.8	83.3	76.9	90.4	88.3	94.2

Ward name	PQ SI	PQSII	SQ SI	SQSII	MDT SI	MDT II	WM SI	WM SII	LC SI	LC SII	EQ SI	EQ SII	GQ SI	GQ SII	HMQ SI	HMQ SII
Ward 18	76.3	75.1	72.5	78.6	87.9	94.5	70.9	95.4	46.4	79.5	75.8	93.9	76.9	76.9	88.3	92.5
Ward 21 LRI	81.4	82.6	77.4	77.4	71	93	54.7	74.5	74.1	90.2	72.7	100.0	84.6	73.1	88.3	94.2
Ward 17 LRI	79.7	75.3	67.6	83.5	65.3	99.2	65.1	89.3	71.4	97.3	78.8	90.9	74	94.2	88.3	94.2
Ward 37 LRI	73	78.3	69.9	94.2	75	98.4	90.7	100	55.4	84.8	54.5	98.5	89.4	90.4	88.3	94.2
Ward 40 LRI	77.7	80.5	74.5	80.5	90.3	91.4	94.8	88.8	72.3	88.6	86.4	87.9	78.8	97.1	88.3	94.2
Ward 31 LRI	71.3	87	62.5	96.7	69.4	99.2	72.7	100	56.3	81.3	62.1	95.5	84.6	96.2	88.3	94.2
Aston	72	74.1	74.9	69.9	85.5	97.7	62.8	69	51.8	62.5	83.3	78.8	100	92.3	94.2	66.7
Langley	83	81.2	73.5	75.3	90.3	89.8	92.4	93.4	63.4	65.2	89.4	97	100	95.2	94.2	66.7
Lindhurst ward	85.5	87.6	84.4	83.4	83.9	81.3	75.6	85.7	74.1	73.2	81.8	93.9	93.3	94.2	57.5	44.2
Ward 20	74.3	78.4	74.9	86.6	86.3	93.8	98.3	97.4	77.7	94.6	84.8	95.5	96.8	75.6	55.8	60
Ward 21 RPH	77.6	76.8	72.1	75.8	76.6	94.5	69.8	99.5	79.5	81.3	77.3	86.4	94.8	79.8	55.8	60.8
Bleasdale Ward	83.4	80.1	85.6	77.2	77.4	96.9	96.5	92.9	73.2	83	75.8	81.8	87.5	71.2	55.8	60.8
Barton Ward	73.8	80.8	76.7	82.1	99.2	89.8	62.2	70.9	92	88.4	66.7	77.3	79.8	95.5	55.8	60.8
Rookwood A	79.5	76	68.2	82.6	65.3	99.2	91.3	99.5	73.2	81.3	69.7	95.5	81.7	82.7	55.8	60.8
Rookwood B	79.8	75.9	73.2	80.6	75	88.3	96.5	99	72.3	84.8	75.8	98.5	90.4	97.1	55.8	60.8
Eashing	76	78	70.1	77	72.6	91.4	55.2	78.1	69.6	77.7	72.7	77.3	98.1	82.7	63.3	64.2
Coombe Ward	74.8	91..4	71.4	86.1	74.2	86.7	76.7	93.4	68.8	86.6	95.5	92.4	73.9	95.2	66.7	91.7
Midford	81.3	86.2	70.4	78.2	99.2	96.9	76.7	98	76.8	97.3	93.9	93.9	80.8	86.5	66.7	52.5
Waterhouse Ward (formerly Pulteney)	76.7	75.4	75.8	75.4	85.5	83.6	65.1	85.2	63.4	73.2	75.8	75.8	71.2	80.8	66.7	91.7
Dalby Ward	70.1	79.5	69.6	80.7	75	73.4	94.8	72.4	82.1	92.9	63.6	51.5	83.7	75	63.3	68.3
Heberden ward	77.2	79.6	68.8	84.1	87.9	88.3	73.3	94.4	66.1	90.2	77.3	80.3	89.1	97.6	63.3	68.3
Elizabeth Ward	82.6	83.9	70.1	86.6	84.7	95.3	63.4	98	46.4	75.9	93.9	100	84.6	86.5	91.7	94.2
Harpur Ward	85.5	92	79.9	79.6	88.7	98.4	84.9	89.8	50.9	77.7	97	97	90.4	88.5	91.7	94.2
Lister Ward	76.1	83.2	73	79.4	83.9	86.7	69.2	82.7	80.4	76.8	75.8	87.9	98.1	87.5	60.8	55

Quality Mark for Elder-Friendly Hospital Wards

Ward name	PQ SI	PQSII	SQ SI	SQSII	MDT SI	MDT II	WM SI	WM SII	LC SI	LC SII	EQ SI	EQ SII	GQ SI	GQ SII	HMQ SI	HMQ SII
Locke Ward	72.2	75.2	77.2	74	75.8	86.7	73.8	76.5	64.3	75	80.3	84.8	86.5	98.1	60.8	61.7
Ray Ward	77.9	80.4	72.8	81.8	91.1	89.1	49.4	88.3	67.9	66.1	65.2	84.8	63.5	80.1	55	61.7
Ward 14 RPH	77.5	81.3	69	73.2	72.6	89.8	61	81.1	70.5	72.3	48.5	89.4	75	86.5	60	61.7
Ward 16 RPH	78.2	86.1	60.2	73.6	81.5	84.4	61	85.2	68.8	72.3	68.2	78.8	84.6	67.9	60	61.7
Ward 2 TGH	82.1	90.8	80.6	90.7	92.7	96.1	86.6	95.9	70.5	92	75.8	97	89.4	100	79.2	75.8
Ward 4 TGH	83	95.5	82.1	92.9	96	98.4	84.3	95.9	86.6	100	57.6	98.5	86.5	91.3	80	75.8
Jersey Ward	77.9	79.4	69.4	84.2	87.9	97.7	67.4	86.7	64.3	87.5	81.8	90.9	93.3	97.1	50.8	89.2
Tarrant Ward	90.3	89	74.6	76	96	94.5	79.7	89.3	72.3	78.6	93.9	95.5	96.2	98.1	92.5	90
Stanley Purser	85.5	85.4	70.4	85.4	93.5	95.3	65.7	80.1	69.6	61.6	69.7	81.8	92.3	76.9	79.2	79.2
Fayrewood	90.7	82.2	82.1	86.7	98.4	92.2	83.1	83.2	73.2	95.5	90.9	97	93.3	100	58.3	87.5
Radipole	80.2	79.5	64.8	72.8	97.6	95.3	75.6	82.1	62.5	64.3	83.3	97	77.9	87.5	54.2	70

References

Aiken, L., Sermeus, W., Van den Heede, K., et al. (2012). *Patient safety, satisfaction, and quality of hospital care: cross sectional surveys of nurses and patients in 12 countries in Europe and the United Sates. BMJ* 2012; 344, e1717.

Care Quality Commission (2013). *Time to Listen in NHS Hospitals. Dignity and Nutrition Inspection Programme 2012. CQC*, Newcastle Upon Tyne.

Dicks, S., Chaplin, R., Hood, C. (2013). *Factors Affecting Care on Acute Hospital Wards. Nursing Older People.* 25, 1, 18-23.

Francis, R. (2010). *Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust January 2005-March 2009 Volume I.* The Stationery Office, London.

Help the Aged (2008). *On Our Own Terms – The Challenge of Assessing Dignity in Care.* Help the Aged, London.

Oliver, D., Foot, C., & Humphries, R. (2014). *Making out Health and Care Systems Fit for an Ageing Population.* The King's Fund, London.

Parliamentary and Health Service Ombudsman, (2017). Breaking Down the Barriers: Older People and Complaints about Health Care. Available at https://www.ombudsman.org.uk/sites/default/files/Breaking_down_the_barriers_report.pdf [Accessed 27 June 2018]

Royal College of Psychiatrists (2013). *National Audit of Dementia Care in General Hospitals 2012-13. Second Round Audit Report and Update.* Healthcare Quality Improvement Partnership, London.

Tadd, W., Hillman, A., Calnan, S., et al. (2011). *Dignity in Practice: An exploration of the Care of older Adults in Acute NHS Trusts.* NIHR Service Delivery and Organisation Programme, Southampton.