

SAMPLING HANDBOOK FOR THE NHS ADULT INPATIENT SURVEY 2007

THE CO-ORDINATION CENTRE FOR THE
ADULT INPATIENT SURVEY

Contacts

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Adherence to the procedures outlined in this document

It is not permissible to deviate from the agreed protocol as set out in this guidance manual, for example, by offering financial inducements or lottery prizes to respondents. The terms of the ethical approval do not permit these types of alteration. Furthermore, such alterations might mean that the comparability of the survey would be compromised, and such results may not be acceptable for computation of the Annual Health Check for that trust. If trusts want to make any adjustments to the method set out in this guidance, they will need to seek local research ethics approval, and check with the Co-ordination Centre that the proposed alteration would not compromise comparability.

Updates

Before you start work on your survey, check that you have the latest version of this document, as there might be some small amendments from time to time (the date of the last update is on the front page). In the very unlikely event that there are any major changes, we will e-mail all trust contacts and contractors directly to inform them of the change.

This document is available from the Co-ordination Centre website at:

www.NHSSurveys.org

¹ Previously the NHS Patient Survey Advice Centre

1 About this handbook

This handbook is produced by the Co-ordination Centre for the adult inpatient survey, on behalf of the Healthcare Commission.

This handbook is comprised of excerpts from the *Guidance Manual for the NHS Adult Inpatient Survey 2007* and is intended to assist in the sampling for the survey. This abridged handbook is aimed at those carrying out the sampling for, but not directly coordinating or managing, the adult inpatient survey at each trust. Those who are co-ordinating the survey for the trust are strongly recommended to read the full guidance manual, with special attention to Section 3 entitled “What’s new for 2007?”

A glossary of terms is provided at the end of this document, and the new requirements of the acute patient survey programme, namely weekly submissions of outcome and helpline monitoring information.

2 What's new for 2007?

Sampling period: Trusts can now sample back as far as the 1st January 2007 (from June, July or August 2007) to generate their sample if required. In previous surveys, trusts which needed to do this had to seek permission from the co-ordination centre first.

Current inpatients: Trusts are instructed to exclude current inpatients from the sample when generated. This should be the only time current inpatients are excluded from the survey process. When checks for deceased patients are carried out immediately prior to each mailing, do not check for, or exclude, current inpatients at these times.

Choosing sampling month for 2007: We suggest that trusts use the same month of sampling as used for the 2006 inpatient survey to maximise comparability between years. However, recent work by the Co-ordination Centre has shown minimal seasonal effect between choosing any one of the three months and trusts can choose to use the month most reflective of their normal performance. Please contact the Co-ordination Centre if you plan to change your sampling month so that we can monitor the effect upon survey findings.

Ethnic category: Ethnic category as defined by the NHS Dictionary maintained by Connecting for Health should now be used instead of ethnic group. Ethnic category is a 17 item alphabetical code that will replace the 6 item code previously used in patient surveys. The code "Z" ("not stated") should be used when a person had been asked for their ethnic category and had declined either because of refusal or genuine inability to choose. A blank or full-stop should still be used to indicate where ethnic category is "not known" ie where the patient had not been asked or the patient was not in a condition to be asked, eg unconscious. Further information can be found in section 3.4 – Create the sample file.

Glossary: To review new definitions of terms used in the national inpatient survey, please use the glossary, which been included at the end of this guidance manual.

3 Compiling a list of patients

This section explains how to draw a sample of patients. This task will need to be carried out by a member of staff at the NHS Trust. In hospital trusts, the sample will normally be drawn from the Patient Administration System (PAS). Prior to sending out questionnaires, the list will also have to be checked by the NHS Strategic Tracing Service (NSTS) to identify deceased patients.

Please follow the instructions below carefully and allocate sufficient work time to check the sample with NSTS before the first mailing and within the trust prior to each mailing.

We strongly advise that you read all of this section BEFORE you start to compile your patient list.

3.1 Compile a list of eligible patients

- 1) Select the month of inpatient discharges in which your survey sample will end. You should start counting back from the last day of **either** June 2007 **or** July 2007 **or** August 2007. For optimal consistency, sample the same month as was used for the 2006 inpatient survey. If you have good reason to believe that this month was irregular in a way and would generate an unusual sample, your next choice should be the most recent month you can manage. If you change month of sampling, please inform the Co-ordination Centre for our records.
- 2) Compile a list of 900² adult (**aged 16 and over**) inpatients consecutively discharged alive from your trust working back from the last day of the sampling month. That is, once you have decided on the latest date of patient discharge you will include in the sample (ie 30th June 2007 **OR** 31st July 2007 **OR** 31st August 2007), you should count back through the list of patients discharged live from the trust, including all eligible patients, until you have 900 patients.

Note

Some trusts have a much lower discharge rate than others. If necessary, a trust can include all patients discharged back as far as the 1st January 2007 to generate their sample of 900 adult inpatients submitted to NSTS.

The information you obtain about each patient will be used both for administering the survey and for sending to the tracing service to check for deceased patients. It saves time and effort if all the information is gathered at the same time.

The list should **include**:

ALL eligible adult patients, who have had at least **one overnight stay** (see Glossary) within the trust.

² The final sample size must be no greater than 850, but this allows for a safety margin of a few extra patients, once any deceased patients have been taken out of the sample.

The list should **exclude**:

- deceased patients
- children or young persons aged under 16 years
- obstetrics/maternity service users (see Glossary)
- patients admitted for termination of pregnancy
- psychiatry patients (see Glossary)
- day cases
- private patients (non-NHS)
- current inpatients
- patients without a UK postal address (but do not exclude if addresses are incomplete but useable eg no postcode).

3.2 Treatment Centres

Patients who stayed as an inpatient at a NHS treatment centres at the trust are eligible for inclusion in the sample for the 2007 inpatient survey, provided they meet the criteria above. These patients should be flagged up by inserting a '1' in the appropriate column on Table 1 (Sample Excel file of patient details).

3.3 Checks carried out by the trust

Once you have compiled your list of 900 patients, you should carry out the following checks before you send the list to the NSTS to carry out a further check for deceased patients.

- **Deceased patients.** Check hospital records do not have a record of a patient's death from a subsequent admission or visit to hospital

Checks for deceased patients

One of the most reliable and up-to-date sources of information on patient deaths is your own trust's records. **It is essential that you check that your trust has no record of a patient having died at your trust.** Relatives are likely to be particularly upset if they receive a questionnaire or reminder from the trust where their relative died. Clearly, patients may also have died at home or while under the care of another trust, so you still need to check with the tracing service (NSTS) as well.

The methodology for this survey requires three stages of checks for deceased patients before the first mailing is sent out. The checks are carried out sequentially by:

- 1) the trust
- 2) NSTS
- 3) again by the trust (for patients who may have died in hospital after submission of the sample to NSTS).

You are also advised to repeat this check before the second and third mailings, and to ensure that approved contractors are advised immediately if any patients in the sample die during the survey period.

- **Overnight stay.** Check that patients had at least one overnight stay in hospital. Patients are considered to have had an overnight stay if they were admitted as an inpatient and

occupying a bed at midnight, eg patients who are admitted as an inpatient on Day 1 and discharged on Day 2 are considered to have had a single overnight stay regardless of their admission time or discharge time. Day cases and outpatients are **not** included in this survey

- **Current inpatients.** Check that none of the patients are known to be current inpatients in your trust (or elsewhere, if possible)
- **Patient ages.** Check that all patients are aged 16 or over at the time of sampling
- **Postal addresses.** Exclude any addresses that are outside the UK
- **Incomplete information.** Check for any records with incomplete information on key fields (such as surname and address) and remove those patients. However, do not exclude anyone simply because you do not have a postcode for them. Only remove a patient if there is insufficient name or address information for the questionnaire to have a reasonable chance of being delivered. The more cases that are removed at this stage, the poorer the sample coverage and the greater the danger of bias
- **Duplications.** Check that the same patient has not been included more than once
- **Obstetrics/maternity service user.** Check that the list does not include maternity service users
- Check again that none of the patients were admitted for a **termination of pregnancy**
- **Psychiatry patients.** Check that the list does not include psychiatry patients
- **Private patients.** Remove any private patients from the sample
- **Patients treated at private hospitals.** Remove any patients who were treated by the trust as NHS patients in private hospitals.

3.4 Create the sample file

An example of the spreadsheet you should complete has been included below. This is available to be downloaded from our site (<http://www.nhssurveys.org/categories.asp?parent=272>) and is entitled "*Sample construction spreadsheet*". The column headings will match to the validated spreadsheet produced by the Co-ordination Centre for final submission of data and so it will be advantageous for you to use this spreadsheet.

This file has three purposes:

- 1) It will be used to keep a record of which patients have not returned questionnaires so that reminders can be sent to them.
- 2) It will be used to generate weekly response rates for your trust that must be forwarded to the Co-ordination Centre every Thursday from the 20th September 2007 until the closing date of the survey.
- 3) The anonymous data in this file (ie all the data **except** patient name and address information) will form part of the file that you will submit to the Co-ordination Centre when the survey is completed.

Table 1 – Sample Excel file of patient details

<i>Patient record number</i>	Title	Initials	Surname	Address1	Address5	Postcode	<i>Year of birth</i>	<i>Gender</i>	<i>Ethnic category</i>	<i>Day of admission</i>	<i>Month of Admission</i>	<i>Year of Admission</i>	<i>Day of discharge</i>	<i>Month of discharge</i>	<i>Year of discharge</i>	<i>Length of Stay</i>	<i>Main Speciality on discharge</i>	<i>PCT of Residence</i>	<i>Treatment centre admission</i>	<i>Day of questionnaire being received</i>	<i>Month of questionnaire being received</i>	<i>Year of questionnaire being received</i>	<i>Outcome</i>	Comments
1001	Mrs	AM	Abbot			AB1 1YZ	1934	2	A	5	8	2007	11	8	2007	6	100	5LS	0				3	Informed that patient had
1002	Mr	EC	Ahmed			AB2 6XZ	1970	1	J	20	7	2007	12	8	2007	23	101	5LT	1	22	10	2007	1	
1849	Ms	K	Yoo			AB4 7MX	1950	2	R	17	6	2007	31	8	2007	75	300	5LS	0					
1850	Ms	F	Young			AB9 5ZX	1946	2	A	14	8	2007	31	8	2007	17	100	5GT	0	6	11	2007	1	

Important note about table 1

The headings of Table 1 are in three different colours:

Bold black headings: these columns contain information on patients' names, addresses and comments that may allow them to be identified. This information should be deleted from all files sent to the Co-ordination Centre

Red italic headings: these columns should be completed during the sampling phase and submitted to the Co-ordination Centre prior to mailing for final inspection (see Section 4) and at the conclusion of the survey

Green italic headings: these columns should be completed when the patient responds to the survey, either by returning a completed questionnaire, or the trust is notified the patient will not be participating (patient deceased, moved address, too ill, or called to opt out).

The following information is compiled using hospital records:

- Title (Mr, Mrs, Ms, etc.)
- Initials (or First name)
- Surname
- Address Fields ³
- Postcode

³ The address should be held as separate fields (eg street, area, town, and county), consistent with the address format required by the NSTS.

Note

The **Patient Record Number**, **Title**, **Initials**, **Surname**, **Address** fields and **Postcode** are used for printing out address labels. You (or your contractor) can use the mail merge function in a word processing package for this purpose.

- The **Year of Birth** should be included in the form of NNNN.
- **Gender** should be coded as 1 = male and 2 = female.
- **Ethnic Category** coding has changed for the 2007 inpatient survey. The ethnicity of a person is specified by that person, and should be coded using the 17 item alphabetical coding specified by NHS Connecting for Health⁴. The codes are as follow:

National Codes:

White

- A British
- B Irish
- C Any other White background

Mixed

- D White and Black Caribbean
- E White and Black African
- F White and Asian
- G Any other mixed background

Asian or Asian British

- H Indian
- J Pakistani
- K Bangladeshi
- L Any other Asian background

Black or Black British

- M Caribbean
- N African
- P Any other Black background

Other Ethnic Groups

- R Chinese
- S Any other ethnic group

- Z Not stated

- **Day** of the month of admission (1 or 2 digits; eg 7 or 26)*
- **Month** of admission (1 or 2 digits; eg 9 or 10) *
- **Year** of admission (4 digits; eg 2007) *
- **Day** of the month of discharge (1 or 2 digits; eg 2 or 30) *

⁴ These codes can be found in the NHS Data Dictionary provided by Connecting for Health on the following website:
http://www.datadictionary.nhs.uk/data_dictionary/attributes/e/enh/ethnic_category_code_de.asp?shownav=1.

* Date fields must be supplied in separate columns (eg date, month, and year).

- **Month** of discharge (1 or 2 digits; eg 9 or 10) *
- **Year** of discharge (4 digits; eg 2007) *
- **Length of Stay** (Units = Days)⁵
- Main Specialty on Discharge is recorded in the form NNN as outlined in the Updated National Specialty List which was implemented on the 1 April 2004. See [Supporting Information: Main Specialty And Treatment Function Codes](#).
- **PCT of Residence** should be coded using the **first three** characters of the PCT character codes (maintained by the National Administrative Codes Service). They provide postcode files which link postcodes to the PCTs
- **Treatment Centre Admission** should be coded as '1' for patients who spent any part of their inpatient stay at an NHS treatment centre within the trust, and coded as '0' if they did not.

Additional information should also be entered on this spreadsheet. The details of this information are discussed below:

- 1) **Patient record number.** This field will be a series of consecutive whole numbers (for example, 1001 through to 1850). This number is unique for each patient. It can be seen in the example that the numbers are in ascending order, starting at 1001 at the top of the list, through to 1850 at the bottom. The patient record number will be included on address labels and on questionnaires. Later, when questionnaires are returned (whether completed or not), you (or the approved contractor) will be able to use these numbers to monitor which patients have returned their questionnaires and to identify any non-responders, who will need to be sent reminders. If an approved contractor is used, you will need to agree with them on the range of serial numbers that will be used for your patients.
- 2) **Day of questionnaire being received.** This can only be completed if and when a questionnaire is received by the trust or approved contractor. It should be a one or two digit numerical response eg N or NN, **not** a date format eg 12/07/74.
- 3) **Month of questionnaire being received.** This can only be completed if and when a questionnaire is received by the trusts or approved contractor. It should be a one or two digit numerical response, **not** a date format.
- 4) **Year of questionnaire being received.** This can only be completed if and when a questionnaire is received by the trusts or approved contractor. It should be a four digit numerical response, **not** a date format.
- 5) The **Outcome** field will be used to record which questionnaires are returned to the freepost address, or are returned undelivered, or which patients opt out of the survey, etc.
 - 1 = Returned useable questionnaire
 - 2 = Returned undelivered by the mail service or patient moved house
 - 3 = Patient died
 - 4 = Patient reported too ill to complete questionnaire, opted out or returned blank questionnaire
 - 5 = Patient was not eligible to fill in questionnaire
 - 6 = questionnaire not returned (reason not known).

The outcome column is left blank at first if the survey has not been returned (on table 1 you can see that Ms Yoo has not yet returned her questionnaire).
- 6) The **Comments** column is useful for recording any additional information that may be provided when someone calls the helpline – for example, to inform you that the respondent has died or is no longer living at this address.

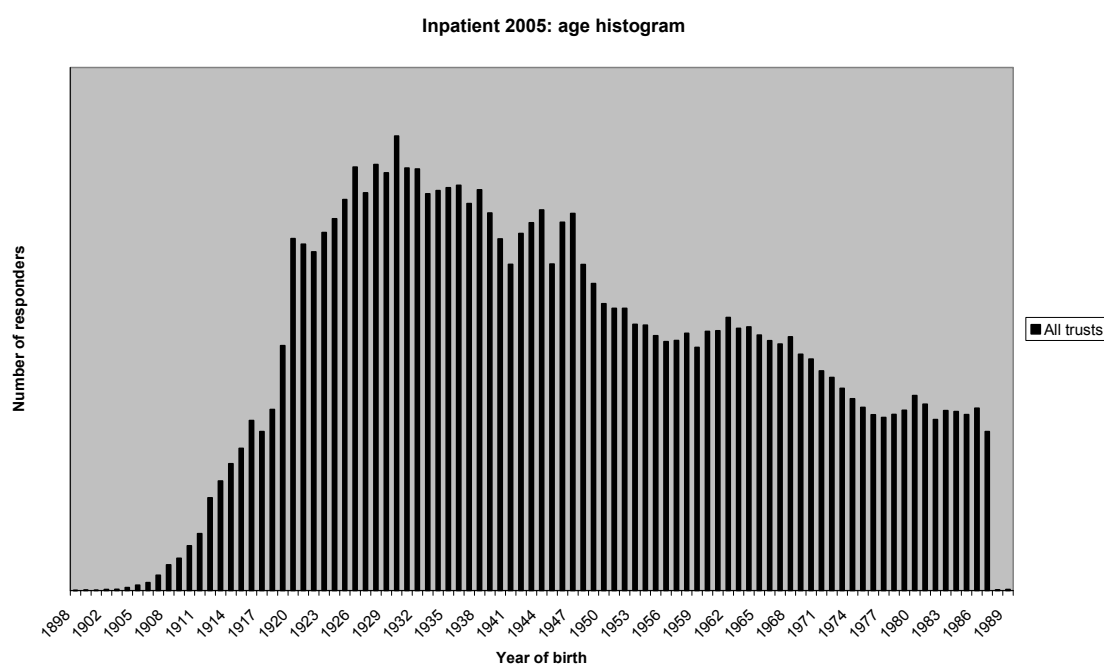
⁵ Calculate this by subtracting the admission date (day/month/year) from the discharge date (day/month/year). For example, if discharge date = 15/7/2007 and admission date = 14/7/2007, the Length of Stay = 1. Do not use any other type of unit to calculate Length of Stay (ie do not use hours/minutes/seconds). All patients in the sample should have a Length of Stay greater than or equal to 1 day.

3.5 Distribution of patient ages

You should check that patients of all ages are included in your sample, especially for those aged 16, 17 or 18 years or those over 75 years. We have found these age groups are the most likely to be excluded due to poor sampling. It is possible there may not be any young adults or very old adults in your sample, but this should be confirmed by checking your original sample (before exclusion criteria were applied) and your sampling techniques.

Check that your sampled patients' ages cover the full range of expected ages. Ideally, you should do this by checking the distribution of ages on a histogram (See Table 2). For most trusts the histogram should start out with a broad base (representing substantial numbers of young adults), then increase for those aged around 60 years (baby-boomers), before entering a slow decline to reflect fewer people at extreme old age.

Table 2 - Age Histogram for Inpatient 2005 survey



3.6 Distribution of patient gender

With the exception of hospitals specialising in one gender, your sample will probably have similar proportions of men and women. You should check each of these genders are included and that you can explain if the sample is skewed toward male or female patients.

3.7 Check for other sample errors

Further information on the sampling errors made in the 2006 inpatient survey can be found on the following webpage:

http://www.nhssurveys.org/docs/Inpatient_survey_sampling_errors_2006_v1.doc.

Using this document to check for any errors may reduce delays caused by mis-sampling and consequentially improve your response rate to this survey.

3.8 Submit the patient list to the NHS Strategic Tracing Service (NSTS)

Before sending out the questionnaires, the list of patients **must** be checked for any deceased patients by the NHS Strategic Tracing Service (NSTS). NSTS will return your sample file with deceased patients clearly identified.

The NSTS contact details are as follows:

Help desk telephone number: 0121 788 4001
Website: <http://www.connectingforhealth.nhs.uk/nsts/>

The time required to carry out the checks depends partly on the compatibility of the patient list you submit to the NSTS with their system requirements. NSTS tracing takes between 12 to 48 hours if submitted correctly. To avoid any delay, check carefully that your list is in the correct format for NSTS. The Caldicott Guardian for your trust will be able to provide you with details on how to carry out a “batch trace” for deceased patients.

Remember to keep a copy of the file you send to NSTS!

Specific details are required by the NHS Strategic Tracing Service (NSTS). These should not be submitted to the Co-ordination Centre. One of these is the patient’s NHS number. The NHS number can assist more accurate tracing, especially if addresses are incomplete. It is advisable to liaise with the registered NSTS batch trace user to ensure that you have extracted all the required fields.

For further help on batch tracing for patients, please view the document:

http://www.connectingforhealth.nhs.uk/nsts/docs/trace_out.pdf

Note

Please be aware that tracing services are not foolproof and even after your patient list has been checked for deaths, some patients may die in the period between running the check and the questionnaire being delivered. You may find that some recently deceased patients remain in your sample. You need to be prepared for this. Special sensitivity is required when dealing with telephone calls from bereaved relatives.

3.9 When the patient file is returned from the NSTS

The file returned from NSTS can be used to identify any records that need to be deleted from the sample file. This will reduce the numbers in your sample list slightly.

If you have more than 850 patients remaining on your list

When your patient list is returned by NSTS, and you have removed all deceased patients, there should still be more than 850 patients in the list. You will need to remove the **least recent** patients from your sample so that only the 850 most recent patients remain.

If you have fewer than 850 patients remaining on your list

If your patient list has fewer than 850 patients after deceased patients have been removed, you **MUST** contact the Co-ordination Centre. If possible, the next most recently discharged patients after the sample will need to be added to create a sample of 850 patients, although these must also be checked by NSTS.

Important note

You are aiming for a **response rate of at least 60%**, which means that you should have about 500 completed questionnaires if you send questionnaires to 850 patients. You will be able to maximise your response rate by following this guidance carefully, and you will need to send out two reminders. It is **not** acceptable to try to boost the number of responses you receive by sending out questionnaires to a larger number of patients as this would bias the survey. The Co-ordination Centre will only be able to accept responses from the patients in your list of 850 that have been correctly sampled and mailed.

Remember, you should only have 850 patients in the list at this stage.

3.10 Sharing the patient sample file with an approved contractor

If you are working with an approved contractor and have an honorary contract, the full sample information **and** the name and address information should be sent to those contractor staff covered by the honorary contract. If you are working with an approved contractor, but **not** using an honorary contract to share patients' name and address details, you should supply them with a version of the list shown in **Table 1 (Ssample Excel file of patient details)**, with names and addresses removed. The contractor can use this list to record the outcome codes, and you should ensure that the contractor is kept up to date with any information that comes directly to the trust about patient deaths, etc.

3.11 Creating the mailing and response spreadsheets

At this point, you should generate two copies of your sample file and name them "<NHStrustName>_Inpatient2007.xls" and "Inpatient 2007 mailing spreadsheet". The following changes should be made:

- <NHStrustName>_Inpatient2007.xls: delete all name, address and comment columns ie all columns in bold black in **Table 1 (Sample Excel file of patient details)** produced by the Co-ordination Centre (available on our website: www.NHSSurveys.org), which has all the required columns for the sample information, as well as columns for the response data from returned questionnaires. Only this "anonymised" version can be used to record patient responses. It is this version of the spreadsheet that must be submitted to the Co-ordination Centre
- Inpatient 2007 mailing spreadsheet: this spreadsheet is used for mailing purposes. It is essential that the "Outcome" column (about whether patients have responded, or why they have not responded) is kept accurate and up-to-date. Reminders can then be sent to patients who have not yet responded.

For patient confidentiality reasons, **it is essential that you do not keep patient name and address details in the same file as their survey response data.**

4 Final sampling inspection by the Co-ordination Centre

Trust data should still be checked for errors and received back from NSTS before being forwarded to the Co-ordination Centre. An anonymised sample file⁶ **must** be submitted to the Co-ordination Centre **prior** to the first mailing. This is to allow us to make final quality control checks. All columns *in red italics* in Table 1 (sample Excel file of patient details), must be submitted, but name, address and postcode details must be removed.

If you are using an **approved contractor**, the sample should be checked as normal by the trust and by NSTS before being submitted to the contractor. We strongly recommend the contractor carries out the same high standard of checks as in previous years, but will then submit the file to the Co-ordination Centre. The Co-ordination Centre will address any issues arising from these final checks to the approved contractor.

The Co-ordination Centre will be checking for extraordinary errors. These are more visible when viewing data from many trusts at one time. For this reason, samples will be checked as collated files. Emails discussing any sample anomalies will be returned to the trust or approved contractor which provided them on Tuesday of each week. Initially, we will be working to the timetable included below but, if sufficient samples are submitted during a week, we hope to be able to respond to trusts and approved contractors earlier:

Date sample received	Date sample returned
3 rd -10 th September 2007	11 th September 2007
11 th -17 th September 2007	18 th September 2007
18 th -24 th September 2007	25 th September 2007
25 th -1 st October 2007	2 nd October 2007

Samples should reach the Co-ordination Centre by the 1st October 2007. If they do not, there is a risk your trust will not have enough time to correct any problems in the sample and complete the survey with an acceptable response rate.

⁶ Created by removing the patients' names, addresses and postcodes.

5 Increasing sample size beyond minimum requirement

Your trust may wish to use the adult inpatient survey an opportunity to gather data in addition to that required by the Healthcare Commission. One way to do this is to increase the number of patients you sample, ensuring that you target sufficient numbers from each of the units you want to compare so that you can get enough responses to make comparisons. However, before you decide to do this, there are some important points to consider:

- The core sample for the 2007 inpatient survey must be drawn as specified in this guide. It is essential that any additional sample drawn can be easily distinguished from the core sample, and that it is drawn in such a way as to not interfere with selection of the core sample
- Small, limited surveys are easier for in-house staff to handle than large surveys. You may wish to consider keeping the two things separate by doing the large hospital patient survey on its own (either in-house or with an approved contractor) and then following it up with smaller, targeted in-house surveys.

To summarise

If you do choose to increase your sample size, it is essential that you ensure that the sample of patients you draw according to the requirements for the national survey can be easily distinguished from any additional patients you include in the sample.

You must **only** send the Co-ordination Centre data for the 850 patients sampled according to these guidelines, and these patients **must** be those discharged most recently. Any additional patients selected to increase your survey beyond the minimum requirements of the 2007 inpatient survey must have been discharged **earlier** than the core sample.

6 Glossary

Adult inpatient

Any person having at least one overnight stay (see below) and aged 16 years or over.

Current inpatient

For the purposes of this survey, we define a current inpatient as a participant who meets the inclusion criteria for the survey, but is a current inpatient at any hospital in England. Please check your own trust records for any current inpatients during sampling and exclude these people from the sample during the sampling phase only. If you are aware that they are current inpatients at another trust, also exclude these people. When checks for deceased patients are carried out prior to subsequent mailings, do not check for, or exclude current inpatients.

Overnight stay

Patients are considered to have had an overnight stay if they were admitted as an inpatient and occupying a bed at midnight, ie patients who are admitted as an inpatient on Day 1 and discharged on Day 2 are considered to have had a single overnight stay regardless of their admission time or discharge time

Obstetrics/Maternity patients

Any patients coded with a main specialty of 501 (obstetrics) or 560 (midwife) and admitted for management of pregnancy and childbirth, including miscarriages, should be excluded from the sample. A separate survey of maternity service users' experiences was conducted in 2007.

Psychiatry patients

Patients admitted as an inpatient to hospital for primarily psychiatry reasons should not be included in the sample. This will include all those with main specialties of:

- 700 learning disability
- 710 adult mental illness
- 711 child and adolescent psychiatry
- 712 forensic psychiatry
- 713 psychotherapy
- 715 old age psychiatry