

SAMPLING HANDBOOK FOR THE NHS ADULT INPATIENT SURVEY 2008

THE CO-ORDINATION CENTRE FOR THE
ACUTE SURVEY PROGRAMME



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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 relevant measures within the Healthcare Commission Annual Health Check for that trust. If trusts want to make any adjustments to the method or materials 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 About this handbook

This handbook is produced by the Co-ordination Centre for the Acute Survey Programme, on behalf of the Healthcare Commission.

This handbook is comprised of excerpts from the *Guidance Manual for the NHS Adult Inpatient Survey 2008* 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 2008?”

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 2008?

New sample data requested: To allow more accurate interpretation of the data, we request that trusts submit an additional field containing data on the patient's route of admission to hospital. This field has two codes; "1" for those admitted for an emergency or urgent admission and "2" for those admitted for a planned admission or from a waiting list. This field should be left empty (a blank or full-stop) if this information is not available. Further information can be found in *Section 3.4 - Create the sample file*.

Isolating postal details from sample information: In the interests of data security, we suggest that the names, addresses and postcodes of each patient are removed from the rest of the sample information as soon as the sample is finalised. Prior to this, it is essential to provide each patient with a unique patient reference number (PRN) and to ensure this number is correctly applied to the two dataset. The "mailing data" file should be used to send out the questionnaires and reminders, and returning questionnaires should be logged in the "sample data" file. Before the reminders are mailed, the outcomes from the "sample data" file should be used to check hospital records for any deceased patients and to finalise the non-responders to be mailed to. Further information can be found in *Section 3.10 - Separating mailing details from sample information*.

Ethnic category: As in 2007, ethnic category will be requested in the standard 16 + 1 alphabetical format. However, there was some confusion over what data should be coded as "Z" ("not stated"). This code should be used **only** 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. For most trusts, ethnic category will contain both "Z" codes **and** "blanks". Further information can be found in *Section 3.4 – Create the sample file*.

NHS Strategic Tracing Service (NSTS): There is additional security information provided by NSTS on batch tracing (Appendix 1) and password/phrase guidance for batch encryption to AES 256-bit strength (Appendix 2). This new guidance is also available as separate files on the NHS Surveys website under the 'Guidance' category of the 'Adult Inpatient Survey 2008' section of the website (<http://www.nhssurveys.org/surveys/343>).

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 2008 **or** July 2008 **or** August 2008. For optimal consistency, sample the same month as was used for the 2007 inpatient survey. If you have good reason to believe that this month was irregular in a way that 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 900¹ 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 2008 **OR** 31st July 2008 **OR** 31st August 2008), you should count back through the list of patients discharged live from the trust, including all eligible patients, until you have 900 patients. Trusts can sample back as far as the **1st January 2008** to generate their sample, if required.

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 2008 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.

¹ 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 at time of discharge from hospital
- obstetrics/maternity service users, including spontaneous miscarriages (see Glossary)
- patients admitted for planned termination of pregnancy
- psychiatry patients (see Glossary)
- day cases
- private patients (non-NHS)
- any patients who are known to be current inpatients²
- 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 2008 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.

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 selected for the survey 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 check your hospital records for any further deaths prior to posting 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.

² **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

- **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. Please ensure that no episode of a patient's care has a maternity speciality code
- 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 can be downloaded from our site (<http://www.nhssurveys.org/survey/620>) 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 25th September 2008 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.

deceased patients are carried out immediately prior to each mailing, do not check for, or exclude, current inpatients at these times. This improves the comparability of samples between trusts and thus reduces bias.

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 Specialty on discharge</i>	<i>PCT of Residence</i>	<i>Treatment centre admission</i>	<i>Route of 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	2008	11	8	2008	6	100	5LS	0					3	Informed that patient had died	
1002	Mr	EC	Ahmed			AB2 6XZ	1970	1	J	20	7	2008	12	8	2008	23	101	5LT	1	2	22	10	2008	1		
1849	Ms	K	Yoo			AB4 7MX	1950	2	R	17	6	2008	31	8	2008	75	300	5LS	0							
1850	Ms	F	Young			AB9 5ZX	1946	2	A	14	8	2008	31	8	2008	17	100	5GT	0	1	6	11	2008	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. This data, along with a copy of the Patient Record Number should be removed from the sample file after when the 850-patient sample is finalised to create the "mailing data" file

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**⁴ coding has changed for the 2008 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 Health⁵. 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 ⁶

⁴ It is acknowledged that patient records might not always contain complete data on patients' ethnic category. However, this field should be included wherever possible. This data is required in order to evaluate non-response from different ethnic categories. This is in keeping with the aims of the Healthcare Commission and Department of Health to be more responsive to all ethnic groups and to ensure all groups are appropriately represented in their assessments.

⁵ 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

⁶ The code "Z" should only be used if the patient was asked for their ethnic category but refused to provide it. If this code is missing for any other reason, ethnic category should be left blank in the sample information.

- **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 2008) *
- **Day** of the month of discharge (1 or 2 digits; eg 2 or 30) *
- **Month** of discharge (1 or 2 digits; eg 9 or 10) *
- **Year** of discharge (4 digits; eg 2008) *
- **Length of Stay** (Units = Days)⁷
- 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 http://www.datadictionary.nhs.uk/web_site_content/pages/codes/main_specialty_and_treatment_function_codes.asp?shownav=1.
- **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
- **Route of Admission** should be coded as '1' for patients admitted for an emergency or urgent admission, and '2' for those admitted for a planned admission or from a waiting list. A blank or full-stop should be used if this information cannot be obtained for a patient.

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. Please note: this number should be available in, and correctly referenced for, every patient dataset for this survey.
- 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 12/09/08.
- 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

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

⁷ Calculate this by subtracting the admission date (day/month/year) from the discharge date (day/month/year). For example, if discharge date = 15/7/2008 and admission date = 14/7/2008, 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.

- 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).

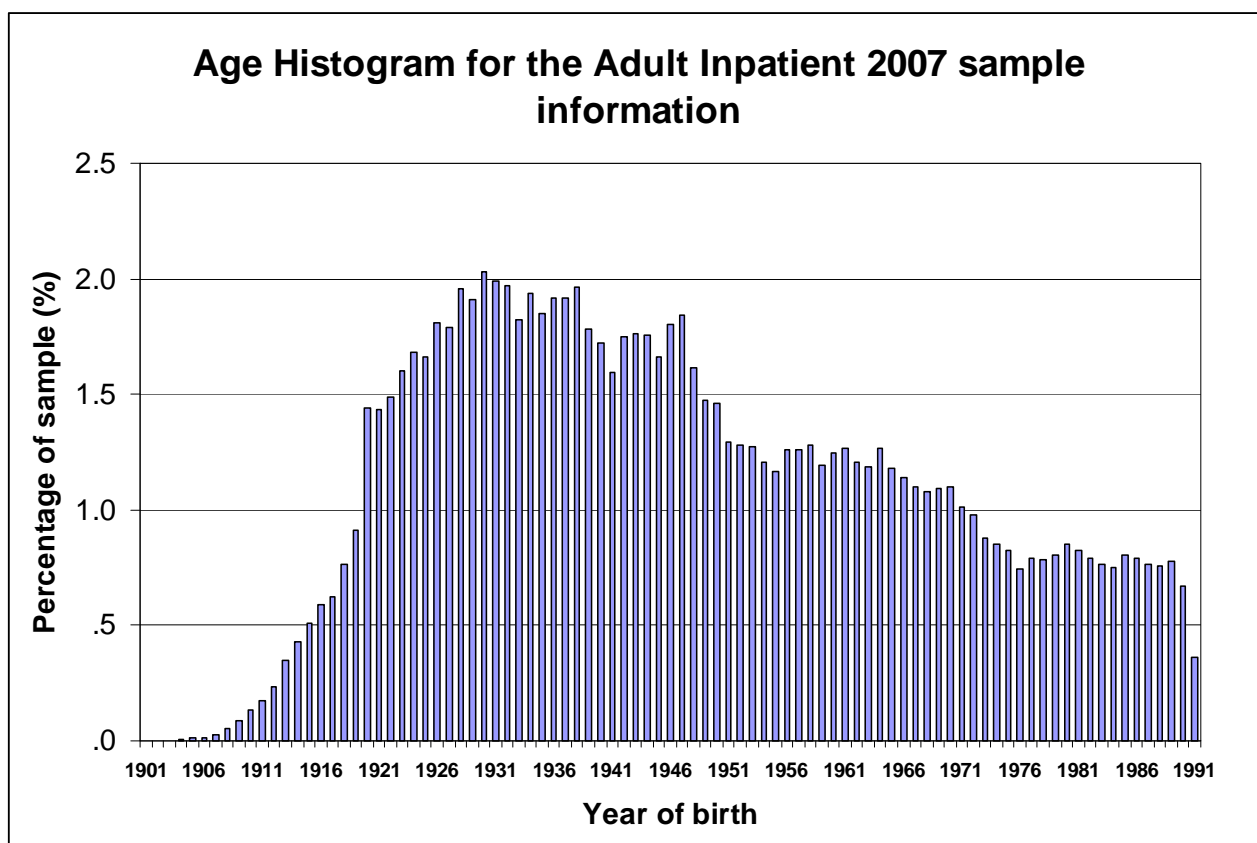
- 6) The **Comments** column is useful for recording any additional information that may be provided when someone calls the helpline – for example, to inform you that the respondent has died or is no longer living at this address.

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 – Example Age Histogram for Inpatient survey](#)). 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 – Example Age Histogram for Inpatient 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 2007 inpatient survey can be found on the following webpage:

http://www.nhssurveys.org/Filestore/documents/Inpatient_survey_sampling_errors_2007.pdf.

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.

Please be aware that **only** NSTS registered organisations can submit files. If your organisation is not registered to use NSTS, or if you are unsure of your organisation's status, please contact the NSTS Service Management Team via nsts.servicemgmt@nhs.net **before** sending any data.

Data submitted for tracing to NSTS must be in the correct format and must be submitted using the correct process.

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. Please allow up to 5 days when submitting data via portable media such as floppy discs or CD ROMs. 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.

Format

To avoid any delay, please ensure that your list (trace file) is in the correct format for NSTS.

Summary 'briefing' information on this is at:

http://www.connectingforhealth.nhs.uk/systemsandservices/nsts/docs/brief_batch_trace.pdf

The TS2 form which must be submitted with each batch is at:

<http://www.connectingforhealth.nhs.uk/systemsandservices/nsts/docs>

Additionally, your organisation's registered NSTS batch trace user should be familiar with all aspects of NSTS batch tracing. NSTS can advise you who this is if necessary.

Security

The security of data is of paramount importance so please review these documents on data encryption **before** sending anything to NSTS:

- Batch Trace Advice (in Appendix 1)
- Password Guidance (in Appendix 2)

Both documents can also be found on our website at: <http://www.nhssurveys.org/survey/617>. Failure to follow this guidance will result in your submission being destroyed and a security incident being raised.

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. For this reason it is preferable to avoid any unnecessary delay between the checks and the mailing of questionnaires. Even so, 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.

You should not exclude patients just because it was not possible for the NSTS to match them on their records. If you did this, you would bias the sample.

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 including more patients when compiling the sample of 850 for the survey 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. (See section 10.12 for the accepted options for increasing your sample size)

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

3.10 Separating mailing details from sample information

Once the final 850-patient sample is finalised, we strongly suggest that the names, addresses and postcodes for each patient in the sample are transferred to a new file. At this point, you should have two datasets: the “Inpatient 2008_mailing data” file and the “sample data” file.

Prior to removing the mailing information, it is essential to provide each patient with a unique patient reference number (PRN) and to ensure this number is correctly applied to the two dataset. It is essential that this number is correctly applied so that checks for deaths can be made and reminders mailed to non-respondents.

The “Inpatient 2008_mailing data” file should be used to send out the questionnaires and reminders, and returning questionnaires should be logged in the “outcome” column of the “sample data” file. Before the reminders are mailed, the outcomes from the “sample data” file should be cross-referenced to the “Inpatient 2008_mailing data” file to check hospital records for any deceased patients and to finalise the non-responders who need to be sent reminders. As the “Inpatient 2008_mailing data” file will only be used occasionally during the survey, we recommend you keep this file encrypted. The “Inpatient 2008_mailing data” file should be destroyed when the last mailing process is complete.

3.11 Sharing the patient sample file with an approved contractor

If you are working with an approved contractor and have a contract to cover transfer of patient identifiable information (i.e. names and addresses the full “sample data” file **and** the “Inpatient 2008_mailing data” file should be sent to the contractor staff in encrypted format. If you are working with an approved contractor, but **not** using the contract to share patients’ name and address details, you should supply them with just the “sample data” file (this will resemble **Table 1 – Sample Excel file of patient details** but with the patient names, addresses and postcodes removed). The contractor can use this list to record the outcome codes, but you should ensure that the contractor is kept up to date with any information that comes directly to the trust about patient deaths, etc.

3.12 Creating the mailing and response spreadsheets

At this point, you will have two separate datasets connected using the unique patient record number: the “Inpatient 2008_mailing spreadsheet” file and the “sample data” file. These files should be treated as follows:

- “Survey data” file: to this file will be appended the response data from returning questionnaires as well as information on the whether this individual responded, and when. Firstly, download the “data entry spreadsheet” produced by us and available on our website: www.NHSSurveys.org). This document has all the required columns for the sample information, as well as all columns needed to enter the response data from returned questionnaires. Transfer the sample information to the appropriate columns of this file and save it using the name format: “<NHStrustName>_Inpatient2008.xls”. This file should not contain any patient names or address information. Only this “anonymised” format should be used to record patient responses. This spreadsheet must be submitted to the Co-ordination Centre at the conclusion of the survey.
- “Inpatient 2008 mailing spreadsheet”: this spreadsheet is used for mailing purposes. It should only consist of:
 - Patient Record Number
 - Patient Names
 - Patient address
 - Patient postcode

This file should remain encrypted and used to check for deceased patients prior to reminder being sent out and to cross-reference with the <NHStrustName>_Inpatient2008.xls file to find who reminders need to be sent to.

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 file⁸ **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
15 th -22 nd September 2008	23 rd September 2008
23 rd -29 th September 2008	30 th September 2008
30 th -6 th September 2008	7 th October 2008
7 th -13 th October 2008	14 th October 2008

Samples should reach the Co-ordination Centre by the 13th October 2008. 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. Major errors may then result in the data from the trust being excluded from the relevant Healthcare Commission assessments.

It is very important that the samples are mailed out as soon as possible after the sample has been approved by the Co-ordination Centre. Not only does this maximise the collection period for returning questionnaires, but it ensures that the checks made for deceased patients are as current as possible and therefore reduces the need for trusts to re-submit their sample to NSTS.

Further information can be found on the sampling errors made in the 2007 inpatient survey on the following webpage:

http://www.nhssurveys.org/Filestore/documents/Inpatient_survey_sampling_errors_2007.pdf.

⁸ Created by removing the patients' names, addresses and postcodes.

5 Increasing sample size beyond minimum requirement

Your trust may wish to use the NHS adult inpatient survey as 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 2008 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 2008 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.

Ethics Committee

The purpose of Research Ethics Committees in reviewing a proposed study is to protect the dignity, rights, safety, and well-being of all actual or potential research participants. A favourable ethical opinion from the committee implies that the research does protect the participant's aforementioned rights.

Multi-Centre Research Ethics Committee (MREC)

A MREC can grant a favourable ethical opinion for studies carried out in multiple regions of England. The inpatient survey operated under approval from the North West MREC and applies prior to each survey for a substantial amendment to cover any changes in questionnaire content or wording in the cover letters. The favourable ethical opinion for the study covers all NHS hospital trusts in England.

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

Research Governance Framework

This outlines the principles of good research practice and is key to ensuring that health and social care research is conducted to high scientific and ethical standards.