SAMPLING INSTRUCTION MANUAL FOR THE NHS ADULT INPATIENT SURVEY 2015

IN-HOUSE TRUSTS

THE CO-ORDINATION CENTRE FOR THE NHS PATIENT SURVEY PROGRAMME

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Contacts

The Patient Survey Co-ordination Centre
Picker Institute Europe
Buxton Court
3 West Way
Oxford
OX2 0JB

Tel: 01865 208127
Fax: 01865 208101
E-mail: ip.cc@pickereurope.ac.uk
Website: www.nhssurveys.org

Key personnel

Chris Graham (Director)

Caroline Killpack   Eliza Swinn
Kaeleigh Schroeder   Rory Corbett

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. Please note that Section 251 approval which has been sought for this project to provide a legal basis for trusts using a contractor to provide names and addresses to them. Although in-house trusts are not undertaking this, we expect them to follow the standard practices and procedures outlined here, in the interest of protecting patient confidentiality and maintaining high standards. For example, trusts must not send patient identifiable data such as patient names and/or addresses to the Co-ordination Centre. It is also not permitted to offer financial inducements or lottery prizes to respondents. Similarly, we do not recommend translation of questionnaires into other languages within the national survey. More guidance on how to reach ethnic minority groups can be found in Section 6. 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 Care Quality Commission assessments 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

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1 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, a number of important checks must be carried out on the sample, including a check by the Demographics Batch Service (DBS) to identify deceased patients.

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

Before compiling your patient list

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

1.1 Compile a list of eligible patients

1) This year, the sample month for the adult inpatient survey has been fixed to July. You must start counting back from the last day of **July 2015**. If you are unable to sample enough patients from July alone then you will have to include patients discharged in previous months. However, posters **must** be displayed for your chosen sample month(s) to attain compliance with section 251- patients must have the chance to dissent.

2) Compile a list of 1350 adult (**aged 16 and over**) inpatients consecutively discharged alive from your trust working back from the last day of the sampling month. You must count back through the list of patients discharged alive from the trust, including all eligible patients, until you have 1350 patients. The reason for including 1350 patients at this stage is to allow for the removal of some patients following checks (for example deceased patients will need to be removed following DBS checks).

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 2015 to generate their sample of 1350 adult inpatients submitted to DBS.

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** within the trust.

The list should **exclude**:

- deceased patients
- children or young persons aged under 16 years at the time of sampling
- obstetrics/maternity service users, including spontaneous miscarriages
- patients admitted for planned termination of pregnancy
- psychiatry patients
- day case patients (i.e. patients who arrive and leave on the same day. If the patient stays overnight and is occupying a bed, then they should be included in the sample.)
- private patients (non-NHS)
- NHS patients treated at private hospitals
- any patients who are known to be current inpatients
- patients without a UK postal address (but do not exclude if addresses are incomplete but useable, e.g. no postcode).
- Any patient known to have requested their details are not used for any purpose other than their clinical care, including requests made following sight of survey pre-publicity (you must ensure that you remove these patients from your sample list at this stage).

Treatment Centres

Patients who stayed as an inpatient at an NHS treatment centre at the trust are eligible for inclusion in the sample for the 2015 Inpatient survey, provided they meet the criteria above. These patients should be flagged up by inserting a '1' in the appropriate column in the sample file (see the example sample file in Table 1, in Section 1.5).

1.2 Checks carried out by the trust

Once you have compiled your list of 1350 patients, you should carry out the following checks *before* you send the list to the DBS (who will 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. More information on checking for deceased patients is shown in the text box below.

- **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, e.g. 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). 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. This improves the comparability of samples between trusts and thus reduces bias.

- **Patient ages**. Check that all patients are aged 16 or over at the time of sampling (i.e. on the day you draw your sample the patient must be aged 16 or over). Please do not exclude patients treated at children's hospitals as such sites do treat patients who are 16 years and over.

- **Postal addresses**. Exclude any addresses that are outside the UK. Patients whose address is in the British Islands (Isle of Man, the Channel Islands) are eligible. Equally patients whose address is a military base, care home or prison establishment are also eligible.

- **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.

- **Community Hospitals**. As a general rule, patients who have only spent time in a community hospital should not be included in the sample. Patients who have spent time in both a community hospital and an acute hospital can be included depending on circumstance - please contact the Co-ordination Centre for further advice.

- **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 specialty code and that there are no Route of Admission codes indicating a maternity admission. You should not include patients with a Route of Admission code of 31 (ante-partum) or 32 (post-partum). There should also be no patients included who have a Main Specialty code of 501 (obstetrics) or 560 (midwife). If codes of 500 (obstetrics and gynaecology) are included, please ensure any included patients have been treated for gynaecology and not obstetrics.

- Check again that none of the patients were admitted for a **termination of pregnancy**.

- **Psychiatry patients**. Check Main Specialty codes and ensure that the list does not include psychiatry patients i.e. patients with the following Main Speciality codes should be excluded:
    - 700   learning disability
    - 710   adult mental illness
    - 711   child and adolescent psychiatry
    - 712   forensic psychiatry
    - 713   psychotherapy
    - 715   old age psychotherapy

- **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.

- **Dissent**. Any patient known to have requested their details are not used for any purpose other than their clinical care, including requests made following sight of survey pre-publicity (you must ensure that you remove these patients from your sample list at this stage).

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

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 the sample is immediately updated if any patients in the sample die during the survey period.

1.3 Submitting your patient list to the Demographics Batch Service (DBS)

Before sending out the questionnaires, the list of patients should be checked for any deaths by the Demographics Batch Service (DBS).

The DBS enables users to submit and receive a file containing relevant patient records electronically using dedicated client software. The patient records in the file are matched against the NHS Spine Personal Demographics Service (PDS). The PDS does not hold any clinical or sensitive data such as ethnicity or religion.

Create a trace request file

Using your list of patients, you need to create a correctly-formatted batch trace request file to send to DBS. You should take advice from your local trust PAS team on the correct format to submit files. Technical details on the file format are available from http://www.hscic.gov.uk/demographics/

For each patient you will need to include as a minimum:

- NHS number and full date of birth (yyyymmdd) – this is the recommended approach *OR*

- Surname, first name, gender, date of birth and postcode (can be wildcarded e.g. LS1*)

Although residential postcode is not mandatory it is highly recommended to include it to avoid incorrect matches. Due to the way addresses are recorded throughout the NHS, it is very difficult to get an exact match on address lines. For this reason, **do not** include address lines in the trace request file.

Submitting the trace request file

Please note that the DBS does **not** accept the transfer of files by encrypted emails or on physical media. Instead, **request and response files must be transferred electronically using the dedicated DBS client software**. The DBS client software should have already been installed on a server within your trust. Please speak to a member of your IT department or PAS team if you do not know how to access and use the application. If your IT department cannot help, contact the DBS implementation team at: demographics@hscic.gov.uk and they should be able to advise you.

If you have been set up to use DBS, then once you have created the request file, it should be placed in the client in-box. The DBS client will then send the file to the Spine and, if you are registered, you will receive an email to say that the file was received. The DBS processes the file overnight and it should be ready the following morning. You will be notified by email when the file has been processed. During periods of high demand for DBS service, it may take 48 hours for your file to be returned.

1.4 Identifying deceased patients when the patient file is returned from DBS

The trace response file returned from DBS can be used to identify any patients who have died and therefore need to be deleted from the sample file (see below). This will reduce the numbers in your sample list slightly. **Please note that you should not exclude patients just because it was not possible for DBS to match them on their records. If you did this, you would bias the sample.**

The response file

The DBS will return a header row, response body and trailer row. The response row will be in two parts:
- The response containing all the data supplied in the request record, together with a trace outcome indicator. The main record is returned in all cases.
- An additional response column, which is returned only when there is a single unique match. It is in this additional response column that patients found to be deceased will be indicated (by a letter 'D').

For further information see: http://www.hscic.gov.uk/demographics/

> ## Note
>
> Please be aware that tracing services are not infallible 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.

What to do if you have more than 1250 patients remaining on your list

When your patient list is returned by DBS, and you have removed all deceased patients, there should still be more than 1250 patients in the list. You will need to remove the **least recent** patients from your sample so that only the 1250 most recent patients remain.

What to do if you have fewer than 1250 patients remaining on your list

If your patient list has fewer than 1250 patients after deceased patients have been removed, you **MUST** contact the Co-ordination Centre on 01865 208127 or email ip.cc@pickereurope.ac.uk. If possible, the next most recently discharged patients after the sample will need to be added to create a sample of 1250 patients, although these must also be checked by DBS.

Important note

You will be able to maximise your response rate by following this guidance carefully, drawing your sample and mailing out as soon as possible, 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 1250 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 1250 that have been correctly sampled and mailed. (See Section 1.11 for the accepted options for increasing your sample size)

1.5 Create the sample file

Information relating to your sample of patients should be entered into an Excel file which should resemble Table 1 below. A pre-designed spreadsheet including all the required column headings can be downloaded from the NHS Surveys website (http://www.nhssurveys.org/surveys/833) and is entitled 'Sample construction spreadsheet'. The column headings in this spreadsheet are identical to those supplied in the validated spreadsheet produced by the Co-ordination Centre for final submission of data (the 'Data entry spreadsheet') and so it will be advantageous for you to use the sample construction spreadsheet at this stage, rather than to create your own spreadsheet. Enter the required information and save this file as <NHStrustname>_Inpatients2015.

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 **31st August 2015** until the closing date of the survey.

3) The anonymous data in this file (i.e. 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.

More details about the information required in this file are provided below.

Table 1 – Sample construction spreadsheet of patient details

Patient record number	Title	Initials	Surname	Address1	Address5	Postcode	Year of birth	Gender	Ethnic category	Day of admission	Month of Admission	Year of Admission	Day of discharge	Month of discharge	Year of discharge	Length of Stay	Main Specialty on discharge	ICD 10 (Chapter Code)	CCG code	Treatment centre admission	Route of admission	NHS Site code on admission	NHS Site code on discharge	Day of questionnaire being received	Month of questionnaire being received	Year of questionnaire being received	Outcome	Comments
IP15RX10001	Mrs	A	Abbot	-	-	AB1 1YZ	1934	2	A	5	8	2015	11	8	2015	6	100	XI	12H	0		RR115	RR115				3	Informed that patient had died
IP15RX10002	Mr	EC	Ahmed	-	-	AB2 6XZ	1970	1	J	20	7	2015	12	8	2015	23	101	IX	10Q	1	11	RTE03	RTE03	22	10	2015	1	
IP15RX11249	Ms	K	Yoo	-	-	AB4 7MX	1950	2	R	17	6	2015	31	8	2015	75	300	IV	09Y	0		RR115	RR115					
IP15RX11250	Ms	F	Young	-	-	AB9 5ZX	1946	2	A	14	8	2015	31	8	2015	17	100	VII	08L	0	22	RR120	RR117	6	11	2015	1	
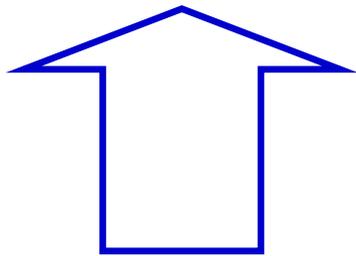
FIRST NAME, SURNAME, ADDRESS1…ADDRESS5 and POSTCODE columns are PATIENT IDENTIFIABLE DATA.

MUST NOT BE INCLUDED IN THE ANONYMISED SAMPLE FILE.

Important note about Table 1

The headings are in three different colours:

Black headings: these columns contain information on patients' names, addresses and comments that may allow them to be identified. This information must not appear in any files sent to the Co-ordination Centre. This information, along with a copy of the patient record number should be removed from the sample file as soon as your sample is finalised and saved to a new file (your "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 (to allow for final inspection by the Co-ordination Centre) and at the conclusion of the survey.

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

The information that must be entered into this spreadsheet will come from a number of different sources:

Information from hospital records

The following information can be compiled from hospital records:

- **Title** (Mr, Mrs, Ms, etc.)
- **Initials** (or First name)
- **Surname**
- **Address Fields:** This should be held as separate fields (e.g. street, area, town and county)
- **Postcode**

> **Note**
>
> The **Patient Record Number** (see 'Additional information' section below), **Title**, **Initials**, **Surname**, **Address Fields** and **Postcode** are used for printing out address labels. You can use the mail merge function in a word processing package for this purpose. (See Section 1.5)

- **Year of Birth** should be included in the form NNNN.
- **Gender** should be coded in numeric form: 1 = male, 2 = female.
- **Ethnic Category** is required in order to evaluate non-response from different ethnic categories. The ethnicity of a person is specified by that person and should be coded using the 17 item alphabetical coding specified by the Health and Social Care Information Centre (HSCIC). Further information is available at: http://www.datadictionary.nhs.uk/data_dictionary/attributes/e/end/ethnic_category_code_de.asp?query=ethnicity&rank=70&shownav=1. Please note that only patients who refuse to provide ethnic category should be coded as "Z" (not stated). If this code is missing for any other reason, ethnic category should be left blank in the sample information. Ethnic codes are as follows:

  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; e.g. 7 or 26) *

- **Month** of admission (1 or 2 digits; e.g. March = 3 or October = 10)*

- **Year** of admission (4 digits; e.g. 2015)*

- **Day** of the month of discharge (1 or 2 digits; e.g. 2 or 30)*

- **Month** of discharge (1 digit; e.g. June = 6, July = 7 or August = 8)*

- **Year** of discharge (4 digits; e.g. 2015)*

- **Length of stay** (Units = Days). Calculate this by subtracting the admission date (day/month/year) from the discharge date (day/month/year). For example, if discharge date = 15/7/2015 and admission date = 14/7/2015, the length of stay = 1. Do not use any other type of unit to calculate length of stay (i.e. do not use hours/minutes/seconds). All patients in the sample should have a length of stay greater than or equal to 1 day.

- **Main Specialty (of consultant) code on discharge.** It is recorded in the form NNN as outlined by the Health and Social Care Information Centre (HSCIC). Please see: http://www.datadictionary.nhs.uk/data_dictionary/attributes/m/main_specialty_code_de.asp

- **ICD 10 (Chapter Code):** Please enter the ICD10 (4th Edition) chapter code in Roman Numerals (i.e. III, VI, IX etc.) **Please note:** This should be based on the **primary diagnosis at discharge**. For a list of the chapter codes please see: http://apps.who.int/classifications/icd10/browse/2014/en

- **CCG code:** please provide the 3 character CCG code. This should be the CCG which will be billed for the care of the patient. Please see: http://systems.hscic.gov.uk/data/ods/datadownloads/othernhs

- **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:** Please include the two-digit descriptive code as used within the NHS Commissioning Data Sets. A blank or full-stop should be used if this information cannot be obtained for a patient. Please see: http://www.datadictionary.nhs.uk/data_dictionary/attributes/a/add/admission_method_de.asp?shownav=1

- **Hospital Site Code on Admission:** Please record the site of admission of the patient using the five character NHS Trust Site Codes (maintained by HSCIC). Please see: http://systems.hscic.gov.uk/data/ods/datadownloads/othernhs

- **Hospital Site Code on Discharge:** Please record the site from which the patient was discharged using the five character NHS Trust Site Codes (maintained by HSCIC). Please see: http://systems.hscic.gov.uk/data/ods/datadownloads/othernhs

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

Additional information

A number of additional pieces of information should also be entered into this spreadsheet:

1) **Patient record number (PRN)**. This is a unique serial number which must be allocated to each patient by the trust (if the survey is being carried out in-house). It should take the following format: IP15XXXNNNN where XXX is your trust's 3-digit trust code and NNNN is the 4-digit number relating to your sampled patients, e.g., 0001-1250. The PRN will be included on address labels and on questionnaires. Later, when questionnaires are returned (whether completed or not), you 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. Please note: this number should be available in, and correctly referenced for, every patient dataset for this survey (e.g. sample file, mailing file, final data).

2) **Day of questionnaire being received**. This can only be completed if and when a questionnaire is received by the trust. It should be filled in as a one or two digit numerical response which will range from 1-31, **not** a date format (e.g. N or NN **not** 12/10/15).

3) **Month of questionnaire being received**. This can only be completed if and when a questionnaire is received by the trust. It should be a one or two digit numerical response, ranging between 1 and 12, **not** a date format.

4) **Year of questionnaire being received**. This can only be completed if and when a questionnaire is received by the trust. It should be a four digit numerical response (e.g. 2015), **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 questionnaire has not been returned (in 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.

1.6 Checking the distribution of patient ages in your sample

You should check that patients of all ages are included in your sample, paying particular attention to those aged 16, 17 or 18 years and 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.
A good way to check that your sampled patients' ages cover the full range of expected ages is to examine the distribution of ages on a histogram (See Figure 1). The histogram for your trust should resemble the shape of the histogram below.

Figure 1 – Example Age Histogram for Inpatient Survey 2014
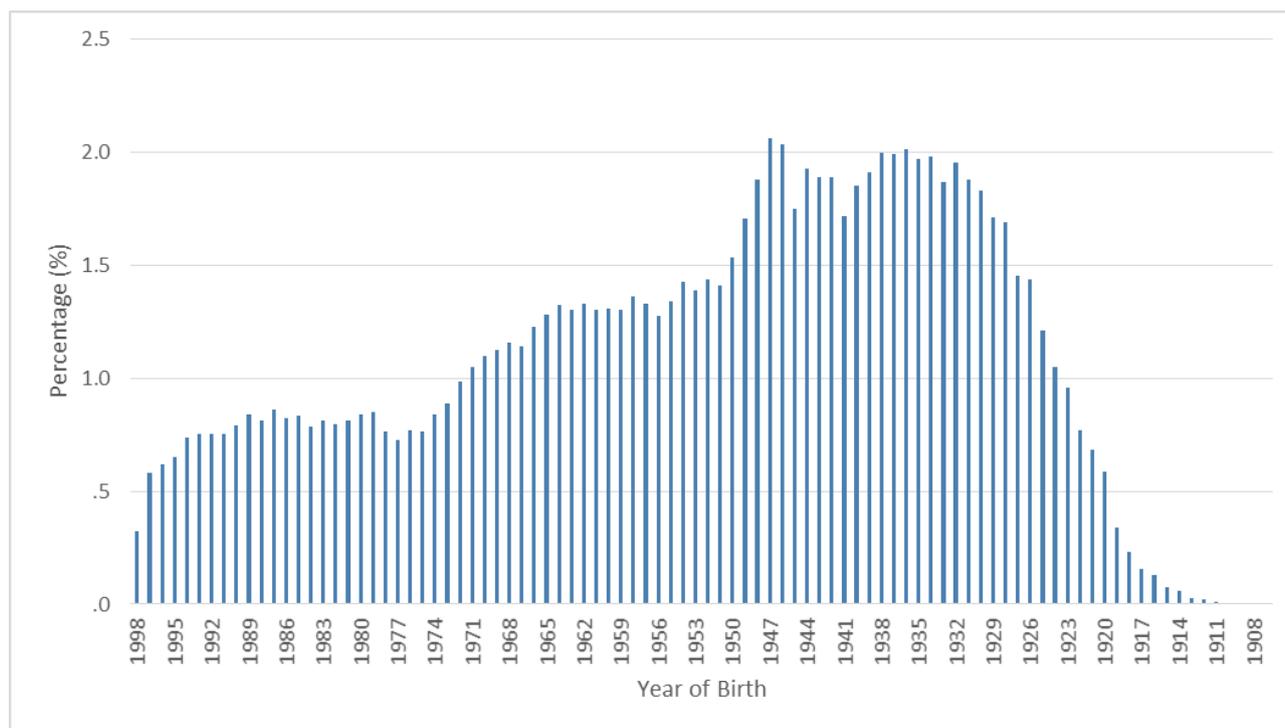
1.7 Checking the distribution of patient gender

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

1.8 Checking the distribution of patient route of admission

Please also check that the split of patients between emergency versus planned admissions is similar to the proportions which were in your sample last year. If there is a substantial change there should be an explanation. For example, if your hospital is now conducting more day case surgery this year than last you may expect to see an increase in the proportion of emergency admissions in your patient sample.

1.9 Checking for other errors with your sample

Information on the errors made when samples were drawn for the 2014 inpatient survey can be found on the following webpage: http://www.nhssurveys.org/surveys/833. **Using this document to check for any errors may reduce delays caused by incorrect sampling and consequentially improve your response rate to this survey.**

1.10 Separating mailing details from sample information

At this point you must transfer the names, address and postcode for each patient in the sample to a new file – your 'mailing file'. The patient record number (PRN) for each patient should be copied to the new file, so that the two datasets are connected using the unique PRN. It is essential to ensure this number is correctly applied to the two datasets. Save this new file as 'Inpatients2015_mailing data'. It should resemble Table 2 below.

This file should be used for mailing purposes: it will be used to check for deceased patients prior to reminder mailings and will be cross-referenced with the sample file (<NHStrustname>_Inpatients2015) to identify patients who will need to be sent reminders.[1]

As this mailing file will only be used occasionally during the survey, we recommend you keep this file encrypted. The mailing file should be destroyed when the survey is complete, along with all other files created for the survey (aside from the survey response file).

Remember

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**.

Table 2 – Example mailing file

Patient record number	Title	Initials	Surname	Address1	Address2	Address3	Address4	Address5	Postcode
IP15RX10001	Mrs	AM	Abbot	14 Station Road	London				AB1 1YZ
IP15RX10002	Mr	EC	Ahmed	Flat 7	Short Street	Oxford			AB2 6XZ
IP15RX11249	Ms	K	Yoo	The Maltings	Birch Road	Little Abington	Cambridge	Cambs	AB4 7MX
IP15RX11250	Ms	F	Young	634 Tyne Road	Newcastle-Upon-Tyne	Tyne and Wear			AB9 5ZX

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[1] As shown in Table 1 (see section 1.5), the 'outcome' field in the sample file is used to record which questionnaires are returned completed, or are returned undelivered, or which patients opt out etc...

1.11 Making more use of the survey locally

Up to this point, this section of the guidance has described in detail how sampling must be undertaken to provide the basic required sample of 1250 patients for the NHS adult inpatient survey. In addition to this minimum requirement, though, your trust may wish to use the survey as an opportunity to gather further data beyond that required by the Care Quality Commission. A good way to do this would be to increase your sample size.

Increasing the sample size for the survey may be helpful if, for example, you wish to analyse or compare results for specific subgroups (for example, patients treated at different sites or patients of different ethnicities) in more detail than would be possible from a sample of 1250 patients. By increasing the sample size you can ensure that you have a large enough sample of patients from each group.

Alternatively, if your trust regularly treats very large numbers of patients, you may wish to draw an extra sample of patients to survey in addition to those included in the main survey. For example, you could select patients discharged in a different time period from those in the national survey and send them questionnaires either at the same time, or at some point after, the national survey. By running the survey locally in addition to the national survey, you can establish a more frequent pattern of reporting enabling you to track experience over time, or test the impact of recent quality improvement initiatives. If you decide to carry out an inpatient survey locally at the same time as the national survey you will need to ensure that you are sampling two distinct and separate groups of patients which do not overlap. Guidance for carrying out a local survey is available at: http://www.nhssurveys.org/localsurveys

The Co-ordination Centre will be able to advise on any queries you might have via e-mail at ip.cc@pickereurope.ac.uk or by calling 01865 208127.

Important points to consider

Before you decide whether to gather additional patient feedback (e.g. by increasing your sample size), there are some important points to consider:

- The core sample for the 2015 inpatient survey **must** be drawn as specified in this guide; any deviation from the guidance may make it impossible for the Care Quality Commission to use the data that you collect. It is therefore 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.
- If you are planning to undertake surveys more frequently than the national programme, then you should consider how any increased sample here will fit with the additional surveys you will be undertaking.

> **Remember**
>
> 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. The Co-ordination Centre will be able to advise you on this.
>
> You must **only** send the Co-ordination Centre data for the 1250 patients sampled according to these guidelines, and these patients **must** be those discharged most recently. If you decide to carry out an Inpatient survey locally at the same time as the national survey you will need to ensure that you are sampling two distinct and separate groups of patients which do not overlap.

1.12 Summary of key steps

By following the guidance in this section you should have completed all of the tasks set out below:

1. Compiled a list of eligible patients (Section 1.1)
2. Checked your patient list to make sure it meets requirements and only includes eligible patients (Section 1.2)
3. Sent the list to the DBS to check for deceased patients and removed these patients from your list (Section 1.3 and 1.4)
4. Created a sample file (Section 1.5)
5. Checked the distribution of patient age, gender and route of admission (planned versus emergency) in your sample file (Section 1.6, 1.7 and 1.8)
6. Checked for other errors that may have occurred when drawing your sample (Section 1.9)
7. Removed personal data from the sample file and created a mailing file (Section 1.10)
8. Submit your sample declaration form to the Co-ordination Centre, and **wait for approval before sending your sample**
9. Share the anonymised sample file with the Co-ordination Centre

2. Appendices

Appendix 1: Inpatient survey 2015 sampling declaration: in-house trusts

This declaration is to be signed by your trust's Caldicott Guardian, and the member of staff responsible for drawing the sample of patients as set out in the 'Inpatient Survey Guidance Manual'. This checklist will be used for audit purposes to ensure that the sample conforms to the guidance and if all steps are completed, will greatly help avoid any breaches of confidentiality occurring.

The national survey has received 'section 251 approval' from the Health Research Authority to enable data to be transferred to survey contractors for the purposes of this survey only. In order to be operating under that approval, you must follow the steps outlined below, otherwise the 'approval' will not apply. For more information on the approval requirements and confidentiality, please refer to the survey guidance manual (http://www.nhssurveys.org/surveys/768).

For staff drawing the sample:
Please complete this form once you have drawn your sample of patients. You must send this form to the patient survey co-ordination centre (ip.cc@pickereurope.ac.uk) **before** you send your anonymised sample file and separate mailing file.

Please confirm that the following tasks have been completed on behalf of your NHS trust by **initialling the boxes** and **signing the declaration**:

A sample of up to 1250 inpatients who attended in July 2015 has been drawn according to the instructions in the instruction manual.	Initials
Patients who indicated dissent have been removed from the sample (PALS team and Survey Lead to check records).	Initials
Please record how many dissenting patients were removed: **If none removed, please record as 0**	Initials
The sample has been checked by the Demographic Batch Service (DBS)	Initials & Date
The sample has been checked by Trust staff as outlined in the guidance manual.	Initials & Date
The sample and mailing files have been separated, with no identifiable information (patient name and address) in the sample file.	Initials
The sample file has been prepared and is ready to send to your approved contractor alongside this form for the sample checking, and no name or address details are contained within the sample file. The only fields within the sample file are: NHS Trust code Patient Record Number (THIS IS NOT THE NHS NUMBER – the URN for the survey) Year of birth Gender Ethnic category Day, month, and year of admission Day, month, and year of discharge Length of stay Main specialty on discharge ICD10 Chapter Code Treatment centre admission Route of admission NHS site code on admission NHS site code on discharge CCG Code	Initials

Please note you will be required to amend or update the sample and mailing files if any errors or deviations are identified during the sample check conducted by the Survey Co-ordination Centre.

If sample files are sent to the Survey Co-ordination Centre mistakenly containing patients' names and addresses, or any other directly identifiable data, the Survey Co-ordination Centre is obliged to report this to the Care Quality Commission. Your trust will have to consider logging the incident as a serious incident on the Information Governance Toolkit - see the 'Guidance for Reporting, Managing and Investigation Information Governance Serious Incidents Requiring Investigation'. The Confidentiality Advisory Group at the Heath Research Authority will also be notified by CQC.

Declaration by trust staff drawing the sample

I confirm that the above steps have been completed and that the sample has been drawn in accordance with the survey guidance.

Trust name

Contact name

Contact signature

Contact email address and phone number

Declaration by Caldicott Guardian

I confirm that the above steps have been completed and all steps have been followed.

Name

Signature

Contact email address and phone number