

SAMPLING HANDBOOK FOR THE NHS ADULT INPATIENT SURVEY 2016

IN-HOUSE TRUSTS

THE CO-ORDINATION CENTRE FOR THE NHS PATIENT SURVEY PROGRAMME

Last updated: 19 July 2016

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)

Carolina Casañas i Comabella

John Latham-Mollart

Steve Sizmur

Lizzie Thwaites

Maeve Waite

Rory Corbett

Nick Potheary

Eliza Swinn

Paul Wagner

Alison Wright

Adherence to the procedures outlined in this document

It is not permissible to deviate from the agreed protocol as set out in this instruction manual. Please note that Section 251 approval 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 permissible to offer financial inducements or lottery prizes to respondents. Similarly, we do not recommend translation of questionnaires into other languages within the national survey. 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.

Data from the inpatient survey are used in an increasing number of outcomes frameworks and indicators and have now achieved National Statistics status. If the sampling guidance issued for the survey is not adhered to, and errors are detected too late for remedial action to be taken, this will impact on the use that can be made of data. CQC use patient survey data for purposes of risk monitoring, and data is also used by NHS England and the Department of Health for Patient Experience Outcome Measures and the NHS Outcomes Framework. If data is excluded because sampling errors are detected, this will impact on the assurances these organisations can have about the experiences of your patients.

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

Contents

1	Compiling a list of patients	1
1.1	Compiling a list of patients.....	1
1.2	Checks carried out by the trust	2
1.3	Submitting your patient list to the Demographics Batch Service (DBS).....	4
1.4	Identifying deceased patients when the patient file is returned from DBS	5
1.5	Create the sample file.....	6
1.6	Checking the distribution of patient ages in your sample.....	12
1.7	Checking the distribution of patient gender.....	13
1.8	Checking the distribution of patient route of admission.....	13
1.9	Checking for other errors with your sample	13
1.10	Separating mailing details from sample information	13
1.11	Sample declaration form.....	14
1.12	Making more use of the survey locally.....	15
1.13	Summary of key steps	16
2	Appendix	17
	Appendix 1 Inpatient survey 2016 sampling declaration: in house trusts	17

List of tables

Table 1	Sample construction spreadsheet of patient details	7
Table 2	Example mailing file	14

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.

Please note: Data from the inpatient survey are used in an increasing number of outcomes frameworks and indicators and have now achieved National Statistics status. If the sampling guidance issued for the survey is not adhered to and errors are detected too late for remedial action to be taken, this will impact on the use that can be made of data. CQC use patient survey data for purposes of risk monitoring and data is also used by NHS England and the Department of Health for Patient Experience Outcome Measures and the NHS Outcomes Framework. If data is excluded because sampling errors are detected this will impact on the assurances these organisations can have about the experiences of your patients.

We have recently encountered incidences of historical errors having been made in previous surveys and unfortunately we have to respond to these errors by, for example, removing trust results. We request that all trust staff involved in drawing samples are made aware of the importance of checking previously written codes and other historical arrangements, to minimise the risk of future cases being discovered and the risk that your trust's survey results cannot be used. It is essential that the person who draws the sample understands the importance of following these instructions carefully. Also, this person's line manager must give them the time and support they need to do the task properly. An incorrectly drawn sample can delay the start of the survey or can result in the questionnaires being sent to the wrong patients, both of which can have serious implications.

Before compiling your patient list

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

Please note: your sample should only be used for the purposes of distributing the Inpatient Survey 2016 and up to two reminder letters. This is because the precise use of the sample collated for the survey is described in the survey protocol that forms part of the ethical approval for the survey and any additional use of the sample would therefore require a separate ethics application. For example, it would not be appropriate to send additional reminder letters to people in the sample nor to contact them as a group either before or after the survey.

1.1 Compiling a list of patients

1. As in 2015, the sample month for the adult inpatient survey has been fixed to July. You must start counting back from the last day of **July 2016**. 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 2016 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 under 16 years old 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; if this information is collected by your trust you should 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 2016 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 treatment function code, that there are no route of admission codes indicating a maternity admission and no ICD-10 chapter codes of XV (if ICD-10 codes are available). 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 treatment function 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 and Treatment Function codes and ensure that the list does not include psychiatry patients i.e. patients with the following Treatment Function 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.
 - 720 eating disorders
 - 721 addiction services

- 722 liaison psychiatry
 - 723 psychiatric intensive care
 - 724 perinatal psychiatry
 - 725 mental health recovery and rehabilitation service
 - 726 mental health dual diagnosis service
 - 727 dementia assessment service.
- **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 approved contractors are advised immediately 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 recently discharged** 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 these instructions carefully, drawing your sample accurately and sending your mailing out as soon as possible. You will also 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.

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/935>) 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>_Inpatients2016.

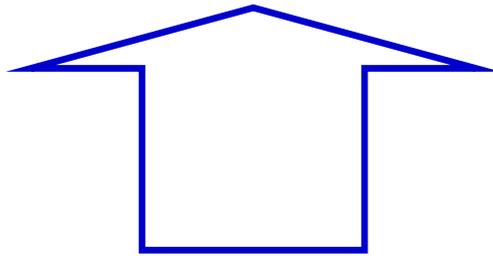
This file has three purposes:

- 1) It will be used by you to keep a record of which patients have not returned questionnaires so that reminders can be sent to them.
- 2) It will be used by you to generate weekly response rates, which must be forwarded to the Co-ordination Centre every Thursday from **1st September 2016** 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

<i>Patient record number</i>	<i>Title</i>	<i>Initials</i>	<i>Surname</i>	<i>Address1</i>	<i>Address5</i>	<i>Postcode</i>	<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>Treatment Function code</i>	<i>ICD 10 (Chapter Code)</i>	<i>CCG code</i>	<i>Treatment centre admission</i>	<i>Route of admission</i>	<i>NHS Site code on admission</i>	<i>NHS Site code on discharge</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>	<i>Comments</i>
IP16RX10001	Mrs	A	Abbot	-	-	AB1 1YZ	1934	2	A	5	8	2016	11	8	2016	6	100	102	XI	12H	0	12	RR115	RR115				3	Informed that patient had died
IP16RX10002	Mr	E	Ahmed	-	-	AB2 6XZ	1970	1	J	20	7	2016	12	8	2016	23	101	101	IX	10Q	1	11	RTE03	RTE03	22	10	2016	1	
IP16RX11249	Ms	K	Yoo	-	-	AB4 7MX	1950	2	R	17	6	2016	31	8	2016	75	300	306	IV	09Y	0	21	RR115	RR115					
IP16RX11250	Ms	F	Young	-	-	AB9 5ZX	1946	2	A	14	8	2016	31	8	2016	17	100	107	VII	08L	0	22	RR120	RR117	6	11	2016	1	



FIRST NAME, SURNAME, ADDRESS1...ADDRESS5 and POSTCODE columns are PATIENT IDENTIFIABLE DATA.

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 should be removed from the sample file as soon as your sample is finalised and saved to a new file (your "mailing data" file). The patient record number must be retained in both files, in order to be able to link data, where necessary.

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).

Green italic headings: these columns will be completed by you 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.

- **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. 2016)*
- **Day** of the month of discharge (1 or 2 digits; e.g. 2 or 30)*
- **Month** of discharge (1 digit; e.g. June = 6 or July = 7)*
- **Year** of discharge (4 digits; e.g. 2016)*
- **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 = 15/7/2016 and admission date = 14/7/2016, 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
- **Treatment Function Code.** 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/t/tran/treatment_function_code_de.asp
- **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>
- **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/2016/en>. We have produced a mapping tool for assigning ICD-10 chapter codes. This tool allows trusts to enter detailed ICD-10 codes (as they are held on trust databases) and converts them into the broad chapter codes. The tool is available on the NHS surveys website at: <http://www.nhssurveys.org/surveys/935>. **If ICD-10 codes are not available when you draw your sample, please contact the Co-ordination Centre.**

* 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**. It should take the following format: IP16XXXNNNN 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 will only be completed if and when a questionnaire is returned.
- 3) **Month of questionnaire being received.** This will only be completed if and when a questionnaire is returned.
- 4) **Year of questionnaire being received.** This will only be completed if and when a questionnaire is returned.
- 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)
 - 7 = Service user deceased prior to fieldwork.

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).

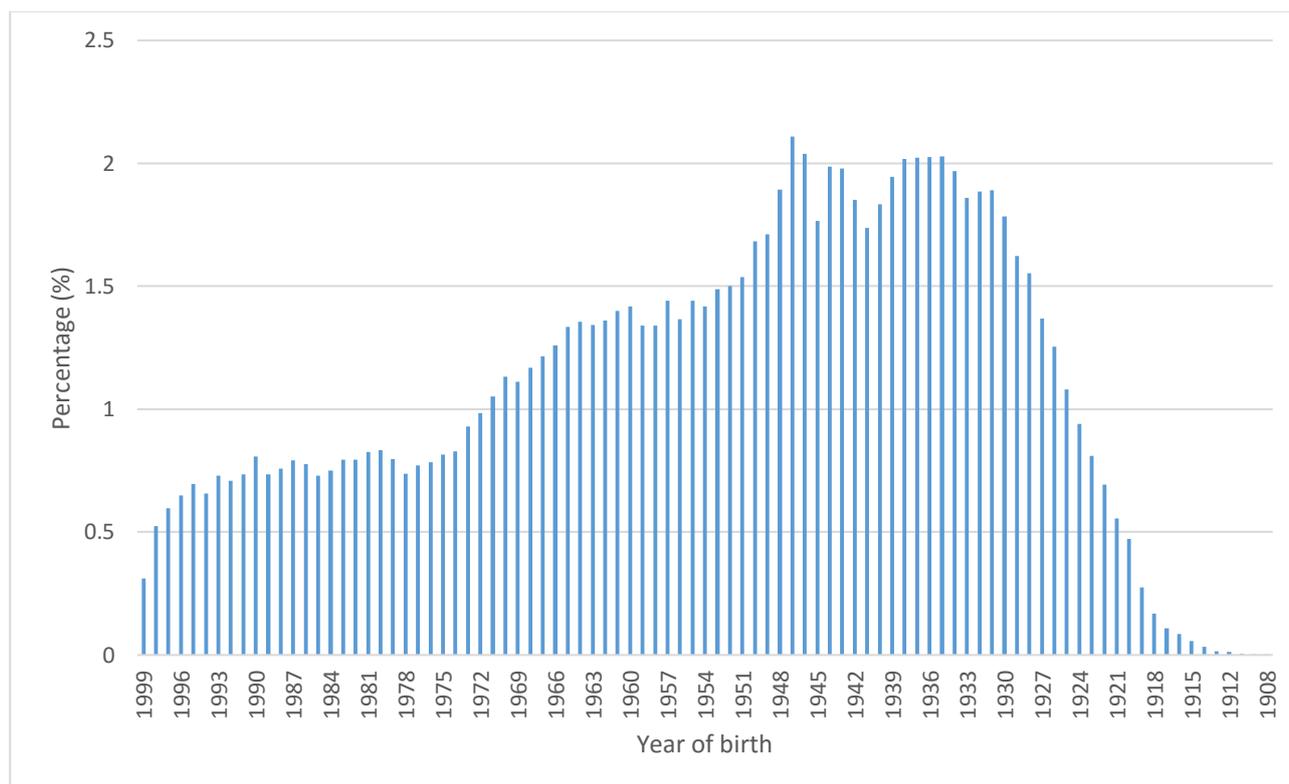
- 6) The **Comments** column is useful for recording any additional information that may be provided when someone calls the helpline – for example, to inform the trust that the respondent has died or is no longer living at this address.

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 2015



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 that 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 2015 Inpatient survey can be found on the following webpage: <http://nhssurveys.org/survey/1731>. **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 should 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 'Inpatients2016_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>_Inpatients2016) 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

<i>Patient record number</i>	Title	Initials	Surname	Address1	Address2	Address3	Address4	Address5	Postcode
IP16RX10001	Mrs	AM	Abbot	14 Station Road	London				AB1 1YZ
IP16RX10002	Mr	EC	Ahmed	Flat 7	Short Street	Oxford			AB2 6XZ
IP16RX11249	Ms	K	Yoo	The Maltings	Birch Road	Little Abington	Cambridge	Cambs	AB4 7MX
IP16RX11250	Ms	F	Young	634 Tyne Road	Newcastle-Upon-Tyne	Tyne and Wear			AB9 5ZX

1.11 Sample declaration form

For this survey, there is a sample declaration form that needs to be completed by the person preparing the sample ([see appendix 1](#)). The sample declaration form is available on the NHS Surveys website to download at <http://www.nhssurveys.org/surveys/935>. The form has a number of compliance statements that both the person drawing the sample and also the Caldicott Guardian must sign. An online version of the sample declaration is available.

The form **must** be completed and sent to the Co-ordination Centre **prior to submitting your** anonymised sample file for checking. You will receive notification when you are permitted to submit your data. The form has a separate compliance statement for you to sign to confirm that there are no patient identifiable data (names and addresses) in the sample file before it is submitted to the Co-ordination Centre. This is a key element of the survey methodology as approved under section 251, and must be followed in order to minimise the risk of any data breaches occurring.

Trusts must submit the sample data to the Co-ordination Centre no later than **26th August 2016**. If you do not meet this deadline, 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

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.

may result in the data from the trust being excluded from the relevant Care Quality Commission assessments.

Samples that have not been submitted for checking by the **2nd September 2016** will be followed up by the Co-ordination Centre to discuss any problems you are having and how we can help with the process. However, if samples are not received by the **9th September 2016**, then we are required to notify the Care Quality Commission of this and they will contact you to discuss any implications for inclusion in Care Quality Commission produced data.

1.12 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, your trust may wish to use the National Inpatient 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 as, 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>

If you are using an approved contractor for the national survey they will be able to advise you on the best way to increase your sample size to achieve your specific goals.

Please note that the application for Section 251 approval has been made by the CQC on behalf of all trusts for a national standardised survey. **Therefore Section 251 approval covers the national surveys only, and will not apply to any local surveys.** Please contact your trust's Caldicott Guardian for advice as to whether it is appropriate to contact the Health Research Authority for further approval.

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 2016 Inpatient survey **must** be drawn as specified in this sampling instruction manual; any deviation from these instructions 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.

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.

1.13 Summary of key steps

By following the instructions 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. Complete the sample declaration form ([see appendix 1](#)) and send this to the Co-ordination Centre **before** sending them your sample file. **Do not send these files before your sample declaration form has been approved.**
9. Share the anonymised sample file with the Co-ordination Centre.

PLEASE NOTE: trusts will NOT be permitted to submit any files to the Co-ordination Centre with more than 1250 records (maximum), from which the Co-ordination Centre **would draw the sample on behalf of the trust**. If trusts do this, it will be considered a breach of the Section 251 Approval for the survey, resulting in follow up action being taken. It is not permissible for the Co-ordination Centre to draw the post DBS sample on behalf of the trust.

2 Appendix

Appendix 1 Inpatient survey 2016 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 2016 Instruction Manual'. **This checklist will be used for audit purposes to ensure that the sample conforms to the instructions and if all steps are completed will greatly help avoid any breaches of confidentiality occurring.**

This declaration is also available to complete online. Trusts wishing to complete the declaration online will need to provide the Co-ordination Centre with the names and email addresses for the person drawing their sample and the trust's Caldicott Guardian. Unique links will be sent to these named individuals by email.

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. 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. 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 instruction manual.

For staff drawing the sample:

Please complete this form once you have drawn your sample of patients. You must send this checklist to the Co-ordination Centre (ip.cc@PickerEurope.ac.uk) **before** you send your sample file. The Co-ordination Centre will confirm that you are able to send your sample file to them once they have checked this form. **PLEASE NOTE: the sample file will not be opened unless this form is submitted fully complete.**

Please confirm that the following tasks have been completed by **initialling and ticking the boxes** and **signing the declaration**:

A sample of up to 1250 inpatients who attended in July 2016 has been drawn according to the instructions in this sampling instruction manual.	Initials
<p>Have you excluded the following groups?</p> <p>Patients who did not stay overnight <input type="checkbox"/></p> <p>Deceased patients <input type="checkbox"/></p> <p>Patients known to be current inpatients <input type="checkbox"/></p> <p>Patients under the age of 16 at the time of sampling <input type="checkbox"/></p> <p>Obstetrics/Maternity service users <input type="checkbox"/></p> <p>Patients admitted for planned termination of pregnancy <input type="checkbox"/></p> <p>Psychiatry patients <input type="checkbox"/></p> <p>Private patients or NHS patients treated at private hospitals <input type="checkbox"/></p> <p>Patients without a UK postal address <input type="checkbox"/></p> <p>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 <input type="checkbox"/></p>	Confirmed
<p>Have you included the following groups?</p> <p>All eligible patients who had at least one overnight stay <input type="checkbox"/></p> <p>Patients born in 2000 who were 16 at the time of sampling <input type="checkbox"/></p> <p>Patients treated by a consultant with main specialty 500 or 501, who were not actually treated for obstetrics and maternity <input type="checkbox"/></p> <p>Patients whose address is incomplete, but contains enough information to have a reasonable chance of being delivered <input type="checkbox"/></p> <p>Patients with an address in the UK, but not England (Wales, Scotland, Northern Ireland, Isle of Man, Channel Islands, etc.), including military personnel <input type="checkbox"/></p>	Confirmed
<p>Please check your extraction code/data logic, to ensure you do not exclude ANY patients simply because they are missing an item of data or are NULL for a sample data field.</p>	Initials

<p>Please check your extraction code/data logic again, to ensure you have not accidentally excluded any eligible patient groups, or any other patient groups not specified in the sampling instructions.</p>	<p>Initials</p>
<p>Please check that your sample consists of the most recently discharged, eligible patients, counting back from the 31st July (inclusive): You must not use admission dates, or a random number generator, or any other criteria to select which eligible patients you include in your sample.</p>	<p>Initials</p>
<p>Patients who indicated dissent have been removed from the sample (PALS team and Survey Lead to check records).</p>	<p>Initials</p>
<p>Please record how many dissenting patients were removed: (If none were removed, please record as 0)</p>	<p>Initials</p>
<p>The sample has been checked by the Demographic Batch Service (DBS)</p>	<p>Initials & Date</p>
<p>How many records were submitted to DBS for checking, in total?</p>	<p>Initials</p>
<p>How many records could not be matched by DBS?</p>	<p>Initials</p>
<p>The sample has been checked by Trust staff as outlined in the instruction manual.</p>	<p>Initials & Date</p>
<p>The sample and mailing files have been separated, with no identifiable information (patient name and address) in the sample file.</p>	<p>Initials</p>
<p>The sample file has been prepared and is ready to send to the Co-ordination Centre alongside this form for the sample checking, and no name or address details are contained within the sample file.</p> <p>The only fields within the sample file are:</p> <p>NHS trust code Patient record number (THIS IS NOT THE NHS NUMBER – it is a unique reference for this survey only) 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 Treatment Function code ICD10 chapter code Treatment centre admission Route of admission NHS site code on admission NHS site code on discharge CCG code</p>	<p>Initials</p>

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 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 Health Research Authority will also be notified by CQC.

Declaration by trust staff drawing the sample

I understand that any errors with the way the sample has been drawn may limit, or prevent, the use of the survey data. Where data cannot be used, this would mean survey results would not be available for my trust in 2016 and may increase my trust's level of risk within CQC's risk monitoring tools. I confirm that the above steps have been completed and that the sample has been drawn in accordance with the survey instructions.

Trust name:

Contact name

Contact signature

Contact email address

Contact 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

Contact phone number