



## Practice Based Commissioning Information for PBC at a glance

### Introduction

Information is at the heart of practice based commissioning. This 'at a glance' guide aims to clarify how practices and PCTs can work together to use information effectively.

This guide will discuss

- Information basics
- Budget management – spotting and understanding trends
- Data validation - checking the validity of what *did* happen
- Information for Service redesign – planning what *should have* happened
- Bringing it all together – key tasks for practices

### 1. Information basics

Information to support PBC is available on service use (HES data), contract monitoring (SLAM reports), disease prevalence (public health data and QOF data), and individual patient data for each hospital spell.

PCTs have a duty to support practices by:

- providing the practices with practice-level information (a “practice information pack”)
- providing data analysis support
- following up on the contracting issues

Practice based commissioners use information to:

- manage their budgets
- help make strategic commissioning decisions

Clinical coding (the allocation of ICD-10 and OPCS 4 codes) is used to generate the charges to commissioners for healthcare activity, and as such is crucial to the practice based commissioning process. Commissioners need to be assured that the coding is fair and accurate, and may conduct internal or external coding audits to check for errors, including:

- absolute errors (code combinations that cannot be correct under any circumstances)
- sequencing errors (e.g. codes appearing in the primary field that are not allowed)
- codes or combinations of codes that are unlikely to occur and therefore merit scrutiny

Further information, including specific codes to check, is provided in appendices 2 and 3.

### 2. Budget management: spotting and understanding trends

Across a PCT the likely financial impact is in the region of hundreds of thousand pounds and is therefore a key priority. This is a role where PCT information analysts support practices. PCTs will analyse the quarterly SLAM (Service level agreement monitoring) report from the local hospital in the following way:

- Compare actual activity numbers and costs with those forecast
- Investigate any variations from the forecast
- Track any actions taken in previous months to check they are having desired effect

*Note: PCTs need to estimate costs for uncoded/ missing data so that the overall picture is not misleading.*

Significant variation from forecast activity will indicate either, a change in referral practice, or a change in hospital practice, or a change in how the activity is coded. The PCT and practice based commissioners will firstly want to understand the reason for the change, and then, if appropriate, challenge the hospital. Hospitals are not allowed to change their coding practice in-year, and must give notice to commissioners if they intend to do so in the following year.

*Case study: A PCT in the North of England spotted significant over performance on A&E attendances and admissions that amounted to £500,000 activity. On investigation, this turned out to have been the result of the hospital changing its previous coding practice, charging the PCT for unvalidated attendances. The PCT has successfully challenged the hospital.*

There are variations in coding practice between hospital Trusts for historic reasons. For example, some providers will code day-case endoscopy as a hospital admission but other providers may currently code this as an out-patient attendance. If the provider wants to change their coding practice then they must give notice to the PCT that they intend to change their practice in the following year. Maternity admissions are another area where coding changes have been identified, particularly for ad-hoc attendances by patients who have on-going issues throughout their pregnancy. Again, any changes in coding practice need to be advised to the PCT before implementation.

Source of referral is another area to check for trends. Some PCTs and practices have found that even though GP referrals have been reducing there is an unexpected increase in consultant-to-consultant referrals. Some PCTs have specified in the contract the circumstances under which a consultant-to-consultant referral is acceptable.

*Case study: A PCT discovered that "cystoscopy with complications" has risen well above planned activity, but "cystoscopy without complications" is below planned activity. This has prompted them to discuss the reasons with the hospital and consider challenging on the basis of coding change.*

If a hospital Trust gives notice of a change in coding practice, then commissioners may want to investigate the possibility of providing primary care or community alternatives.

### **3. Data validation – checking the validity of what *did* happen**

Only practices are in a position to check the validity of patient level data. Checking individual invoices can be time-consuming, and although some inaccuracies may be found that have implications in the several hundred (or thousands) of pounds region, this has a smaller impact than the budget monitoring activity (above).

When practices have checked invoices common errors that have been identified include-:

- Being charged for a patient that is not yours
- Admission date or discharge date not correct (resulting in excess bed days charge)
- Wrong procedure code

Practices may use both the basic referral data (from the practice's information system) and the hospital discharge summary received for each patient. Many practices will find it impractical to check every single patient spell and will identify a *sample* of their data to check. The data

sample may be, say, one record in 5, or 1 in 10, or may concentrate on the most expensive spells. Some practices find it helpful to keep a folder of photocopies (or scan to the patient record) all discharge summaries as they are received to use in the validation process.

*Case study: A PCT in the South of England has conducted a study, with practices, of the impact of data validation at practice level and has concluded that it is not cost effective to continue validating all invoices at practice level. The practices have agreed with the PCT to continue data validation in the short term but only on the most expensive patient spells, and to check that discharge summaries have been received. The PCT will continue working on emergency admissions data after uncovering a number of anomalies*

Templates including key questions for the validation process have been developed by PCTs. Examples from Uttlesford (now part of West Essex PCT) and North Tyneside PCT can be accessed via the Improvement Foundation website. [Link here](#)

The PCT have the responsibility for following up with the relevant provider service any patient-level inaccuracies found, including non-receipt of discharge summaries.

#### **4. Service redesign – planning what *should* have happened**

Hospital activity data (HES data) can be used by a practice to assess which clinical pathways are being used by their patients and to come to conclusions about what *should* happen.

*Comparison of practice level data with other practices in the PCT*

Comparative data across the PCT will be available from the PCT as part of the information pack. To help practices get the most out of this information some PCTs have developed a 'top sheet' to highlight key areas that need investigating or which are different to the PCT average. An example can be found at [LINK to Uttlesford example](#)

*Questions that practices should ask themselves:-*

- Are we a particularly high referring practice in certain specialties? Do we have different follow-up rates for our patients in certain specialties? What are the reasons for this? Are we making best use of community services? What are other practices doing differently?
- Are we a particularly low referring practice in any specialties? What are the reasons? Do we have expertise that we could offer to other practices?
- Do we have a high proportion of patients attending A&E? Why might this be?

Once an area has been highlighted to require further investigation then systematic detailed audits (e.g. all practice A&E admissions in a month) will help understand underlying issues.

*Case study: A practice in Devon found that they were a high referring practice for ophthalmology. From 1<sup>st</sup> Nov have contract with local optometrist to see 10 glaucoma patients each month for 'closer to home' service at less than hospital tariff price.*

*Case study: A practice with a Dermatology GPSI was able to offer this to other local practices*

*Case study: A GP and Health Visitor in North London have followed up all patients with high A&E attendances from a single postcode with a personal conversation about how to meet their healthcare needs. The practice has seen a big impact on A&E attendances.*

*Comparison of clinical activity data between different providers*

This should be available in the information pack provided by PCTs to each practice. The comparison may indicate possible differences in clinical practices between providers or

between clinicians. For example, there may be a higher ratio of follow-up appointments in a certain specialty compared with other provider hospitals. Clinical discussion at PBC consortium (or PCT) level with clinicians in the provider hospital may clarify what the issues are and what service the commissioners want to commission. Commissioners may want to conduct an impact analysis to decide which issues to focus on first.

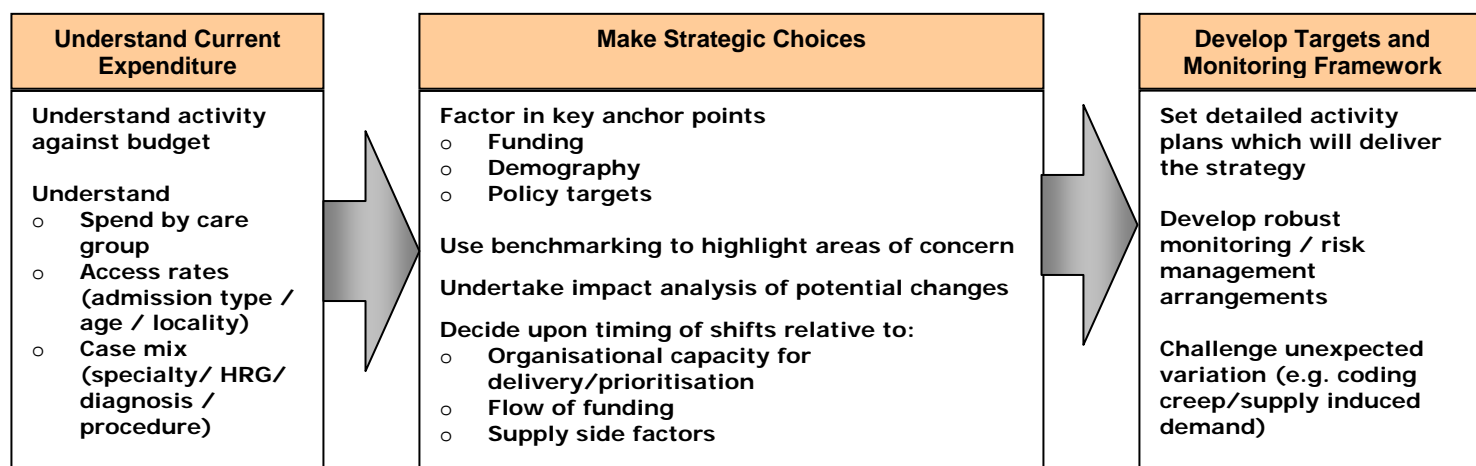
#### *Comparative QOF data on disease prevalence at practice level*

An understanding of what the QOF information is telling you about your practice population's needs relative to other areas should be shaping commissioning decisions, particularly with respect to the development of new services. Comparative QOF data should be available from the PCT and additional practice level and clinical area data is available on the NHS Information Centre QOF portal at <http://www.ic.nhs.uk/servicesnew/qof06/spreadsheets/>.

## 5. Bringing it all together – with key tasks for practices

Practices and PCTs should develop an agreed integrated strategic approach to using information for PBC. All of the following areas need to be developed.

- Getting a process in place for budget monitoring and having a strategy for challenging coding trends is clearly a priority for PCTs and practices.
- Patient level validation should be used selectively in high impact areas (agreed between Practices and PCTs).
- Practice consortia will need to develop a strategy for identifying clinical areas for redesign, from the intelligence provided in the data. This will include an impact analysis and a business case development strategy to determine what will make most difference.



### Key tasks for practices

1. Validate high cost spells and high excess bed days
2. Agree with PCT patient level validation activities to support follow-up of trends identified by PCT information specialists.
3. Identify areas where practice is an outlier in use of services (your PCT may be able to provide a quick reference summary sheet)
4. Set up a discussion/review system in the practice to discuss reasons and possible action that can be taken by the practice
5. Work with other practices and with the local hospital trust to identify services that need a whole system redesign

## Frequently Asked Questions

### Q: What information does the DH specify must go into the Practice Information pack?

A: PCTs need to provide their GPs with practice-specific information on

- elective activity – inpatient and day case;
- non elective admissions, including information on length of stay;
- first outpatient appointments, and follow up appointments;
- use of diagnostic tests and procedures;
- consultant to consultant referrals;
- prescribing;
- community and mental health services;
- primary care including essential and enhanced PMS and GMS services; and
- accident and emergency attendances

Plus benchmarking data (allowing both local and national comparisons) on

- referral rates;
- admission rates;
- first outpatient attendances; and
- follow up rates

### Q: What is “Code Creep”?

A: Code Creep is the process by which Trusts increase the cost of activity through increasingly diligent coding practices. Additional diagnosis, procedure or complexity codes are added to acute episode records which may previously have not been included. This means that costs to the commissioner rise even though activity may be falling. Commissioners must monitor this carefully and challenge providers if the increase is too pronounced.

### Q: How can I get hold of HES data?

A: Hospital Episode Statistics (HES) is a data warehouse containing admissions to NHS hospitals in England. HES admitted care data can be found at HES online:

<http://www.hesonline.nhs.uk/Ease/servlet/ContentServer?jsessionid=dbzy05qhx1?siteID=1937&categoryID=192>

Data is available to download in PDF and XLS formats by primary diagnosis, main operation, specialty, hospital provider, PCT of responsibility, SHA. Users can also request tailor-made reports. The latest year that statistics are available is 05/06.

### Q: What other hospital performance data can I get?

A: The Department of Health performance pages <http://www.performance.doh.gov.uk/> include access to:-

- Hospital Activity statistics (including bed use, A&E, cancelled operations)
- Monthly diagnostics statistics by commissioner and provider
- Hospital waiting time and waiting lists by commissioner and provider

Data is usually available approximately 6 weeks after the end of the period covered.

### Q: What is SUS data and when will it be available?

A: Secondary uses service (SUS) is part of the National Programme for IT. National data warehouse system designed to provide timely, pseudonymised patient-based data for purposes other than direct patient care, including commissioning. SUS took over from NHS-Wide Clearing Services (NWCS) on 31<sup>st</sup> December 2006.

## Appendix 1 – A Sample Data Record

Field	Data
lopatid	XXXXXX
startage	85
admidate	06-Jul-04
disdate	14-Oct-04
admimeth	21
patclass	1
spec	430
hrg	C58
SpellLoS	100
Trim Point	6
Xs days	94
pdiag	C900
diag1	A408
diag2	K140
op1	W365
pctcode	5X9
procode	RXZ
Group	18
Spell cost	1,551
Xs day cost	26,387
Spec services cost	171
Total cost	28,109

Inpatient admitted via A&E

Elderly medicine

Intermediate mouth or throat procedure

Patient stay exceeded normal distribution cut off point. PCT liable for the cost of excess days

Patient has multiple myeloma, other streptococcal septicaemia and glossitis

Diagnostic puncture of bone

Infectious disease flag attracts an 11% tariff uplift

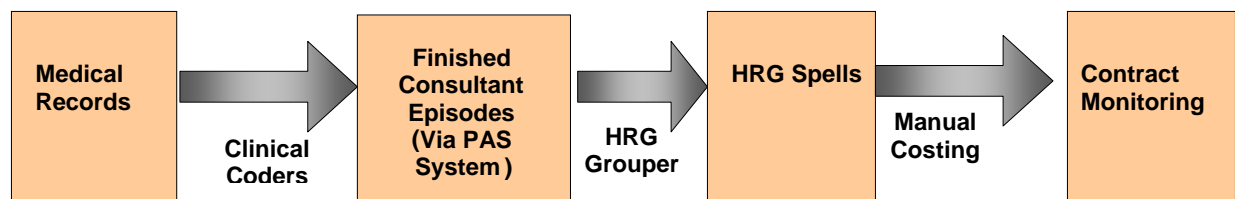
Calculated by the Acute Trust using codes provided by HRG grouper

## Appendix 2: Hospital Coding and Billing Process

Payment by Results (PbR) sets the national price (tariff) for acute care using Healthcare Resource Groups (HRGs). HRGs are standard groupings of clinically similar treatments, which use common levels of healthcare resource. These are split into approximately 600 codes across 18 disease area 'chapters'. Following a patient's stay, the provider Trust will group HRGs into Spells; which are continuous hospital stays that may include more than one consultant episode. The cost of the spell depends on a patient's age, diagnoses and the procedures carried out.

Further information on HRGs and HRG Grouper can be found at the NHS information Centre's website at <http://www.ic.nhs.uk/casemix/toolkit> and an example data record can be found in Appendix 1

### The Hospital Coding and Billing Process



## **Appendix 3: Examples of Coding Errors**

### **Gender Related Error:**

e.g. Female patient with N40X Hyperplasia of prostate assigned to her record.

Certain sections of codes can clearly only be assigned to either of males or females. (*Be aware that in some circumstances you may have transsexuals or patients exhibiting characteristics of both genders for whom "wrong" sex codes could actually be correct*).

### **Specialty Related Error:**

e.g. P05.1 Small for gestational age on the mothers coded record – (a perinatal condition)

Certain sections of codes clearly relate to specialties – you would only expect to see codes from chapter XV on a mothers record and codes from chapter XVI on a babies record.

### **Code Rule Error:**

e.g. N18.9 Chronic renal failure and I10X Hypertension appearing on the same episode, (Absolute coding error – these two codes cannot occur in combination)

There are many combinations of codes that under the classification rules can never appear in combination.

### **Sequencing Errors:**

Codes that cannot appear in a primary field.

I69.3 Sequelae of a cerebral infarction in a primary field.

Under the rules of ICD-10 sequelae codes can never appear in a primary position.

Y76.1 Functional endoscopic sinus surgery in a primary field.

Under the rules of OPCS 4.3 Y codes can never go in a primary field.

G40.1 pyloromyotomy followed by A27.1 truncal vagotomy.

Under the rules of OPCS these would be sequenced the other way around. (There are a significant number of such "pair" code rules.)

### **Example Requiring Further Scrutiny:**

N39.0 Urinary tract infection site unspecified followed by A49.0 staphylococcal infection unspecified.

(These codes may be being used independently of each other, but might also indicate that the coder has incorrectly used a primary infection code instead of a secondary infection code from the block B95-B97).

*Information provided by Sue Eve-Jones, Director, Professional Association of Clinical Coders (UK)*