Payment by results data assurance framework
Report on the local audit programme for Ashford & St Peter’s Hospitals NHS Foundation Trust
May 2013
For the 2012/13 PbR data assurance programme reporting on local work for NHS Surrey PCT cluster will comprise a single report covering all work undertaken on behalf of that cluster.

This document is an extract of that report and covers all audit work undertaken at Ashford and St. Peter’s Hospitals NHS Foundation Trust. It is being made available prior to the production of the cluster report to provide feedback to the Trust on the findings of the audit work.

An action plan has been included at the end of this report for the Trust to complete. The technical appendices and error examples have also provided separately.
The Statement of Responsibilities of Auditors and Audited Bodies issued by the Audit Commission explains the respective responsibilities of auditors and of the audited body. Reports prepared by appointed auditors are addressed to non-executive directors, members or officers. They are prepared for the sole use of the audited body. Auditors accept no responsibility to: any director/member or officer in their individual capacity; or any third party.
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INTRODUCTION

Background

1. For the past six years the Payment by Results (PbR) data assurance framework has provided assurance over the quality of the data that underpin payments as part of PbR, promoting improvement in data quality and supporting the accuracy of payment within the NHS.

2. In March 2012 the Audit Commission set out the framework’s programme for 2012/13. This year’s work will focus on both local and national assurance by:
   - providing a flexible audit resource to commissioners to deliver local audit programme focused on specific areas of local risk to PbR data quality; and
   - supporting tariff development and implementation by undertaking national data quality reviews of PbR in mental health and best practice tariffs.

3. The assurance framework’s 2012/13 work programme has been developed and delivered by the Audit Commission’s business partner, Capita Business Services Limited. The Commission’s team responsible for developing and delivering the assurance framework for the past six years has transferred to Capita and all local audit work will be undertaken by Capita staff. The Audit Commission remains responsible and accountable for the overall assurance framework.

4. Details of the Audit Commission’s work can be found at: wwwaudit-commission.gov.uk.

The local audit programme

5. This report describes the findings from the local audit programme for Ashford and St. Peter’s Hospitals NHS Foundation Trust. The local audit work draws on audit approaches developed and applied under previous years of the framework.

6. Each PCT cluster has been allocated a resource to be managed at a cluster level. This audit resource has been targeted on areas of risk identified by the cluster. This could be at one or many providers, use a trust wide audit sample or focus on one specific area of treatment.

1 Payment by Results Data Assurance Framework 2012/13: Improving the quality of contracting and commissioning data, Audit Commission, March 2012
7. The options we gave to the PCT cluster were:
   - admitted patient care - clinical coding audits and the data items that drive payment;
   - outpatients – attendance review including procedure coding and other data items that drive payment; and
   - accident and emergency – data items that drive payment.

8. Clusters have been provided with risk profiles to help inform the local programme – these profiles combine comparative analysis from the National Benchmarker\(^2\) and previous audit results. SUS continues to be the source of data for all aspects of the local audit programme.

9. We will also report our findings to each PCT as they are the statutory body responsible for commissioning this work.

The Audit Commission

10. The Audit Commission is a public corporation set up in 1983 to protect the public purse.

11. The Commission appoints auditors to councils, NHS bodies (excluding NHS foundation trusts), local police bodies and other local public services in England, and oversees their work.

12. We also help public bodies manage the financial challenges they face by providing authoritative, unbiased, evidence-based analysis and advice.

\(^2\) The Audit Commission’s national benchmarker is freely available to the NHS. To request a log-in go to [www.audit-commission.gov.uk/pbrbenchmarking](http://www.audit-commission.gov.uk/pbrbenchmarking).
CARDIOLOGY IN ADMITTED PATIENT CARE

Audit approach
13. Admitted patient care data in cardiology from quarter 2 2012/13 was audited at Ashford and St. Peter’s Hospitals NHS Foundation Trust, focused on HRG subchapter EB cardiac disorders as the activity was higher than expected on the Audit Commission PbR benchmarker.

14. The audit covered the Trust’s clinical coding using the Connecting for Health (CFH) Audit Methodology v6, as well as the accuracy of other data items that affect the price commissioners pay for a spell under PbR: age on admission, admission method, sex, and length of stay. For each of these data items the information in SUS was verified against information in source documentation.

Audit findings
15. In the whole sample audited, the Trust had no spells with an error that affected the price. The commissioner was charged correctly for the audit sample. Table 1 below summarises the main findings.

Table 1: Audit results and their financial impact

<table>
<thead>
<tr>
<th>Episodes in audit sample</th>
<th>60</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spells tested</td>
<td>60</td>
</tr>
<tr>
<td>% spells changing payment</td>
<td>0</td>
</tr>
<tr>
<td>Pre audit payment(^3)</td>
<td>£131,815</td>
</tr>
<tr>
<td>Post audit payment</td>
<td>£131,815</td>
</tr>
<tr>
<td>Gross change</td>
<td>£0</td>
</tr>
<tr>
<td>% gross change</td>
<td>0.0</td>
</tr>
<tr>
<td>Net change(^4)</td>
<td>£0.00</td>
</tr>
<tr>
<td>% net change</td>
<td>0.0</td>
</tr>
<tr>
<td>Episodes unsafe to audit</td>
<td>0</td>
</tr>
</tbody>
</table>

16. The performance of the Trust, measured against the number of spells with an incorrect payment would place the trust in the best performing 25 per cent of trusts compared to last year’s national performance.

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\(^3\) The pre- and post-audit sample is priced using full PbR business rules but does not local amendments into account such as market forces factor (MFF), non-payment for emergency readmissions, non-elective threshold, and any local agreements.

\(^4\) A negative figure represents an overcharge to the commissioner by the provider.
Breakdown of errors

17. Table 2 shows a breakdown of the audit results for cardiology.

Table 2: Full audit results

<table>
<thead>
<tr>
<th>Spells tested</th>
<th>% of spells changing payment</th>
<th>% of spells changing HRG</th>
<th>% clinical codes incorrect</th>
<th>% diagnoses incorrect</th>
<th>% procedures incorrect</th>
<th>% spells with other data items incorrect</th>
<th>% other data items incorrect</th>
</tr>
</thead>
<tbody>
<tr>
<td>60</td>
<td>0.0</td>
<td>0.0</td>
<td>2.6</td>
<td>1.7</td>
<td>3.8</td>
<td>0.0</td>
<td>1.7</td>
</tr>
</tbody>
</table>

18. The quality of cardiology coding was very good, with no errors that impacted the price charged to commissioners. There were, however, areas where the Trust could look to improve its coding accuracy.

19. This included improving the coder’s skills in extracting data for coding. There were 13 errors where coders had not extracted information correctly and this especially affected secondary diagnoses. Although these did not change the HRG it results in poor data quality and an incorrect picture of activity being carried out at the Trust.

20. Coding of co morbidities and secondary codes should be reviewed. We found many mandatory co morbidities were omitted, such as hypertension, anticoagulant use, ischaemic heart disease and smoking. Other relevant co morbidities that were treated or investigated were also omitted, including atrial fibrillation.

21. There were also a number of instances where coders were coding symptoms when a definitive diagnosis has been made or coding symptoms not documented by the clinician. For example, adding a code for chest pain where the primary diagnosis is atherosclerosis (ICD code I25.1).

22. The Trust’s clinical coding standards are supported by good practice initiatives. The coding team regularly meeting with consultants and the Trust’s medical director, who is a cardiologist. With consultant support, a coding sheet for cardiac catheterisations has been developed that has helped to improve coding accuracy for this procedure.

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5 These figures contain all error types. The CFH clinical coding audit methodology excludes errors that are the inclusion of codes which are not relevant to the episode of care from the final audit figures. These errors can occur in four main areas: secondary diagnosis (co morbidities), external causes of injury, primary procedures and secondary procedures. These errors can have a direct impact on the assignment of HRGs and therefore payment. From this year we are including these errors in the coding error rate. The technical appendices of this document also contain the coding error rate calculated using the current CFH methodology.
23. The auditors noted some inconsistency between the diagnoses details recorded in the discharge summaries and the case notes. This did not cause price change errors but did cause coding errors. For example, in one instance the case notes stated “chest pain” as the primary diagnosis but the discharge summary recorded “angina”.

24. In addition to reviewing clinical coding this year, we audited the accuracy of all data items that affect the price commissioners pay the Trust for a spell under PbR rules. There was one data item error regarding the length of stay (spell) for an elective coronary angiography day-case. The data showed that the patient was in hospital for three days. This error did not affect the price.

Unsafe to audit - cases excluded from the audit

25. There were no episodes that were unsafe to audit in the audit sample.

Recommendations

26. Based on the audit competed we have made two recommendation to the Trust, which have been included in an action plan completed by the trust. There were no high priority recommendations.

27. The full action plan is included in the appendix for this section.
TRAUMA AND ORTHOPAEDICS IN ADMITTED PATIENT CARE

Audit approach

28. Admitted patient care data in trauma and orthopaedics in quarter 2 2012/13 was audited at Ashford and St. Peter’s Hospitals NHS Foundation Trust. This area was selected as the activity was higher than expected on the Audit Commission PbR benchmarker.

29. The audit covered the Trust’s clinical coding using the Connecting for Health (CFH) Audit Methodology v6, as well as the accuracy of other data items that affect the price commissioners pay for a spell under PbR: age on admission, admission method, sex, and length of stay. For each of these data items the information in SUS was verified against information in source documentation.

30. All errors have been agreed and signed off by the Trust.

Audit findings

31. In the whole sample audited, the Trust had no spells with an error that affected the price. The commissioner was charged correctly for the audit sample. Table 3 below summarises the main findings.

32. All errors have been agreed and signed off by the Trust.

Table 3 Audit results and their financial impact

<table>
<thead>
<tr>
<th>Episodes in audit sample</th>
<th>61</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spells tested</td>
<td>60</td>
</tr>
<tr>
<td>% spells changing payment</td>
<td>0.0</td>
</tr>
<tr>
<td>Pre audit payment⁶</td>
<td>£161,571</td>
</tr>
<tr>
<td>Post audit payment</td>
<td>£161,571</td>
</tr>
<tr>
<td>Gross change</td>
<td>£0.00</td>
</tr>
<tr>
<td>% gross change</td>
<td>£0.00</td>
</tr>
<tr>
<td>Net change⁷</td>
<td>£0.00</td>
</tr>
<tr>
<td>% net change</td>
<td>0.0</td>
</tr>
<tr>
<td>Episodes unsafe to audit</td>
<td>1</td>
</tr>
</tbody>
</table>

⁶ The pre- and post-audit sample is priced using full PbR business rules but does not local amendments into account such as market forces factor (MFF), non-payment for emergency readmissions, non-elective threshold, and any local agreements.

⁷ A negative figure represents an overcharge to the commissioner by the provider.
33. The performance of the Trust, measured against the number of spells with an incorrect payment would place the trust in the best performing 25 per cent of trusts compared to last year's national performance.

34. We were provided with 61 episodes with a total value of £161,571. We could not audit one episode with a value of £1,667 because there was no evidence in the case notes or source documentation provided to support the data in SUS. We cannot therefore provide commissioners with assurance on these unsafe to audit (UTA) episodes.

**Breakdown of errors**

35. Table 4 shows a breakdown of the audit results for trauma and orthopaedics in admitted patient care.

*Table 4: Full audit results*

<table>
<thead>
<tr>
<th>Spells tested</th>
<th>% of spells changing payment</th>
<th>% of spells changing HRG</th>
<th>% clinical codes incorrect</th>
<th>% diagnoses incorrect</th>
<th>% procedures incorrect</th>
<th>% spells with other data items incorrect</th>
<th>% other data items incorrect</th>
</tr>
</thead>
<tbody>
<tr>
<td>60</td>
<td>0.0</td>
<td>0.0</td>
<td>3.0</td>
<td>1.7</td>
<td>0.8</td>
<td>5.1</td>
<td>5.2</td>
</tr>
</tbody>
</table>

36. Coding was of a good standard though there are areas for improvement. The main cause of coding errors was coders not extracting information correctly from the source documentation caused most errors.

37. The main errors were found in procedure coding. Primary procedure errors included an incorrect description of a ligament repair (OPCS code M2381, not M2481). Examples of secondary procedure errors included omission of a lipoma biopsy (OPCS code Y209) and one procedure with no reference to image intensifier guidance (OPCS code Y535).

38. There were a small number of diagnosis errors, including omission of a benign lipoma diagnosis (ICD code D172).

39. In addition to reviewing clinical coding this year, we audited the accuracy of all data items that affect the price commissioners pay the Trust for a spell under PbR rules. There were no incorrectly coded data items for trauma and orthopaedics.

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8 These figures contain all error types. The CFH clinical coding audit methodology excludes errors that are the inclusion of codes which are not relevant to the episode of care from the final audit figures. These errors can occur in four main areas: secondary diagnosis (co morbidities), external causes of injury, primary procedures and secondary procedures. These errors can have a direct impact on the assignment of HRGs and therefore payment. From this year we are including these errors in the coding error rate. The technical appendices of this document also contain the coding error rate calculated using the current CFH methodology.
40. The coding team regularly meets with orthopaedics consultants to discuss coding issues. The Coding Manager meets with the lead orthopaedic consultant on a monthly basis to specifically to review difficult cases.

Unsafe to audit - cases excluded from the audit

41. The aim of the programme is to provide assurance that the HRGs used as the basis for charging commissioners have been correctly calculated. We could not audit 1 of the 61 episodes in the audit sample 1.6 per cent) because they were Unsafe to Audit (UTA).

42. An episode is recorded as a UTA where there was insufficient or no information regarding the episode in the source documentation provided for audit or the auditor is unable to find any evidence to support the data in SUS. An FCE will not have more than one UTA. If an episode is a UTA it is excluded from the audit. In 2011/12 80 trusts had no UTAs.

43. This UTA had a financial value of £1,667 and was due to no information in the notes pertaining to the episode of care in one set of case notes. The Trust advised that a temporary set of notes might have been created but this could not be located during the audit.

44. We cannot provide commissioners with assurance that these spells are correct as there was no evidence in the case notes or source documentation provided to support the coding undertaken.

Recommendations

45. Based on the audit competed we have made one recommendation to the Trust, which have been included in an action plan completed by the trust. There were no high priority recommendations. The full action plan is included in the appendix.
APPENDIX 1: PBR DATA ASSURANCE PROGRAMME
ACTION PLAN 2012/13

Admitted patient care

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Description</th>
<th>Responsibility</th>
<th>Priority</th>
<th>Date</th>
<th>Target date for completion: 31/03/2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Work with clinicians to improve the consistency between case notes and discharge summaries.</td>
<td>Julianna Tudose – Coding Manager</td>
<td>Low</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Address the issues identified through audit, including • improving extraction skills of coders;</td>
<td>Julianna Tudose – Coding Manager</td>
<td>Low</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• providing addition training on coding of co morbidities and secondary codes; and</td>
<td></td>
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<tr>
<td></td>
<td>• reminding coders of when to code symptoms.</td>
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