Grant Thornton

An instinct for growth™

Getting the data right first time

Lessons from reviewing coding and contracting income at NHS trusts in financial special measures

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Introduction

As the financial position of the NHS has worsened the focus nationally and locally has moved to managing financial pressures through both cost improvement and efficiency programmes within hospitals.

Despite the national move away from Payment by Results (PbR) to Aligned Incentive Contracts (AIC) and similar collaborative contracting models, the accuracy of activity data and resulting income continues to be an issue for many NHS trusts. Boards of trusts need to ensure that the income received for services is not undermined by poor coding and inaccurate data in their contract baseline.

Over the last year, Grant Thornton's specialist Healthcare Assurance team have worked alongside NHS Improvement and a number of trusts in financial special measures to ensure clinical data accurately reflects the care delivered. We have delivered detailed and comprehensive reviews of patient level information to assess the accuracy of their clinical and contracting data. These reviews provide trusts with:

- a detailed understanding of the issues around coding and data recording
- evidence of where data is inaccurate
- financial risk assessments of the inaccuracies identified
- realistic assessments of the impact on baseline income

This briefing summarises some of the consistent issues and messages from our reviews, and provides an understanding of the key areas which all trusts should review to ensure their contract baseline is accurate.

Getting the data right first time

It's not just about coding - poor data recording affects all areas of a trust's income

Coding has become an overarching term to describe all data recording issues impacting on contract income. Clinical coding teams and clinical coding accuracy are often held responsible for issues with income at a trust. But the reality is that there are numerous causes of poor data recording, with the accuracy of the coding being just one. The quality of source documentation, how clinical data is captured in the system, the way information is processed in the data warehouse and how it is finally reported will all impact on the income received by a trust.

Poor data recording will affect the accuracy of payments across all areas of a trust's contract. Admitted Patient Care (APC), the only type of patient activity where clinical coding is mandated, covers less than half of an average trusts income. Patient activity in outpatients, A&E, maternity and all areas of local tariffs such as critical care and pathology, all require accurate data to ensure a trust is paid appropriately for the care delivered. The table below outlines consistent risk areas examined during our reviews.

Area	Example trust income (£500m)	Key issues impacting on income	Impact
APC	£225m	Clinical coding	Inaccurate coding of definitive diagnoses, comorbidities, or procedures may change the Healthcare Resource Group (HRG) and the price of an admission.
		Elective vs non-elective	Inaccurate recording of planned care as emergency (non-elective) activity usually results in a higher price.
		Point of delivery	Inappropriate reporting of activity as an admission usually results in a higher price and more income, such as reporting activity as a day case instead of an outpatient procedure, or the incorrect classification of admissions avoidance or ambulatory care units as an admission.
Outpatients	£90m	Procedure coding	Inaccurate coding of outpatient procedures, which should be coded in line with national guidance, can affect the price paid for that activity.
		Treatment function (specialty) and other data items	Inaccurate classification of other outpatient data will also impact on the income received. The specialty delivering care will determine the price of standard outpatient attendances. Nurse led, non face-to-face and multi-professional outpatient attendances all receive different prices than standard attendances.
A&E	£30m	Coding of investigations and procedures	Inaccurate recording of treatments and tests may change the price of an A&E attendance.
Maternity pathways	£20m	Recording levels of intensity of patients	The payment for a maternity pathway is determined by multiple factors which must all be fully and accurately recorded, such as previous medical history and current comorbidities.
Local tariffs	£125m	Accuracy of tariffs	Local tariffs need to be set at a level that covers the costs of the services they describe, such as critical care or pathology.
		Data underpinning currencies	Local tariffs need to be based on currencies that accurately reflect the care delivered – often there is limited scrutiny on non-PbR data.
Other contracting arrangements	£10m	Activity thresholds or fines relating to data quality	A trust can lose income, both related to the care delivered, as well as additional funds, where commissioners impose fines relating to poor performance against data quality indicators, or where there are unrealistic activity thresholds agreed which are not linked to service or system redesign.

Multiple contracting approaches are currently in use between NHS commissioners and their providers, including cost per case, collar and cap, aligned incentive, risk share, and full block contracts, as well as a combination of these different approaches. Grant Thornton are working with a number of health economies to understand the implications of new contracting models and will be publishing a briefing outlining findings later this year. What is essential for any contracting approach is the need for an correct contract baseline to ensure accurate funding – and this can only be achieved when every patient treated is recorded completely and accurately.

More than just money

Inaccurate contracting data means that a trust's clinical data does not reflect the care it is delivering. This will not only affect income, but will also impact on commissioning and service redesign within the health economy, service management, the monitoring of clinical quality, and opinions drawn by regulators using this information. Our reviews have highlighted that any assumptions made about hospital efficiency or quality – through the Model Hospital, the Getting It Right First Time (GIRFT) programme, or Summary Hospital-level Mortality Indicator (SHMI) – will be undermined by incorrect data.

We have also seen ongoing issues around the lack of trust in data contribute to system-wide risks in healthcare economies. For example, challenges around data accuracy often lead to differences in opinion about year-end positions resulting in arbitration and damaging the relationship between commissioners and providers. System redesign plans developed by Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) require NHS leaders to have confidence that activity and costs are a true reflection of the services they describe.

Data recording inconsistencies often highlight other areas of concern. For example, the issues with the classification of short stay activity such as day surgery, admissions avoidance units and ambulatory care services often reflect inefficient care pathways and lead to disputes between commissioners and providers. They are also distorting the national picture of emergency care performance and provision.

Our work with trusts in financial special measures

Grant Thornton's Healthcare Assurance team use bespoke methodologies and analytics developed through 10 years of working with both the NHS and regulators on costing, income and contracting. Our reviews are targeted on areas of material risk by analysis of a trust's income across all service lines within its contracts. Work is delivered in two stages.

Firstly, using proven data quality indicators, we analyse all service lines and points of delivery in a trust's contract enabling us to define a set of lines of enquiry to focus our work on areas of material risk. Next, we undertake a detailed, patient record level review, supplemented by assessments of cost information underpinning agreed local tariffs and other contracting arrangements. This bottom-up approach reviews all data items that inform payment across a broad sample of patient notes, and uses a flexible approach to follow through on issues identified. We discuss errors with service, clinical and trust management to identify the underlying causes of incorrect data, risk assess our findings against the trust's ability to address the issues identified, and the implications of national contracting rules.

Our reviews are not focused on controls or arrangements, nor do they rely on analysis to form judgments, only to focus investigation. We believe the only way to fully assess data accuracy is through a detailed, patient level approach. The knowledge and experience of our team allows us to triangulate errors with behaviours at the trusts we review, enabling us to produce detailed recommendations that address processes and culture behind the causes of error.

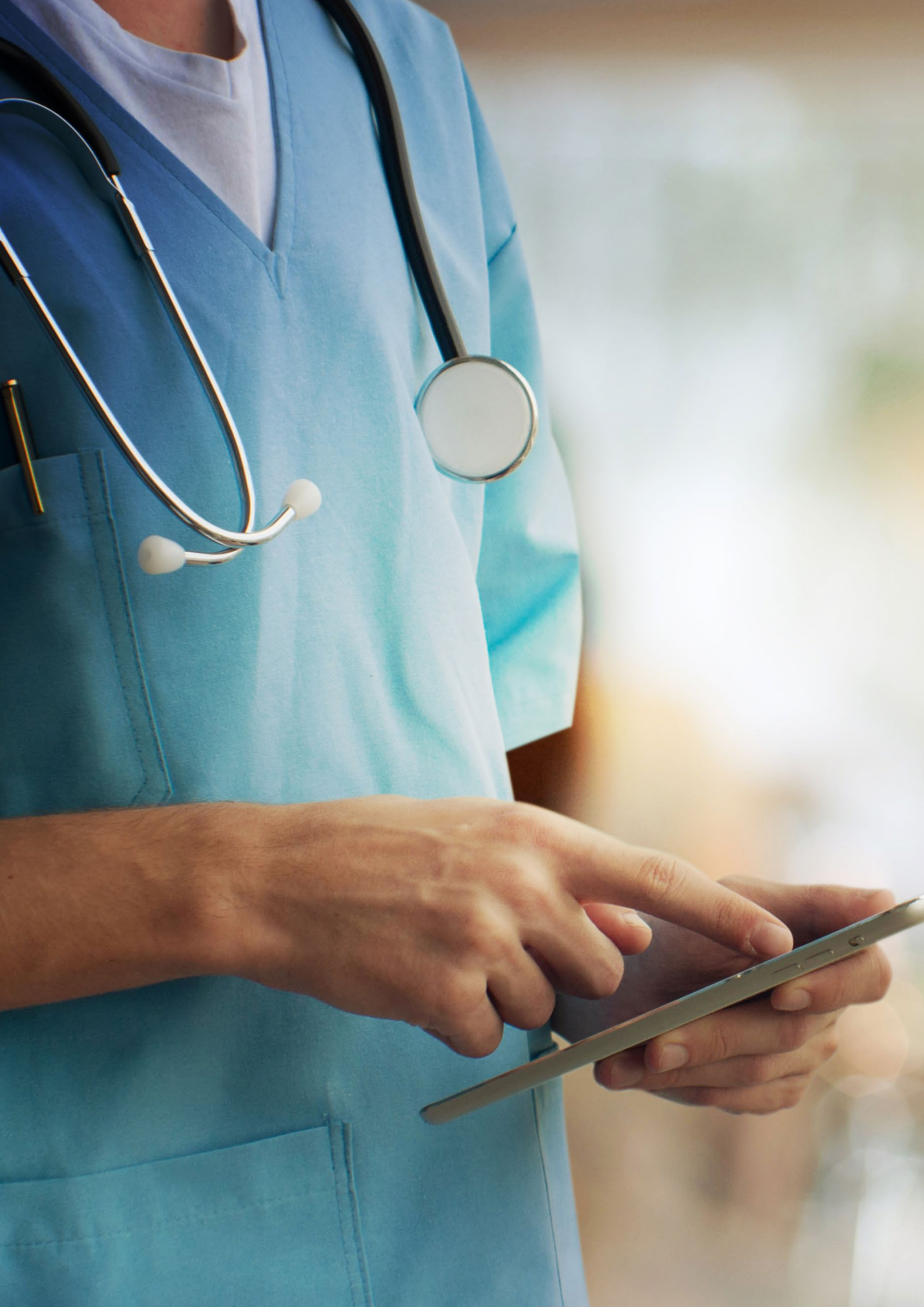
What we found

Our work to date has identified areas where contract baselines and in year income do not reflect the care a trust is actually delivering. The errors found have been across all areas reviewed and are not just limited to clinical coding in admitted patient care. Outpatient procedures, A&E and maternity pathways are all subject to far less scrutiny by trusts than APC data and often have many areas of inaccuracy. In addition, local tariffs have often not been reviewed for years, which means that in some areas, although income has been received it does not cover the actual costs of care. In total, the financial risk identified from our work has ranged from £9m to £21m depending on the size of the trust and the magnitude of issues found.

Across those trusts we have worked with so far, there have been a number of consistent themes that led to issues with data capture, governance and accountability. These include:

- unfit source documentation
- poor processes for data capture
- IT system issues, such as poor implementation and lack of training
- lack of support for the coding team and other key staff
- limited or no clinical ownership, engagement and validation of clinical data
- challenging relationship with commissioners
- lack of routine audit and review of data

Often the root cause of the errors identified related to the management of the trust, where there was inconsistent senior leadership and no overall active responsibility for data quality. Senior staff often do not understand issues, or do not believe there are problems with income data, and as such are not driving or measuring improvement. This results in pressure being placed on more junior staff, such as coding managers, to resolve intractable issues within the trust, without the necessary support. Often these failures in controls and governance are accompanied by a lack of capability and capacity, meaning there is not enough resources, or not the right resources necessary to address the causes of poor clinical data.



Consistent issues and their impact

Below are real examples of errors and their financial impact found through our reviews.

01

Admitted patient care

Unfit source documentation – access, completeness, accuracy

Impact: Clinicians failing to identify definitive diagnoses, patient comorbidities and intra-operative procedures in the source documentation. Coded data failed to reflect the complexity of patients treated

Full year effect: £4.4 million

Example error: Patient undergoing knee replacement had obesity comorbidity missed – reducing income by £1,416 a patient

Issues with the coding team – structure, grades, staffing levels, training

Impact: Errors in clinical coding by the coding team: incorrect diagnoses, unspecific comorbidities and missing procedures. Errors in coding will impact on income considerably under HRG4+

Full year effect: £5.8 million

Example error: Not recording epidural or induction of labour during a delivery spell reduces income by £1,301 a patient

Short stay activity incorrectly classified as admission

Impact: Over-charge for simple activity delivered through admissions avoidance schemes. Resulting in incorrect national data on emergency admissions

Full year effect: -£1.0 million

Example error: Patient with migraine waiting for clinical assessment that should have been completed in A&E

02

Outpatients

Poor processes for data capture – outcome forms with incorrect options

Impact: Failure to record outpatient procedures fully because outcome forms did not contain the correct options. Outpatient data should accurately reflect the care delivered where procedures are undertaken

Full year effect: £2 million

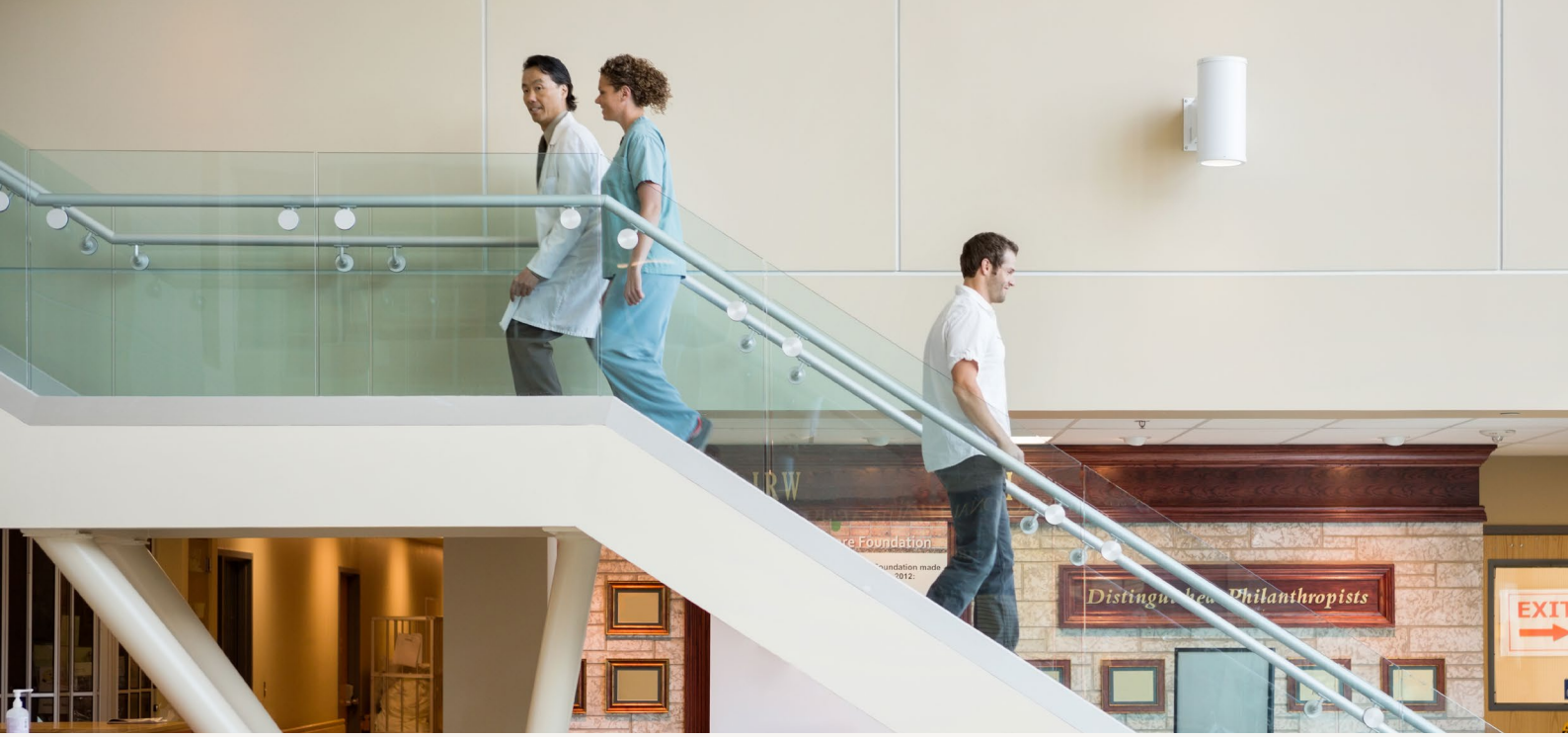
Example error: Not including the code to describe which breast was operated on reduced income by £140 per patient

Lack of routine audit and review of data

Impact: Poor coding of outpatient procedures – whilst procedures were being recorded the coding was not in line with national guidance to receive the correct price

Full year effect: £0.4 million

Example error: Coding an aspiration of knee joint as an injection will reduce income by £287 per attendance



03

A&E

System issues – poor implementation and lack of training

Impact: Under-recording of A&E treatments and tests changed the price of A&E attendances. The impact of minor errors can be considerable due to high throughput

Full year effect: £1.8 million

Example error: Missing out an x-ray can reduce payment by £70 per attendance

04

Maternity

Limited or no clinical ownership, engagement and validation

Impact: Under-reporting of maternity pathways – staff unclear that key information such as previous medical history (eg caesarean section) and current comorbidities (eg BMI) needed to be recorded

Full year effect: £0.6 million

Example error: Not capturing that the mother has cardiac disease reduced payment by £1,758 per patient

05

Local tariffs

Challenging relationship with commissioners

Impact: Local tariffs not covering costs. Tariffs should be set at a level that covers the costs of the services they describe

Full year effect: £4.4 million

Example error: Local tariffs for critical care under-funded by £4.4m when comparing income to cost base

Addressing the issues

Often, the scale of the issues identified and the manner in which they are currently managed means that many cannot be easily resolved and will therefore continue to impact upon income at the trusts we visit. The recommendations we make address a number of consistent themes that all trusts should consider when ensuring their data capture processes are fit for purpose.

Area	Issues	Recommendation
Leadership	Lack of active and consistent senior leadership across a trust executive team enables poor behaviours at lower levels, leading to limited scrutiny on activity data and related processes	Senior accountability for contracting data quality should sit with the Director of Finance, supported by the Chief Operating Officer and the Medical Director
Accountability	Errors often occur when the responsibility for key steps in data capture and management fall between two departments or areas	Trusts should clearly define the accountability and responsibilities for the capture, production and review of contract information across finance, performance, informatics, IT systems, coding, services and clinical leaders
Clinical engagement	Only through use by clinical teams in the management of services will data truly reflect the care delivered	Trusts should ensure they have a programme of clinical engagement in place to establish ownership of clinical data, including the routine validation of activity, costs and income
Source documentation	Clinical data, including clinical coding, is only as accurate as the case notes and clinical notation it is based on	Trusts should ensure all source documentation is fit for purpose, in particular any discharge summaries, comorbidity checklists and outcome forms used to support coding should be completed accurately and fully
Audit and assurance	Without scrutiny at patient level a trust's executive team do not have assurance that clinical data is accurate	Trusts should ensure there is adequate capability and capacity in place to deliver a structured audit programme across all service lines, targeted by analytics, with a focus that goes beyond clinical coding
Coding team	Lack of support for the coding team and poor team structure will result in poor coding quality	Staffing levels and team structure should be reviewed to ensure coding managers and auditors have the opportunity to measure quality and support improvement
Commissioner engagement	Unsupportive or adversarial relationships can result in unnecessary underfunding, either through inaccurate local tariffs, or unfair contracting mechanisms that penalise providers	Trusts should work with commissioners to ensure the trust is funded appropriately for the work it delivers – this should include a transparent approach to sharing all data quality issues, irrespective of who they favour
Models of care	Inaccurate point of delivery classification issues can hide inefficient and ineffective patient care, and adversely affect the relationship between commissioners and providers	Trusts should review the point of delivery of short stay elective and emergency activity to ensure it accurately reflects the care delivered - they should work with commissioners to develop local tariffs for ambulatory care and admissions avoidance units

Ultimately we recommend that trusts share the findings of our data quality and coding audits with commissioners and be transparent on all issues irrespective of which side they favour. In our experience, this increases the trust and desire for joint working between organisations. Overall system sustainability is dependent on ensuring that providers are appropriately reimbursed for the services they provide through contracting models that incentivise innovation and enable services to be managed effectively based on accurate clinical data.

About Grant Thornton

Healthcare Assurance at Grant Thornton

Grant Thornton's Healthcare Assurance team has significant experience of delivering healthcare data assurance and contractual reviews. Supporting both providers and commissioners in health economies to improve the quality of data and the accuracy of contracts and payments, our experience includes managing and delivering the Payment by Results data assurance framework on behalf on the Audit Commission, the Department of Health and Monitor (now NHS Improvement).

Grant Thornton's Healthcare Assurance team transferred from CHKS, part of Capita Group PLC, in 2017.

About Us

Grant Thornton UK LLP is a leading business and financial advisor with client-facing offices in 24 locations nationwide. We've chosen to set our reputation alongside a bold purpose – by unlocking the potential for growth in our people, clients and our communities we believe we can help shape a vibrant economy where businesses and people can flourish and no-one gets left behind.

We have been working with the NHS and local authorities for over 30 years and are the largest employer of CIPFA members and students in the UK. Our national team of NHS specialists, including those who have held senior positions within the sector, work closely with our clients to provide the growing range of assurance, tax and advisory services the NHS requires.

Our approach combines a deep knowledge of the NHS, supported by a wider understanding of public sector issues. We understand regional differences and, through proactive, client-focused relationships, our teams deliver solutions in a distinctive and personal way, not through pre-packaged products and services.

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