XXX CCG
Coding & Counting Diagnostic Review

March 2018

Assista Consulting UK Ltd

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James Wilson
Managing Director

Any queries or observations on the information contained in this report should be addressed to:

Assista Consulting UK Ltd, Regent House, 12-16 Regent Road, Liverpool L3 7DS

Email: enquiries@assista.co.uk, telephone: 0845 111 8775

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Disclaimer

The issues raised in this report are based wholly on the comments and information provided by XXX CCG during interviews carried out by Assista Consulting UK Ltd and in other supporting documents. The scope of our work does not include confirming the accuracy of the comments provided to us, although we will normally gain some assurance as to these through our analysis of the data provided. The findings and recommendations presented in this report are made entirely for comment and do not provide assurance to XXX CCG, NHS England, the DH or to any other party as to the likelihood of the CCG's success in delivering the level of potential savings identified, or not. Furthermore, although we aim to be comprehensive in our commentary, given the timeframe for our review the issues raised should not be regarded as exhaustive.

This report is prepared for the purposes of XXX CCG, in identifying potential opportunities to challenge its providers where some activity may be inappropriately being charged to the CCG. No responsibility is accepted in relation to any member of the CCG Board or its staff in their individual capacity, or to any third party.

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Executive Summary

1. The purpose of this review was twofold: firstly to assure the CCG that the correct checks were being carried out on the patient activity data received from their provider trusts and secondly to identify any specific patient records that had been incorrectly billed to the CCG.

2. Assista Consulting UK Ltd ('Assista') carried out a two-part process over a two-week period:

   i) *We undertook a limited diagnostic review of the processes for assessing the appropriateness of contracted activity being charged to the CCG.*

   ii) *We undertook a limited number of analyses of the CCG's contract and contract activity to identify opportunities for potential savings.*

3. This diagnostic review makes 26 separate recommendations. The context and explanation of these recommendations is made in section 3 of this review and a summary of the recommendations can be found in section 5.

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4. A summary of the opportunities identified by the review can be found in the table below:

	Months 1- 3 SUS value	Months 1 - 4 SLAM value	Value lost	Value bankable up to:	Future months' opportunity cost (max)
Access to dialysis at XXX		£2,003	£2,003	£0	£6,009
Complex gynaecology at XXX		£6,850	£6,850	£0	£20,550
Extend PLCVP to out patient procedures		£62,439	£0	£62,439	£187,317
Kidney and prostrate 1 at XXX		£166,325	£115,780	£50,545	£498,975
Teenage cancer at XXX		£17,555	£14,742	£2,813	£52,665
Uretheral construction		£684	£684	£0	£2,052
XXXXX records where short stay tariff was not applied		£9,042	£5,409	£3,633	£27,126
non-XXX SUS specialised	£1,562,543		tbc		tbc
Clarify coding of ophthalmology out patients		tbc	tbc	tbc	tbc
GP miscodes	tbc	tbc	tbc	tbc	tbc
Out patient attendances wrongly coded as first attendances		£726	£612	£114	£2,178
Total	**£1,562,543**	**£265,624**	**£146,080**	**£119,544**	**£796,872**

5. The CCG will need to feed these findings back to their provider trusts. Assista would be able to facilitate this dialogue if required.

1. Overview Of The Current Contract Challenge Process

1.1 Based on the discussions held with staff to date, there are number of functions involved in contract management at the CCG, namely: contracting, finance and business intelligence.

1.2 The CCG is host commissioner for a number of contracts, but primarily XXX, XXX Trust and XXX Trust. Other trusts that the CCG contracts with are co-commissioned and hosted by other CCGs.

1.3 Based on conversations with staff it is understood that the CCG undertakes the following process when assessing the contracted activity being charged to it by its providers:

i) full SUS data for all providers is made available to the Business Intelligence team,

ii) full SLAM data for XXX is made available to the business intelligence team. An early extract is sent by XXX, which is then followed up with an updated extract,

iii) the business intelligence team undertake a series of proprietary checks on the data. These checks are attached as appendix 1 to this report,

iv) a summary report on XXX is produced by the business intelligence team and provided to the finance and contracting teams,

v) a separate analysis is undertaken by the business intelligence team identifying any inpatient and daycase procedures that are covered by the CCG's Procedures of Limited Clinical Value (PLCVP) policy. The details are supplied to the finance department to test against the CCG's policy,

vi) the finance and contracting teams then undertake an analysis of the summary SLAM data and raise any specific queries they might have directly with the Trust. This is done on a finance team to finance team, and contracting team to contracting team basis, via email,

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vii) *each month there is a contract meeting with XXX where any queries and questions regarding the contract are discussed,*

viii) *there is a separate information sub-group held each month which discusses any issues relating to data in more detail,*

ix) *outside of the XXX contract it is understood that monthly invoices are received from other providers that include, as backup, summary information relating to the monthly invoice. A number of high-level checks are done on this information by finance staff in testing that the invoice value is correct, and any queries are raised directly with the trust in question,*

x) *despite the existence of host/co-commissioning arrangements it is understood that each CCG is expected to analyse its own data for all contracts it holds and are expected to make challenges themselves directly with the provider involved. So, for example, XXX CCG only analyses its own SLAM data on a monthly basis, not the activity for other CCGs,*

xi) *in addition to any checks undertaken on the accuracy and appropriateness of the contract activity charged to it, the CCG is also working with the trust to look at the NHS 'menu of opportunities.' At the moment it is unclear as to the extent that the CCG has made progress on these in respect specifically of the 'contract management' elements of the 'menu'.*

2. Analytical Review Undertaken By Assista

2.1 Following initial discussions with XXX CCG staff we were able to identify areas of analysis to initially concentrate upon. These are outlined below.

2.2 We read the specific terms of the main contracts provided to us by the CCG. This was essentially XXX, XXX, and XXX.

2.3 The discussions that were held and the contract detail provided helped to identify which analyses to undertaken given the limited time and scope of the brief.

2.4 It was stated by business intelligence staff that no independent evaluation (i.e. outside of the operational toolkit) was undertaken to ensure that specialised activity was not being inappropriately charged to the CCG. Using our own proprietary toolkit we compared the month 3 SUS data against our own specialised services assessment model for all specialised services flag rules.

2.5 For XXX, where our model identified that activity in SUS was being shown against the CCG where it meets specialised services 'flags' we ran the XXX SLAM data through our model to test whether the CCG was being charged for that activity in SLAM.

2.6 We checked the entire SUS database to ensure that the GP code in the SUS data was a XXX CCG GP practice.

2.7 We checked SUS and SLAM data for any duplicate records, based on the fields that we had extracted.

2.8 We checked the XXX Outpatient SLAM data for TFCs with no national price.

2.9 We checked XXX inpatient data for HRGs relating to trauma.

2.10 We checked each record in the XXX SLAM to ensure that the price being charged was the correct price.

2.11 We checked XXX SLAM Outpatient procedures against the CCG's PLCVP codes to test whether any outpatient procedures carried out were on the list.

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2.12 We checked XXX SLAM outpatient attendances to test whether there are some outpatient attendances that are being coded as first attendances that might, arguably, be coded as follow up attendances.

2.13 We undertook a comparison of episodes with length of stay less than 1 day between 2016/17 and 2017/18.

2.14 We undertook an analysis of comparison by procedure between 2016/17 and 2017/18.

2.15 We undertook an analysis of comparison by diagnosis between 2016/17 and 2017/18.

2.16 Due to the limited time available to undertake the analysis, or missing fields in the SUS/SLAM data there are a number of other checks that we have not been able to undertake as yet:

i) audit of consultant to consultant referrals,

ii) pricing of outpatient TFCs with no national price in SLAM,

iii) ISS/TARN score for individual trauma records,

iv) CCU/ITU beddays associated with records identified as specialised,

v) drug/devices charges associated with activity identified as specialised,

vi) paediatric activity in adult services and vice versa that might otherwise be classified as specialised,

vii) identifying outpatient activity where a specific local workaround is required to identify activity as specialised,

viii) testing of outpatient pricing in SLAM,

ix) linking outpatient activity to IP specialised services.

3. Findings & Recommendations

3.1 This section provides details of the findings from the diagnostic review and information analysis undertaken by Assista.

3.2 In our review of contract documentation we were not able to find many specific contract clauses, outside of the national contract, that the CCG could reasonably undertake as part of its contract management process. The two clauses/policies specifically identified in the XXX contract documentation relate to:

i) the CCG policy on procedures of limited clinical value

ii) consultant to consultant referrals.

3.3 Although there are other clauses in the 'Memorandum of Understanding' for example, these are broadly nonspecific or non-contractual and tend to focus on collaborative working to manage patient activity and demand. As such these are not contractually 'enforceable' in 2017/18.

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Finding 1

The CCG have stated that each month any procedure that falls within the list of procedures on the PLCVP 'list' are identified within the SLAM data provided by XXX. This is tested against the PLCVP policy. It is believed that this analysis is **not** extended to outpatient procedures.

In our testing we checked outpatient procedure codes and found that in the months 1-4 SLAM data there were **429 outpatient procedures** that are covered by the codes in the PLCVP list, carrying a value of **£62,439** with a potential full-year value of **£249,756.**

Having identified this activity it does not mean that it translates directly into savings as these records need to be checked against the online authorisation system, alongside the inpatient and day case checks. It does, however, offer an opportunity for some realisable savings.

Additionally, the cost of any activity that should not have taken place, or required prior authorisation and didn't have it is fully realisable in year as it is the subject of a local agreement, not the national 'flex and freeze' timetable. As such it is covered by paragraph15 of the national standard contract.

Recommendation 1

The CCG should extend the identification of activity covered by the PLCVP policy to include outpatient procedures both retrospectively and prospectively.

Finding 2

It is our understanding that an audit of consultant-to-consultant referrals was undertaken with XXX approximately 18 months ago against the policy included in the contract.

The SLAM and SUS information made available to us for examination did not include the referral source code for admitted patient care and as such we were not able to check the records against this policy in the time available to us.

Recommendation 2

The CCG should undertake an audit of activity against the consultant-to-consultant policy.

Finding 3

Contracts that the CCG holds with other providers through the co-commissioning arrangements were not made available to us as part of the audit.

It is understood that the CCG does not hold copies of these contracts, and as such, any specific clauses are unable to be tested.

Recommendation 3

The CCG should request copies of all contracts where it is a signatory in order to fully understand its full contractual liabilities.

Finding 4

It's our understanding that the CCG does not run an independent validation of the SUS and SLAM data to verify that specialist activity has not been wrongly charged to the CCG. The main focus of our data analysis has therefore been to independently test the SUS and SLAM records against the NHSE Prescribed Specialised Services Identification rules.

The first part of this analysis was to run the SUS records through our own spreadsheet models. We were provided with SUS data for all providers for the first 3 months of the financial year. We found two significant issues:

i) *There were **437** individual APC records in the month 1-3 SUS for non-XXX providers that should have been identified as specialised services that were allocated to XXX CCG.*

ii) *There were a large number of records at XXX meeting the criteria for specialised services that were being allocated to XXX CCG*

Recommendation 4

The CCG should test out the SUS record-level miscodes identified in the Assista audit against invoices received and seek to challenge any significant miscodes.

Finding 5

We recognise that the SUS records are not in themselves the basis on which the CCG is charged. The monthly activity is usually based upon the SLAM data. This is one reason why the records, where it was thought a miscode had occurred, should be tested against the SLAM data.

Unfortunately the record-level SLAM data for non-XXX providers is not received by the CCG and, therefore, an independent check against SLAM data is not possible. Instead the CCG would appear to receive summary level information in support of monthly invoices.

It is suggested that this is not enough detail to test whether the CCG is being charged correctly by those providers. Although the SUS information supplied to us did not include prices we were able to apply national tariffs and trust-specific MFF uplifts to arrive at a notional figure for our **437 miscodes** of **£1,562,543** in the first 3 months. These records will be supplied to the CCG in a separate worksheet and can then be checked against the actual backing information received by the CCG. It is important to recognise two factors, however:

i) *Not all the SUS records will translate into a SLAM record and be charged to the CCG as each trust will undertake a number of adjustments to arrive at the SLAM.*

ii) *Due to the flex and freeze rules the CCG may not be able to recover any overcharging that took place in the first 3 months.*

Recommendation 5

The CCG should undertake a monthly record-level audit of non-XXX providers to test for significant miscodes.

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Finding 6

Given the potential level of miscoding in SUS, the CCG should apply record-level checks to non-XXX providers through either requesting record-level SLAM data each month, in line with the national timetable or by linking up-to-date SUS information to the invoices received from those other providers.

In doing this miscodes in future months can be appropriately challenged.

Recommendation 6

The CCG should request monthly full SLAM records from non-XXX providers.

Finding 7

We also tested out the SUS records for activity where the PSS-IR rules state that there should be no specialist top-up. We found **78 records** at the XXX in the first 3 months where a specialist top up should not apply.

Once again this does not mean that the XXX has charged a top up for this activity, but the record-level SLAM data should be tested out fully to ensure that it hasn't.

Recommendation 7

The CCG should check record-level data at XXX to ensure that specialist top ups are not being applied where they shouldn't.

Finding 8

We tested out the SUS records for activity where the PSS-IR rules state that there should be no specialist top-up. We found **78 records** at XXX in the first 3 months where a specialist top up should not apply.

This does not mean that XXX has charged a top up for this activity, but the record-level SLAM data should be tested out fully to ensure that it hasn't.

Recommendation 8

The CCG should check record-level data at XXX to ensure that specialist top ups are not being applied where they shouldn't be.

Finding 9

It has been possible to run the XXX SLAM data through our workbooks to test out whether there were any specific potential miscodes in the SLAM data. What we did find was that a large number of SUS miscodes were corrected within the SLAM data, but there were two notable exceptions:

i) *Cancer – specialised kidney, bladder and prostrate.*

ii) *Teenage cancer.*

In our analysis of the XXX SLAM we found **24 records** in months 1 to 4 that should have received a kidney, bladder and prostrate specialised services flag. These carried a value of **£173,228,** with a month 4 SLAM value of **£50,545,** and a prospective rest-of-year cost of **£498,975** if these are identified as miscodes and this continues through the rest of the year. This value is the base tariff price before assessing whether there were any ICU/ITU days attached to these episodes and any high-cost drugs or devices that could increase this value further. Again, it is stressed that the months 1 to 3 values may not be recoverable but month 4 costs can be challenged and future months' miscodes could be avoided.

We also found **25** records in the months 1 to 4 SLAM that met the teenage cancer flag, with a tariff value of **£17,555** of which **£2,817** related to month 4 only and a future month potential value of **£52,655.**

Recommendation 9a

The CCG should, if contractually appropriate, challenges the coding of this identified activity against the CCG.

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Recommendation 9b

The CCG should identify any associated ITU/CCU/drugs/devices costs associated with the challenged episodes and challenges these.

Recommendation 9c

The CCG should continue to carry out independent checks each month to ensure that specialised activity is not incorrectly coded to the CCG.

Finding 10

In addition to the specific data-based checks that generate a specialised services flag the PSS-guidance identifies a number of specialised services where additional information is required in order to identify activity as specialised.

Most significant amongst these is the identification of specialised trauma work. This requires the identification of an ISS/TARN score of greater than 8 for activity to be specialised.

In our initial analysis of major trauma HRGs we found **474 records** in the months 1 to 4 SLAM that carry a major trauma HRG. It is not known at time of writing whether and how often the CCG or trust check the individual records against ISS/TARN scores and subsequently manually adjust the SLAM to remove the spell and other associated costs.

This will similarly apply to non-XXX providers, who theoretically at least should issue credit notes against previously charged activity, once the ISS/TARN score is identified.

Recommendation 10a

The CCG should clarify the process for the identification and application of ISS/TARN scores to SLAM data if it has not done so already.

Recommendation 10b

The CCG should request/gather the TARN/ISS data for the activity identified against major trauma HRGS for all providers and challenges the charging of this activity if the ISS/TARN score is greater than 8.

Recommendation 10c

The CCG should identify all those specialised services in the PSS-ir guidance where additional information is required to identify activity as specialised and ensures that these are being applied in a timely and appropriate fashion by all

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Finding 11

We have further undertaken an analysis, on a record-by-record basis, of the individual pricing of activity in the XXX SLAM data and found that in the vast majority of cases the activity has been priced appropriately (including the application of best practice tariffs)

There are a handful of records we found where we believe a short-stay tariff should have been applied, but a full-price tariff has been charged. However, this related to only **5 records** where it is believed the CCG has been overcharged by **£9,042** to month 4 of which **£3,633** should be recoverable with a potential future months' potential cost of **£27,166**.

In respect of best practice tariffs at XXX we have run tests against all activity flagged as best practice and identified two factors:

i) *All best practice tariffs have been identified and priced appropriately.*

ii) *There are some best practice tariffs that carry a supplementary charge once it has been agreed with the CCG that clinical conditions have been met. This supplementary charge has not been included in the SLAM data received by us and it is expected that at some point an additional charge will be due once it has been agreed that clinical conditions have been met.*

Recommendation 11

The CCG should recognise that in some instances a supplementary charge may be applied, slightly increasing the cost of activity in the month 1 to 4 SLAM.

Finding 12

We ran a simple check on all SUS activity to ensure that the CCG is not being charged for activity relating to non-XXX CCG GP practices and found two things:

i) *In months 1 to 3 in SUS there were* ***10 inpatient records*** *that had a GP code that is known not to be a XXX CCG practice, but there were no outpatient GP miscodes.*

ii) *There were* ***380 inpatient records*** *where the patient either did not have a GP practice or it was not known, but there were no outpatient records in this category.*

These could not be checked within the SLAM data as the XXX SLAM data we received had empty GP code fields, and we did not have access to non-XXX SLAM data.

Recommendation 12a

The CCG should undertake monthly checks on SUS/SLAM outputs to ensure that where a GP is not a XXX GP practice the activity is not recorded against XXX CCG.

Recommendation 12b

It is recommended that where a GP code of V81997/998/999 has been recorded the postcode is checked to ensure that it is a XXX CCG resident.

Finding 13

Once we carried out the various data validation checks described above we undertook an analysis of the XXX outpatient activity contained within the SLAM data. A number of analyses were run, specifically:

i) *Test whether any patients, returning to the same clinic and consultant within a six-month period, were being classed as first rather than follow up appointments.*

ii) *Compare activity between 2017/18 and the same period in 2016/17 against every HRG.*

iii) *Compare activity between 2017/18 and the same period in 2016/1 against every procedure*

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Finding 13 cont.

What we found was that when compared with the same period last year, using SLAM data, overall outpatient activity had reduced by **827** attendances/procedures. However, within this there are some anomalies worth noting:

i) There has been a significant increase of **1,074** attendances classed as 'multi-professional' on the same period last year. However, it would appear that this coding change happened at month 3 (June 2016) 2016/17 rather than this year. There has been a corresponding reduction in 'single-professional' attendances of **2,250.**

ii) From an assessment of clinic type there has been a reduction in activity in those clinic areas, which are defined by a specific consultant code, of **1,498** attendances when compared with the same period last year, but an increase of **254** attendances in general clinics. The largest single increase lies in clinic **182** which relates to the Ophthalmology clinic and has an increase of **254** attendances on the same period last year.

iii) From a procedure perspective, there has been a large (**133**) increase in procedure code **P264** – 'Renewal of supporting pessary in vagina', and an increase of **138** attendances in procedure code **S575 –** 'Attention to dressing of skin NEC', when compared to the same period last year.

iv) There are a handful of records that show that a patient has returned to the same clinic and seen the same consultant within a six month period, but the subsequent attendance has been coded as an outpatient first attendance. These have a total value of **£726** to month 4, with a potential future months' value of **£2,178.** The most interesting thing to note, however, regarding patients with multiple attendances relates back to point iii) above and relates to ophthalmology attendances. It would appear that a lot of patients are being referred to an ophthalmology clinic, having a photograph taken, which is coded as an OP consultant led follow up attendance, having an OT assessment, also coded as a consultant led follow up appointment, and then seeing either a consultant or registrar which is being coded as a consultant-led first outpatient appointment. This is typically costing the CCG **£245** per series of attendances, and the CCG may wish to consider whether this is appropriate or not, or a change in coding.

Recommendation 13a

The CCG should consider running checks on the coding of outpatients where a patient returns to the same GP and clinic within 6 months of their last appointment.

Recommendation 13b

The CCG should clarify the coding of outpatients within ophthalmology clinics and confirms that it is happy with the treatment within the coding of outpatient attendances.

Recommendation 13c

The CCG should consider whether it is comfortable that an attendance which is clearly with a registrar or other non-consultant is coded as 'consultant led'.

Finding 14

The final check that we were able to make, within the timescale of the brief, was to look at inpatient activity. The checks we undertook were to look at:

i) *Activity with LoS of 0 days, comparing months 1 to 4 2017/18 with the same period in 2016/17.*

ii) *Compare activity between 2017/18 and the same period in 2016/17 against every diagnostic code.*

iii) *Compare activity between 2017/18 and the same period in 2016/1 against every procedure code.*

Overall, using the SLAM data for 2016/17 and 2017/18 we found that there was an increase in spells of **1,046** in 2017/18, when compared to the same period as last year. Of this increase **434** spells had a length of stay of less than 1 day. The most noticeable aspects of this being increases in endoscopy suite spells (280), SEAL (232) and the Delivery Suite (233). The 'stand out' figure, however, is that in month 4 2017/18 there have been recorded **274** spells of less than 1 day in the delivery suite. It is believed that this must be a coding issue with the SLAM data, as this is 5 times the normal monthly total, and may well be related to the coding of 'well babies'.

From a procedure perspective it is no surprise that the largest increases in procedures is G451 – 'Fibreoptic endoscopic examination of upper gastrointestinal tract', given the increase in Endoscopy suite activity, and H207 'Fibreoptic endoscopic mucosal resection of lesion of colon'. Indeed, there is no recorded activity against procedure H207 at all in the 2016/17 SLAM.

It has to be recognised, however, that the analysis to month 4 may be skewed somewhat, as based on the last update there were still 4,720 spells where the procedure code is 'NULL'. This is some 2,000 more than the natural figure, and suggests that the trust still have some coding refinement to do.

When comparing diagnosis codes between years the stand out figure is the significant growth in spells where the primary diagnosis is A419 'Sepsis – unspecified organism' which shows an increase of **431 spells (239%)** on the same period last year.

Recommendation 14a

The CCG should investigate further the increase in endoscopic examinations at XXX.

Recommendation 14b

The CCG should undertakes a clinical audit of those cases where the primary diagnosis is ‘Sepsis’ to better understand the significant increase in this diagnosis.

Recommendation 14c

The CCG should investigate further the increase in the number of stays of less than one day in the delivery suite, coded in the SLAM data.

Finding 15

Given the limited timescale of the brief and the information available to us there are a number of investigations and analyses that we have not been able to undertake/complete:

i) *Audit of consultant to consultant referrals.*

ii) *Pricing of outpatient TFCs with no national price in SLAM.*

iii) *ISS/TARN score for individual trauma records.*

iv) *CCU/ITU beddays associated with records identified as specialised.*

v) *Drug/devices charges associated with activity identified as specialised.*

vi) *Paediatric activity in adult services and vice versa that might otherwise be classified as specialised.*

vii) *Identifying outpatient activity where a specific local workaround is required to identify activity as specialised.*

viii) *Testing of outpatient pricing in SLAM.*

ix) *Linking outpatient activity to IP specialised services.*

x) *Analysis of A and E attendances.*

xi) *Analysis on non PBR records.*

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Recommendation 15

The CCG should undertake further checks on the SUS/SLAM data as described in this paper to identify any other opportunities for challenges on the charging of activity.

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4. Other Matters For Consideration

4.1 During our discussions with CCG staff it was suggested that last year the contract with XXX operated on a block contract basis which seemingly led to less challenge over the completeness and accuracy of the data supplied in the SUS and SLAM data. With the contract being moved back to a PbR basis and on reading the notes from the information sub-group it would seem that both organisations are still, to some extent, 'finding their feet' in moving back to a 'commercial' relationship.

4.2 As well as the proprietary checks undertaken by the BI team, both the contracting and finance teams would appear to make individual challenges based on the information supplied to them by the trust. This is generally done via email on an individual basis. It was not clear in the discussions we had that all of these queries and questions are logged in a single place and then co-ordinated through the monthly contract meeting or information sub-group. This meant that a single list of the challenges made by the CCG to the trust was not available for us to review.

Recommendation 16

The CCG should co-ordinate its data challenges and queries through a single point and maintains a log of all challenges made, timescales for response, and outcomes.

4.3 During our analysis of data, we looked at both SUS and SLAM data we found difficulty in comparing one set of data with another as there was no individual common single field provided to us that linked the two sets of data directly together. This meant that separate analyses had to be run on both sets of data, which increased the length of time the analysis took. This may be equally so in linking the non-XXX SUS queries, when trying to link them to the backing data received for each invoice.

Recommendation 17

The CCG should consider a solution that allows individual SLAM/SUS and invoice backing information to be linked together through a single common field.

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4.4 During our analysis of specialised services data we noticed that the SLAM data only recovers 14 fields for both procedure and diagnostic level information, and SUS only 23. This means that a large number of records have been 'truncated'. Many specialised services are identifiable by using all diagnoses and all procedures. The result being that SLAM and SUS may not be identifying some records as specialised that should be.

Recommendation 18

The CCG should work with the trust and other data controllers to ensure that all diagnostic and procedure fields are included in future data analysis.

4.5 During discussions some concern was raised regarding the balance between identifying opportunities for challenge and following these up with providers, and the overall benefit derived from the exercise. It was suggested that undertaking the analysis, making the challenge, the time it takes the trust to then undertake their own analysis, and respond, is a resource-intensive exercise, in an environment where the organisations are committed to working together. Whilst it is accepted that this is a perfectly valid perspective, in the context of financial difficulty, it is understood that NHSE expect CCGs to carry out all their contractual management and business functions fully. Contract management is part of the menu of opportunities, CCGs are expected to achieve their planned surplus and NHSE has explicitly encouraged CCGs to use all of the contractual levers available to them in order to achieve their planned surpluses, and as such the CCG should be encouraged to make appropriate data/contract challenges wherever possible.

5. Conclusion And Summary Of Recommendations

5.1 The brief received by Assista was to undertake a diagnostic exercise on the contract management process currently undertaken by the CCG and based on this undertake some specific analyses where there might be opportunity for further contractual challenge and opportunities to identify reductions in contract spend, within a two-week timeframe.

5.2 Assista has completed the exercise and has run a number of analyses and tests on the data held within SLAM and SUS. A fuller analysis has been prevented through the limited time available and in some areas limited data, but we have been able to identify some opportunities for the CCG to make specific challenges to the charges made by the trusts. It is recognised, however, that in order to realise some of these potential savings further work is required. It is also recognised that, due to 'flex and freeze' timeframes, miscodes identified in month's 1 to 3 are unlikely to be realised, and in some analyses the benefits are very small.

5.3 Table 1 identifies the opportunities that have been identified through the work we have undertaken to date. It attempts to distinguish between actual and potential opportunities, and recognises that errors in coding in months 1 to 3 are unlikely to be bankable. It also highlights a potential 'opportunity cost' in the rest of the year if the same level of miscodings continued throughout the year.

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Table 1 – Potential Opportunities Based On Analyses To Date

	Months 1- 3 SUS value	Months 1 - 4 SLAM value	Value lost	Value bankable up to:	Future months' opportunity cost (max)
Access to dialysis at XXX		£2,003	£2,003	£0	£6,009
Complex gynaecology at XXX		£6,850	£6,850	£0	£20,550
Extend PLCVP to out patient procedures		£62,439	£0	£62,439	£187,317
Kidney and prostrate 1 at XXX		£166,325	£115,780	£50,545	£498,975
Teenage cancer at XXX		£17,555	£14,742	£2,813	£52,665
Uretheral construction		£684	£684	£0	£2,052
XXXXX records where short stay tariff was not applied		£9,042	£5,409	£3,633	£27,126
non-XXX SUS specialised	£1,562,543		tbc		tbc
Clarify coding of ophthalmology out patients		tbc	tbc	tbc	tbc
GP miscodes	tbc	tbc	tbc	tbc	tbc
Out patient attendances wrongly coded as first attendances		£726	£612	£114	£2,178
Total	**£1,562,543**	**£265,624**	**£146,080**	**£119,544**	**£796,872**

6.4 There are a number of further analyses and checks that are contained in this report that the CCG is encouraged to consider, whilst also being encouraged to continue the checks and tests undertaken by Assista through its audit process. The full list of recommendations contained in this report are reproduced below for ease of reference:

The CCG should extend the identification of activity covered by the PLCP policy to include outpatient procedures both retrospectively and prospectively

The CCG should undertake an audit of activity against the consultant to consultant policy

The CCG should request copies of all contracts where it is a signatory in order to fully understand its full contractual liabilities

The CCG should test out the SUS record-level miscodes identified in the Assista audit against invoices received and seek to challenge any significant miscodes

The CCG should undertake a monthly record-level audit of non-XXX providers to test for significant miscodes

The CCG should request monthly full SLAM records from non-XXX providers

The CCG should check record-level data at the XXX Centre to ensure that specialist top ups are not being applied where they shouldn't

The CCG should, if contractually appropriate, challenges the coding of this identified activity against the CCG

The CCG should identify any associated ITU/CCU/drugs/devices costs associated with the challenged episodes and challenges these

The CCG should continue to carry out independent checks each month to ensure that specialised activity is not incorrectly coded to the CCG

The CCG should clarify the process for the identification and application of ISS/TARN scores to SLAM data, if it has not done so already

The CCG should request/gather the TARN/ISS data for the activity identified against major trauma HRGS for all providers and challenges the charging of this activity if the ISS/TARN score is greater than 8.

The CCG should identify all those specialised services in the PSS-ir guidance where additional information is required to identify activity as specialised and ensures that these are being applied in a timely and appropriate fashion by all providers

The CCG should recognise that in some instances a supplementary charge may be applied slightly increasing the

cost of activity in the month 1 to 4 SLAM

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The CCG should undertake monthly checks on SUS/SLAM outputs to ensure that where a GP is not a XXX GP practice the activity is not recorded against XXX CCG

It is recommended that where a GP code of V81997/998/999 has been recorded the postcode is checked to ensure that it is a XXX CCG resident

The CCG should consider running checks on the coding of outpatients where a patient returns to the same GP and clinic within 6 months of their last appointment

The CCG should clarify the coding of outpatients within ophthalmology clinics and confirms that it is happy with the treatment within the coding of outpatient attendances

The CCG should consider whether it is comfortable that an attendance which is clearly with a registrar or other non-consultant is coded as 'consultant led'

The CCG should investigate further the increase in endoscopic examinations at XXX

The CCG should undertake a clinical audit of those cases where the primary diagnosis is 'Sepsis' to better understand the significant increase in this diagnosis

The CCG should investigates further the increase in the number of stays of less than one day in the deliver suite, coded in the SLAM data

The CCG should undertake further checks on the SUS/SLAM data as described in this paper to identify any further opportunities for challenges on the charging of activity.

The CCG should co-ordinate its data challenges and queries through a single point and maintains a log of all challenges made, timescales for response, and outcomes

The CCG should consider a solution that allows individual SLAM/SUS and invoice backing information to be linked together through a single common field

The CCG should work with the trust and other data controllers to ensure that all diagnostic and procedure fields are included in future data analysis

Appendix 1 - Monthly Checks Undertaken By The Business Intelligence Team

1. GP Registration,
2. PLCP,
3. Menu of Opportunity, (Below are a list of some of the checks we have in place are currently discussing with the provider)

Data Check	Fails When
IsPaediatricsMismatch	Treatment function code is 420 (Paediatrics) and the patient is greater 25 years old.
IsGeriatricMismatch	Treatment function code is 430 (Geriatric Medicine) and the patient is less than 65 years old.
IsGenderMismatch	Treatment function code is either 501 (OBSTETRICS) or 502 (GYNAECOLOGY) and the patient is a male.
IsA&Edisposal	A&E Disposal Method Code not in national codes
IsEL_OPCSMismatch	The inpatient procedure that was planned has not been carried out by the trust and the HRG code does not WA14z
IsZeroLOS_A&E	The inpatient spell LOS is less than 1 day it is classified as a Non-Elective Admission
IsNoFixedAbode	The postcode begins with ZZ e.g. ZZ99
IsInvalidTFC	The TFC field is NULL
IsOP1st_InvalidRefDate	The difference in days between referral date and 1st appointment date is <=0 or > 300 or if either referral date or 1st appointment date is NULL
IsOP1FUp_InvalidRefDate	The difference in days between referral date and FUp appointment date is <=0 or if either referral date or FUp appointment date is NULL
Invalid Management Intention	The Management Intention (Not in Codes 1 - 5) is not in the defined list
DC with XBD	The Intended Management is Daycase, but XBD recorded
DC with emergency admission method	The patient classification code is daycase, however the admission method is emergency
IsInvalidPatClass	The Patient Classification is not in the defined data dictionary list
Invalid Admin Cat code	The Administrative Category NHS Code is not in the defined data dictionary list
High XBD count	The number of XBDs is greater than 50
XBD with no OP on admission	An XBD and procedure not performed on day of admission
IsConcurrent_AE_APC	Patient has concurrent A&E attendance and APC spell
IsInvalidAge	Patient is older than 110 or Age at Admission Is Null
IsInvalidWardAge	A patient attends a Paediatric ward but is aged 25 or over

– see attached for NHS England

4. Overseas visitor checks (finance yearly check) for XXX

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