Equilibrium

A report on the balance between providers and commissioners over use of the NHS Data Standards in 'admitted patient care'

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Equilibrium

e·qui·lib·ri·um

A condition in which all acting influences are canceled by others, resulting in a stable, balanced, or unchanging system.

The state of a body or physical system at rest or in unaccelerated motion in which the resultant of all forces acting on it is zero and the sum of all torques about any axis is zero.

The state of a chemical reaction in which its forward and reverse reactions occur at equal rates so that the concentration of the reactants and products does not change with time.

Status of a market in which there are no forces operating that would automatically set in motion changes in the quantity demanded or the price that currently prevails.

A stable state characterized by the cancellation of all forces by equal opposing forces: balance, counterpoise, equipoise, stasis.

Condition in which the net force acting on a particle is zero. A body in equilibrium experiences no acceleration and, unless disturbed by an outside force, will remain in equilibrium indefinitely.

A stable equilibrium is one in which small, externally induced displacements from that state produce forces that tend to oppose the displacement and return the body to equilibrium.

An unstable equilibrium is one in which the least departures produce forces tending to increase the displacement. A brick lying on the floor is in stable equilibrium, while a ball bearing balanced on a knife-edge is in unstable equilibrium.

Related concepts: order/disorder

Antonyms: imbalance, unevenness

Executive Summary

- PCT's need to collectively lobby the DH to address the imbalance which currently lies (by default) too greatly in favour of acute trusts.
    - Adherence to the NHS Data Definitions has never been audited as part of a national framework.
    - As such individual hospital sites have reached their own interpretations for various activities.
    - There is no formal method to challenge the decisions made by acute trusts.
    - DH documents appear to assume that all activities by acute trusts are totally consistent with the Data Definitions.
    - The Data definitions can be easily exploited to give a superficial result which is favourable to a Trust but with greater scrutiny can be shown to be deliberately flawed.
    - Foundation Trusts appear to have unchallenged authority to make any decision which has a financially favourable outcome, i.e. the mandate of Monitor is financial performance.

- There is a pressing need for a single organisation that ensures the rules are implemented and arbitrates on them.
    - The remit of the Audit Commission could be expanded to cover both counting and coding.

- The DH should ensure that all DH documents, PbR and SUS guidance is fully compatible with the NHS Data Definitions and that the Data Definitions are likewise framed in words which reflect the PbR framework within which they operate.

- The Data Definitions are not easy to navigate and key statements can be found in obscure locations. The Data Definitions need repackaging in a 'Data Definitions for Dummies' format with clear statements of the correct class for a wide range of common situations.

- Up to the end of 2003 advice coming from the DH regarding emergency admission was consistent with the data dictionary. The growth of zero day emergency admissions via 'assessment units' has arisen due to DH guidance which was outside the scope of the definitions in the data dictionary. The data dictionary requires change to cope with this and in the interim local counting of zero day 'emergency' admissions should be subject to greater challenge given the vast differences between acute trusts over this issue.

- New counting decisions made by acute trusts should be jointly agreed by the PCT and should be accompanied by a PbR cost impact report.

- The tariff (from 07/08 onward) will lag three years behind the data on which it is based. However acute trusts are allowed to make a counting

change in one year and then charge at tariff in the next. In theory, the same three year lag should apply.
    - Where a PCT has jointly approved a counting decision then the Trust should be allowed to use the national tariff in the next year
    - Where the PCT has not approved a counting decision then the three year lag should apply.

- Particular acute trusts are counting far too many events as a ‘day case’ which should otherwise be counted as an ‘outpatient procedure’, a ‘regular day admission’ or a ‘regular day attendance’. These should be identified and paid at an appropriate rate.

- A range of DH recognised clinical exceptions may stay in an A&E department over 4 hours. PCT’s should refuse payment for any short stay ‘emergency admissions’ which are from the clinical exception list since the patient care is within the A&E tariff.

- Given the issues identified above a pragmatic solution has been given which forms the basis for a contract with an acute trust. This solution relies on national averages as a norm against which to assess the counting activities of Trusts.

Key Recommendations

1. In the absence of a national framework for ensuring adherence to the Data Standards any historical (or future) counting decision based solely on an Acute Trust interpretation of the Data Dictionary is open to re-interpretation.

2. All new counting decisions should be jointly agreed by the PCT and acute Trust and should be accompanied by a PbR cost impact study.

3. Attempts to count an activity as' inpatient' should detail all possible coding alternatives (including examples of poor coding) to ascertain the possible range of HRG prices.

4. The medical facts relating to the condition being treated should be given due consideration together with potential GP or Public Health input into whether the activity can be conducted in an alternative and lower cost manner. This is consistent with sections 1.4,1.5, 1.14 and 1.17 in "Options for the future of Payment by Results: 2008/09 to 2010/11" (2007).

5. If a condition can be treated (for whatever reason) in a lower cost outpatient alternative then this way of counting should take precedence. The PCT should be prepared to move these activities to an alternative setting.

6. If there is doubt about the exact definition of an activity, the cut off point for an activity to be classified as admitted patient care, i.e. 'inpatient', is the mid point between the corresponding 'inpatient' tariff and the outpatient alternative. Activities costing less than the mid-point can be regarded as outpatient.

7. Activities containing a 'procedure' supposedly falling into the classification of a 'surgical' inpatient 'day case' should be conducted in a facility which the Audit Commission or BADS would recognise in their definition of a day surgery unit.

8. Non-surgical activities which are proposed as the 'day case' form of an elective admission should be checked to see if they comply with the definition of an 'inpatient' or they fall into the category of 'outpatient' or 'regular day attender'.

9. Much of what is currently counted as a 'day case' in the non-surgical HRG's is probably non-admitted patient care and should be questioned and paid at an appropriate rate.

10. Gross data errors such as 'day case' admission for a procedure which is far too complex to occur as a 'day case' should be refused payment.

11. A list of elective HRG which should not occur as a day case should be detailed in the contract with each hospital. This list will include major/complex procedures and non-surgical conditions where a category other than day case is more appropriate.

12. A list of emergency HRG which should not occur as a zero day stay should be included in the contract with each hospital. This list will include major/complex procedures; HRG's ending in 99 (complex elderly) and HRG which are gross coding errors.

13. The PCT should agree a list of procedures and diagnoses which will not be reported as a day case but will be recorded as a 'regular day admission'. This will include Renal Dialysis, Cancer care and perhaps a few other conditions.

14. The PCT should agree a list of diagnoses which will not be reported as a day case but will be recorded as a 'regular day attendance'.

15. Trusts should be requested to give a positive assurance that ward staff have access to the outpatient module and have been given adequate training to properly record ward attendances as an outpatient attendance.

16. PCT's may wish to consider if they should request acute trusts to link their offered range of inpatient services to a range of HRG which should arise from an effective coding process or to stipulate those HRG which they do not offer.

17. PCT's should stipulate in their contract that acute Trusts will advise them of the date at which changes to the coding process are commenced and the likely shifts in HRG which will arise from such changes.

18. PCT's are reminded that they have the right to stipulate acceptable levels of emergency re-admissions.

19. According to the Data Definitions most Maternity events falling into HRG N12 would appear to be a 'ward attender' and hence are part of the outpatient tariff (see below for exceptions).

20. Babies are often born with a range of minor conditions/diagnoses which are treated as the normal corse of events for otherwise 'well babies'. The cost of any treatment therefore falls within the remit of the HRG's devoted to birth. Supposed admissions for babies covered by HRG N02 to N05 need to be genuine admissions made to a specialist baby unit or dedicated ward, i.e. cannot be used for babies in normal baby cots.

21. According to the Data Definitions all Renal Dialysis should be reported as a 'Regular Day Admission'.

22. Events outside of the scope of PbR do offer the scope for a local tariff
    - Maternity
    - Renal Dialysis
    - Cancer treatment, radiotherapy, etc
    - Outpatient treatments costing more than twice the outpatient specialty tariff

23. This document can be used to support dispute resolution over how events are counted.

Aims

The aim of this document is to demonstrate that there is a greater need, than has been hitherto formally recognised, for PCT's to be able to both question, and if needed, agree changes to the counting activities within acute Trusts, Foundation Trusts and, if required, with IS providers.

This need has arisen by virtue of the history of application of the Data Definitions both prior to PbR and subsequent to its introduction.

This role is consistent with the direction of government policy for the NHS that activities should be consistently moved to the most cost effective setting (which includes the decision making behind how the activities are counted and coded).

It is also consistent with the aim of HRG's to be a consistent and credible method to facilitate financial flows, i.e. the correct amount of money follows the patient.

However, at the same time, it is recognised that PCT's do not have the resources or the mandate to validate all the counting, coding and policy implementing activities of Acute Trusts. As such a pragmatic solution is given which avoids the need for PCT's to investigate every HRG line in detail.

Summary

The definitions within the NHS Data Dictionary can be misapplied. This is especially important in the area covered by what is called 'admitted patient care'. Due to the single elective tariff (overnight plus day case) there is considerable financial benefit to have an activity re-classified as 'inpatient' usually under the heading of 'day case'.

In this respect, for the non-surgical HRG's a significant proportion of what is currently counted as a 'day case' is probably more correctly a 'regular day admission', a 'regular day attendance' or an 'outpatient'.

This leads to classification of activities which are at variance to a PbR and cost-based view of the resources consumed by the activity.

Lastly the change in the traditional A&E flow to re-direction to medical and surgical assessment units has led to a rapid rise in zero day stay emergency admissions for which there is no adequate description in the Data Definitions and for which there is still no adequate tariff.

Definition of Terms

The terms ‘counting” and ‘coding’ as in Section 18 of the ‘Code of Conduct for Payment by Results’ (V2, March 2007) are used throughout this report to have the following meanings.

Counting

The process of allocating an activity into a class recognised by the NHS Data Dictionary. Hence, it answers a question such as, “Should this activity be counted as an elective ‘day case’, a ‘regular day admission’ or an ‘outpatient attendance’?”

When activities which may otherwise be considered to be outside the remit of admitted patient care are counted as an ‘inpatient’ this results in ICD and OPCS codes being assigned to the activity such their fundamental meaning in terms of resource consumption is no longer valid, i.e. the case mix complexity is diluted.

Counting creep occurs when the total activity across a broad range of HRG grows at a rate which is higher than could otherwise be expected.

Coding

The entire process of recording medical information regarding a patient contact; through to the ultimate translation of this information into ICD and OPCS codes or into a variety of outpatient and A&E codes. In the context of this report the issue of coding is restricted to the use of ICD and OPCS codes to describe non admitted activities as if they were an ‘inpatient’ admission.

Upcoding or ‘coding creep’ is commonly confused with counting, however, in its strict sense it applies only to genuine inpatient admissions where the previous coding process is changed to record either more accurate information or to deliberately choose codes which could lead to the episode being assigned to a more expensive HRG.

While coding creep will lead to changes in the count for individual HRG (i.e. the apparent volume of activity in one HRG should reduce while another HRG should increase by the amount of the reduction) the total volume of activity will only increase in line with expected trends.

Context for the Report

Adherence to the NHS Data Definitions has never been audited as part of a national framework. As such individual hospital sites have reached their own interpretations for various activities. How events are counted today can be the result of decisions made yesterday, last year, five, ten or fifteen years ago. These different interpretations are sufficient to cause material shifts in the reference cost index of an acute Trust. Indeed experience shows that the same activities can be counted in different ways at the different sites within the same acute Trust, i.e. the legacy of trust mergers.

Prior to PbR the Data Standards existed as an independent entity. All parties accepted that their interpretation was problematic and subjective but none were overly concerned since local differences in counting were reflected in local prices and as a result a degree of equilibrium was maintained.

The Data Standards now exist within a PbR framework. They are no longer an independent entity but are an integral part of the operational platform for PbR and the tariff. As such their interpretation and application must be guided by the principles and context set by PbR. In the terms of the NHS Data Model we now have a parent –child relationship. Incorrect application is now a concern since it very clearly leads to financial consequences.

The introduction of PbR has lead to a marked increase in the rate at which counting changes have been implemented, especially since 2003/04, with an apparent shift in counting from non-admitted to 'admitted' care in both the elective and non-elective arenas. The 2004/05 re-basing exercise inadvertently acted as a major impetus to acute Trusts to take the opportunity to change the way events were counted.

Ward Attenders are one example of how counting can even be skewed by organisational rather than Data Definition issues. For example, a patient returns to the ward to have their dressing changed by the nurse. There is no access to the 'outpatient' module of the PAS on the ward (or relevant training has not been given) so the only option available to record this patient contact is to 'admit' the patient using the 'inpatient' module.

PbR relies on the concept that activities within a HRG conform to the national norm for that activity, i.e. iso-resource or roughly costing the same amount.

While, in principal, PCT's should be operating within their remit as a commissioner to question instances of counting which leads to a gross divergence from the national norm, this is not fully the case at present. Indeed PCT's do not (but should) have direct access to the rationale behind future counting decisions made at acute Trusts. Indeed past decisions involving high volume activity should also be open to scrutiny and challenge.

Suggested Interim Solution

A case is made to show that both gross coding errors and questionable counting is usually concentrated in what may be called zero day stay activity.

The tariff relies heavily on the concept of a national norm. Hence the activities behind an 'elective' admission for COPD or asthma (either overnight or day case) should be roughly similar across all Trusts. One is tempted to say - what is an elective (planned) admission for COPD or asthma? However this issue aside there is the assumption of a national norm.

Hence, each HRG will have a national norm for the proportion of zero day elective or non-elective admissions.

If we assume that all surgical admissions covered by the Audit Commission basket or the BADS list of procedures are bona fide 'day case' admissions; then all PCT's are obliged to pay for activity at tariff. Upper and lower GI endoscopies will also be paid without question including any other HRG where both parties agree that there is no possibility for local ambiguity.

The only exception is where the PCT has reason to believe that the intervention rate is too high and under the terms of the PbR Code of Conduct (section 22.3) can request providers to review their threshold for intervention.

However in the non-surgical HRG and HRG where minor procedures can be counted either way it is fair to assume that the national average for the proportion of zero day stays will apply.

Hence the PCT will state in its contract that it will pay for activity in the following way:

All elective zero day stay activity in a HRG where the procedure is too complex to occur as a day case (except in the case of post operative death) will be assumed to be a gross coding error and will not be paid until the Trust can provide the correct information for that patient.

All other elective or non-elective HRG (with the exception of the genuine surgical procedures) will be assumed to be at the national average proportion for zero day stays. The cost[1] of over- and under- activity will be netted off across all such HRG and if the net cost is in 'excess to that expected from national average' the corresponding 'excess to national average' activity will be paid at the corresponding, A&E, regular day admission, outpatient price or agreed local price.

This proposed approach can be shown to be consistent with the code of conduct in the following way.

Section 24.3 states that 'providers will code and bill for activity fairly and accurately'. Hence withholding payment for zero day activity in what has been coded as a highly complex intervention is a valid response to incorrect coding.

Section 24.8 states that 'disputes should not take place where the financial sums are not material'. Hence the act of netting off all under- and over-activity in the zero day stay category satisfies this requirement as well as section 15.3 regarding the tariff being greater or less than actual cost in individual cases. Hence while a particulat trust may have a materially higher cost in a single HRG line it mat also have a series of lower costs across a wider range of HRG lines and so the process of netting off gives a balanced approach to the issue.

[1] Cost = Activity x Tariff

The proposed method is also consistent with section 19.5 that forbids the use of 'caps and floors'. This approach simply implies that the counting is questionable; the PCT has given the Trust the benefit of doubt up to the expected national average, has netted off all over's and under's and still finds a material discrepancy which will be paid at the outpatient or A& E tariff, etc. Hence all activity is indeed paid at full tariff.

The national average for zero day stays from 2005/06 will be used as the basis for 2008/09 contracts since the tariff has been shifted to be based on data from three years ago (see next section).

Where an acute Trust has a lower net cost that expected the PCT can assume that the direction of government policy to reduce costs by moving them to their lowest cost setting has been effectively implemented and the PCT can contract without reference to the above conditions.

Reference Year to Determine National Average

Up to the 2006/07 financial year the tariff was determined from reference costs submitted two years previously. The year 2007/08 marked the point of a move to a three year gap. Hence the 2007/08 tariff was a simple uplift on the 2006/07 tariff rather than a fundamental reference cost-based recalculation. See document '2007/08 Tariff Uplift' (DH 073117).

Hence 2005/06 reference costs (submitted in August 2007 using OPCS 4.2 codes and HRG 3.5) will form the basis of the 2008/09 HRG 3.5 tariff. Likewise 2006/07 reference costs will be collected using OPCS 4.3 codes and using HRG 4 but will not be implemented as the HRG 4 tariff until 2009/10 (DSCN Notice: 11/2007 HRG4, April 2007).

For this reason the appropriate reference point to determine the 'national average' for the proportion of zero day stays will be 2004/05 HES data for the 2007/08 FY and 2005/06 HES data for the 2008/08 FY, etc.

The DH has also signaled the likelihood of a move away from the use of reference costs based on submissions from all acute trusts to a sample of trusts where the reference costs are deemed to be more reliable. This may affect the tariff for 2009/10 and would lead to a situation where the national average for counting/coding would be set by this smaller group of reference trusts rather than the global HES average. PCT's should monitor developments in this area.

Policy Context and DH Guidance

Reforming NHS financial flows: introducing payment by results (October 2002) bought together government policy and DH implementation. The following quotes from "Response to Reforming NHS Financial Flows" (February 2003) provides clues to how the DH interpreted the policy direction.

The payment by results proposals will actively encourage innovative service re-design and technological advances, where these are costs reducing. Providers that can operate below average cost will be able to retain surpluses in the short term. As cost reducing technologies or clinical developments become more widely used, the average cost of treatment will fall, encouraging inefficient providers to adopt the service innovation.

If a proportion of patients currently treated in an acute setting can more cost effectively be treated in the community then that is where they should be treated. If Trust's are correspondingly left with the relatively more complex cases, this will be reflected in the casemix adjusted funding they receive in future years.

The reason that we have decided to pay a single tariff for both day cases and inpatients is because we want to encourage patients to be treated in the most cost-effective manner.

Services covered by the national tariff may be delivered in a number of ways, with different levels of input, from different types of healthcare providers. Some examples were given in the 2003/04 technical guidance of situations where these different service configurations could lead to local variations from the national tariff. (Technical Guidance, page 12 paragraphs 33-35) The purpose here is to support local initiatives that reduce a patient's length of stay in hospital by providing some elements of care, that were traditionally provided as part of an inpatient episode, in other settings whilst maintaining the principle of payment by results. The application of these variations from the national tariff should be made where the local arrangements have a significant effect on the costs born by different healthcare providers.

From the above quotes it is clear that the DH sees the direction of policy leading to a shift into lower cost settings. The same document goes on to say:

'HRG creep is the tendency for hospitals to deliberately shift their reported casemix in order to attract a higher rate of reimbursement. Several organizations of various types expressed concern about how this perceived problem would be addressed' and 'The incentives for correct coding are significantly stronger in a system of casemix adjusted prospective payment, so the HRG's included in the payment by results proposals are likely to experience a significantly lower proportion of uncoded cases. Therefore, we might expect an associated shift in casemix over the first few years of payment by results. However, the extent to which casemix changes are appropriate or due to HRG creep is difficult to determine definitively. Payment by results will provide incentives for patients to be treated in the most effective setting. Therefore, there may be a change in a hospital's casemix simply as a result of relatively easy cases being transferred to the community. However, although this would be expected to lead to a more complex casemix at an aggregate level, at the individual HRG level there would not be expected to be any change in the complexity of cases within the same procedure group. There are two ways to ensure that HRG creep is minimised. The first involves strict audit of coded data provided for reimbursement purposes. We are currently investigating the role of data audit in a system of payment by results. Authorities in the US regularly monitor changes in coding volumes and mix. For example, they look at the ratio of DRGs with complications to their sister DRGs without complications.

In this section the DH is unclear about the difference between counting creep and coding creep, however, counting creep goes against the expected

direction since the point is again emphasised that patients will be treated in the most cost effective setting which presumably also means paid at the tariff appropriate to such a setting.

Some five years later and the DH document "Options for the future of Payment by Results: 2008/09 to 2010/11" (2007) makes the following statement:

"For admitted patient care, the currencies used in England at present are healthcare resource groups version 3.5 (HRG3.5). These groups do not adequately differentiate between routine and complex work, which means that some adjustments have been made to make the tariff more fit for purpose (for example, exclusions from tariff, specialist top-ups and so on). And they were designed to reflect inpatient care so do not lend themselves to the increasing proportion of services provided elsewhere, for example in outpatients and community settings"

The DH therefore by default (and in a somewhat circular manner) assumes that only inpatient activities fall within the remit of events counted by the inpatient HRG's. This tends to give inadvertent credence to any event counted as an inpatient.

Note the acknowledged limitations of V3.5 which will be used through to 2008/09 as the basis for tariff payment (DSCN Notice: 11/2007 HRG4, April 2007).

However, both gross coding errors and the inconsistent application of NHS Data Standards do occur. Experience shows that these are often clustered in particular organisations to such an extent that they do have, from a financial perspective, a material effect on financial flows and go against the principle of value for money to which PCT's and PBC groups are committed to deliver on behalf of their population.

This document is not intended to question the validity of HRG's and PbR. Such activities are futile since it is the mandate of government to set both policy and method. It is intended to demonstrate that given the current state of affairs there is a strong case for PCT's acting in their Commissioning role to both question and change what is counted and coded as 'inpatient' in some acute trusts.

It would appear that part of the problem lies in the difference between the strategic view of the DH and the operational activities of PCT's.

From a DH perspective the direction of government policy is crystal clear. That is, to deliver all heathcare activities in their most cost effective manner and in a setting that is most appropriate to the patient.

Quote from "Response to Reforming NHS Financial Flows" (February 2003)

"If a proportion of patients currently treated in an acute setting can more cost effectively be treated in the community; then that is where they should be treated. If

Trust's are correspondingly left with the relatively more complex cases, this will be reflected in the case mix adjusted funding they receive in future years.

The reason that we have decided to pay a single tariff for both day cases and inpatients is because we want to encourage patients to be treated in the most cost-effective manner"

Hence using this logic the DH sees no inconsistency in the application of HRG's which have a common elective tariff for overnight and day case activities, i.e. in a world where everyone is aligned with the policy this should not create dilemmas.

However in the operational world of PCT Commissioning, different people do have conflicting views on what qualifies as an elective admission and indeed may imperfectly understand how a 'day case' differs from 'regular day admission' and even 'outpatient'. It is at this end of the spectrum where the PCT requires the tools to effect real alignment to the direction of policy.

Data Reliability

To demonstrate that the data underpinning PbR contains major anomalies we need look no further than the 2005/06 reference costs which form the basis of the 2007/08 tariff.

Table One: Component overnight and day case reference costs feeding into the 2007/08 national elective tariff for major surgical procedures.

HRG	Description	IP ON	IP DC
E02	Heart Transplant	£39,590	£381
D01	Lung Transplant	£33,509	£202
C60	Cochlea Implants	£18,005	£1,426
E03	Cardiac Valve Procedures	£10,612	£1,228
C54	Complex Major Mouth or Throat Procedures	£9,132	£1,212
A04	Intracranial Procedures Except Trauma - Category 4	£8,040	£947
G21	Pancreas - Complex Procedures	£7,264	£545
H83	Extracapsular Neck of Femur Fracture with Fixation w/o cc	£7,223	£228
D02	Complex Thoracic Procedures	£6,943	£861
H88	Other Neck of Femur Fracture w cc	£6,541	£587
G11	Biliary Tract - Complex Procedures	£6,435	£577
G02	Liver - Complex Procedures	£6,301	£718
F12	Stomach or Duodenum Very Major Procedures	£6,190	£793
Q02	Elective Abdominal Vascular Surgery	£6,126	£800
F61	Gastrointestinal Bleed - Very Major Procedures	£5,409	£641
G22	Pancreas - Very Major Procedures	£5,099	£544
H99	Complex Elderly with a Musculoskeletal System Dx	£4,904	£596
F02	Oesophagus - Very Major Procedures	£3,457	£436
R05	Vertebral Column Injury without Procedure >69 or w cc	£3,394	£346
J99	Complex Elderly with a Skin, Breast or Burn Dx	£3,362	£343
K17	Diabetes with Lower Limb Complications	£2,660	£264

Table One gives the component national average prices for major surgical elective inpatient overnight (IP ON) and daycase (IP DC) which are combined to give the national tariff for inpatient elective admissions.

In all cases the so-called day case price is orders of magnitude lower than the overnight price. The table demonstrates apparent ‘day case’ heart and lung transplants for less that £400 and seeming complex major procedures at 10% of the overnight price, etc. In fact, in almost all cases in this table, the procedure is too major to be performed on a day case basis.

There are clearly very major coding errors contained in the data upon which PCT’s are expected to pay acute trusts. Especially so given the fact that payment is based on a single tariff covering both overnight and ‘day case’.

At the very least PCT’s should be screening incoming data to detect instances of ‘day case’ activity in situations where only ‘overnight’ admission is possible. Ideally this is a role for SUS, however, at the moment this is not the case and PCT’s must pursue interim measures. Indeed a PCT is within their right to refuse payment for such gross errors or to at least request the correct data to be re-submitted (subject to the cut-off dates).

Note that in both Table One and Table Two the reference costs are collected at the level of ‘day case’ and ‘overnight’ but the combined elective tariff is calculated as the activity weighted average of the two, i.e. the is no separate overnight and day case tariff.

Poor Application of Data Standards

While the DH may feel that everyone in the NHS is actively moving every possible procedure to its lowest possible cost setting the very nature of the combined overnight and day case elective tariff appears to facilitate the opposite effect, i.e. a trust gains far higher financial remuneration for counting an activity as a ‘day case’ that may otherwise be an outpatient procedure.

Table Two gives a few examples of ‘non-surgical’ or ‘medical’ HRG where the so-called ‘day case’ cost is orders of magnitude lower than the elective overnight cost. By implication it is highly financially rewarding for any Trust to reclassify activities such that they can be called a ‘day case’ and hence attract the much higher level of remuneration obtained under the combined elective tariff.

It is of interest to note that for genuine surgical activities the ‘day case’ version of an elective admission is usually in the range of 70% to 110% of the cost of the overnight alternative. For genuine surgical procedures calculating a combined elective tariff using the weighted average cost does in fact achieve the DH’s stated objective since it encourages the more innovative trusts to take advantage of the differential in price and cost.

In Table Two note that the majority of so-called medical ‘day case’ costs fall very close to the cost of an outpatient attendance or that for a regular day admission. This leads us to a very important point as to whether these ‘medical’ activities are a case of genuine ‘admitted patient care’.

To do this we must clearly understand the implications of the NHS Data Definitions and the distinction between an elective inpatient admission with a class of 'day case' and other forms of non-admitted care.

Table Two: Component elective overnight and day case reference costs for 'medical' conditions feeding into the 2006/07 national elective tariff.

HRG	Description	EL ON	EL DC
H99	Complex Elderly with a Musculoskeletal System Dx	£4,904	£596
J38	Skin Ulcers	£4,111	£523
E17	Endocarditis	£4,063	£277
D42	Bronchopneumonia w cc	£3,832	£438
C36	Complex Major Head, Neck or Ear Dx >69 or w cc	£3,499	£386
D44	Inhalation Lung Injury or Foreign Body w cc	£3,446	£390
R05	Vertebral Column Injury w/oProcedure >69 or w cc	£3,394	£346
J99	Complex Elderly with a Skin, Breast or Burn Dx	£3,362	£343
D41	Unspecified Acute Lower Respiratory Infection	£3,191	£476
D16	Bronchiectasis	£3,178	£481
R99	Complex Elderly with a Spinal Primary Diagnosis	£3,148	£469
F48	Intestinal Infectious Disorders >69 or w cc	£2,976	£364
J40	Major Dermatological Conditions <70 w/o cc	£2,892	£404
M16	Non-Surgical Gynaecological Malignancy w cc	£2,886	£321
D23	Pleural Effusion w cc	£2,691	£340
D45	Inhalation Lung Injury or Foreign Body w/o cc	£2,662	£221
K17	Diabetes with Lower Limb Complications	£2,660	£264
J09	Malignant Breast Disorders >69 or w cc	£2,475	£334
D25	Respiratory Neoplasms	£2,470	£373
F99	Complex Elderly with Digestive System Dx	£2,422	£342
J43	Major Skin Tumours	£2,393	£304
J41	Major Skin Infections >69 or w cc	£2,309	£289
B33	Non Surgical Ophthalmology with los >1 day	£2,304	£309
L07	Non OR Admission for Kidney/Urinary Neoplasms >69	£2,231	£321
L09	Kidney or Urinary Tract Infections >69 or w cc	£2,151	£319
D52	Plurisy	£1,544	£228

Such a possibility is acknowledged by the DH; however, as yet the proposed solutions are not commonly available (at least to PCT's).

"Options for the future of Payment by Results: 2008/09 to 2010/11" (2007)

"A concern expressed during the piloting of the audits was that there is often ambiguity due to weaknesses in the data definitions, rather than a problem with the coding process itself. Data definitions have long been identified as problematic and there are no quick fixes, but, using the feedback from the data quality pilots, we are working with NHS Connecting for Health to see how we can tackle the most common causes of complaint. These include grey areas around 'admission' and the classification of different types of outpatient activity. We intend to publish guidance based on the conclusions of this work, as an interim measure in advance of NHS Connecting for Health's ongoing programme of work to improve data definitions"

HRG Where a Zero Day Stay is Questionable

A study of the national HES data reveals that there are around 385 HRG where admission as a zero day stay in either elective or non-elective is highly likely to be invalid or due to a gross error in coding or in recording the admission method.

This list of 385 HRG includes the following:

- the procedure is too complex to have a zero day stay
- the elective HRG describes an 'emergency' admission
- the elective HRG describes 'Regular Day Admission'
- the HRG suggests non-admitted care for a supposed 'elective'

PCT's should do their homework regarding individual acute Trusts and as many HRG as is deemed appropriate should be included in a contract as 'no payment for zero day activity'. The Trust should be given the opportunity to respond and they should indicate (with adequate explanation) which HRG they wish removed from the list. All elective 'day case' and non-elective zero day activity from these HRG will then be refused payment as a gross data error.

See Appendix One for the list of HRG. Note that a national average % day case of up to 10% can arise due to gross errors! Also note that a higher than expected national average for the proportion of zero day stay can arise due to gross data errors or the counting activities of a minority of hospitals.

The List of Services

Each Foundation Trust is obliged by Monitor to give a detailed list of services and to notify changes in this list to PCT's.

PCT's may wish to consider asking acute trusts to link their list of inpatient services to a list of corresponding HRG or to a list of HRG which are not provided.

Code of Conduct for Payment by Results

Before looking in detail at the data definitions and related issues it is useful to investigate how the equilibrium between provider and commissioner is to be maintained.

The key issue to be addressed is how ambiguity in the use of the NHS Data Definitions can be addressed via the code of conduct.

For example, Provider A counts a certain activity as a 'day case' while Provider B counts it as a 'regular day admission' while Provider C counts it as an 'outpatient' attendance. Are PCT's expected to pay two or three different prices for the same activity?

Both sections 9.7 and 9.8 of the code imply that there should be one price per activity irrespective of the ambiguities of counting.

> 9.7 make the system *fairer* and *more transparent*, through consistent fixed price payments to providers based on volume and complexity of activity; and
>
> 9.8 get the price 'right' for services, by paying a price that ensures value for money for the taxpayer and incentivises the provision of innovative, high quality patient care.

The general conduct section indicates organisations will:

> 14.7. Behave and treat each other transparently, openly and fairly
>
> 14.8. Share information with each other wherever appropriate
>
> 14.9. Work together to anticipate and resolve problems
>
> 14.10. Consult and involve each other in decisions and changes wherever appropriate

While the section on information sharing states the following:

> 18.4. Providers may implement changes to clinical coding and counting (i.e. classifications) practices in pursuit of improvements in data quality and the accuracy of transactions under PbR.
>
> 18.5. Changes to coding and counting practices will be implemented in good faith and at all times comply with national data definitions and information standards.
>
> 18.6. Providers will notify commissioners of the details of any proposed changes to coding and counting practices in advance and confirm the date from which such changes are implemented.
>
> 18.7. Any changes to coding and counting practices by individual providers shall not affect the information basis upon which contracts have been agreed or result directly in claims for additional payment, or loss of income, under PbR until the start of the next financial year.

As can be seen the code of conduct appears to shift the point of balance in favour of the provider:

1. It is ambiguous about how to deal with the situation where different providers are counting the same care in different ways. Who is right, who is wrong, who has to change the way they count and what price is the PCT obliged to pay?
2. It is ambiguous about dealing with past decisions on counting which may need changing.
3. It allows providers to make future changes by simply notifying the change to the PCT who presumably is obliged to accept these changes in good faith.

4. It provides no mechanism for the joint agreement of changes whereby the interpretation of data definitions can be put to the challenge.

The above deficiencies makes dealing with a Foundation Trust even more difficult since the Compliance Framework (April 2007) issued by Monitor states:

39. Bodies that have a statutory role in setting, inspecting or monitoring compliance with standards, but lack the powers to enforce them, include the Healthcare Commission, PCT's and patient and public involvement forums. Monitor would only expect to be involved in the resolution of issues covered by such bodies when otherr avenues of resolution had been exhausted…. Monitor does not expect to be involved in specific contractual disputes.

The suggested remedy to these deficiencies is given in the recommendations section at the start of the report.

Given the context of past history a pragmatic approach is recommended where PCT's are advised to address issues in the following context. See section 'Suggested Interim Solution' for a more complete description.

1. If the net effect of past counting decisions leads to a roughly cost neutral effect across the sum of all HRG then PCT's should concentrate on jointly agreeing if future proposed changes in counting may or may not be implemented. This desire should be clearly communicated in the 2008/09 contract.
2. If the net effect of past decisions has led to a material increase in local costs then the PCT and acute Trust should jointly address the principal HRG(s) so affected.
3. If the net effect is a lower than expected cost then the PCT may rightly infer that the direction dictated by policy and DH guidance has been implemented and that events have been moved to the lowest cost setting.

We will now look at the issue of coding and the context for the correct use of ICD and OPCS codes.

Diagnoses, Procedures and HRG

The International Classification of Diseases (ICD) is a classification of diseases and injuries intended to give a diagnosis in cases of morbidity or mortality. The 10th revision ICD-10 was released in 1996. It has detailed rules and conventions and detailed notes to support clinical coding. The detailed notes which give more detailed instances of correct application appear to be less widely used in the UK. There have been a large number of amendments and corrections made since 1996 which have not been incorporated into use in the UK. Refer to the following web document for a summary of NHS coding standards and guidelines.

www.datadictionary.nhs.uk/web_site_content/pages/codes/clinical_coding/clinical_coding_navigation.asp

The main problem is not the classification but the application of the classification. The standard of clinical coding including the recording of diagnoses within the UK is very patchy. There has been no systematic audit of coding accuracy until the Audit Commission commenced limited audits in 2006 This has been extended in 2007/08 under the PbR data assurance framework. This will cover an audit of 300 FCE per acute trust. PCT's with a significant amount of work at the Trust will be given a copy of the Audit Commission report.

Many hospitals make far higher use of the .9 code, i.e. unspecified. For example, M87.9 Osteonecrosis, unspecified instead of say M87.0 Idopathic aseptic necrosis of bone. Some hospitals also make far higher use of Chapter R codes which cover signs, symptoms and unknown causes. This is an indicator of a poor coding process, i.e. from data capture through to assigning codes.

While the coding of valid inpatient admissions is not within the scope of this report the Audit Commission data assurance framework reports should give analysis highlighting many of the above issues. PCT's are advised to give careful thought to the issue of coding creep in their contracts with those acute trusts where coding is poor.

Lastly, and of direct relevance to this report, ICD codes can be assigned to any patient such that 'non-admitted' activities can be given a valid diagnosis code. Given the potential for mis-application of the Data Standards this facilitates these patients being counted as an 'admitted' patient and it is sometimes difficult to know if the excess of a particular diagnosis is due to counting or coding.

The UK has used the 'OPCS Classification of Surgical Operations and Procedures' V4.2 from 1993/94 to 2005/06. The title was then changed by dropping the word 'surgical' and including the word 'interventions' to become the 'OPCS Classification of Interventions and Procedures' in V4.3 which commenced use in 2006/07.

Version 4.2 was specifically designed to cover 'admitted' patient care and as such was not intended to describe outpatient and A&E activities. See Appendix Two for extracts describing the context in which OPCS codes should be used for 'inpatient' care. From Version 4.3 onward the codes have been expaned to cover a much wider range of activities which is supposedly consistent with the move to HRG's which are independent of setting.

The crux of the problem is that the codes are sometimes ambiguous. Skin procedures seem to be a good example where the same procedure conducted as a genuine inpatient by a Plastic Surgeon has a different resource implication to what appears to be the same procedure code applied to the activities of a Dermatologist. The fault lies in the fact that the codes do not have subgroups to describe both the inpatient and outpatient version of the same activity. The same holds true for the inpatient and outpatient versions of laser iridotomy, nasopharingoscopy, etc.

Hence OPCS 4.4 seems to have increased rather than decreased the scope for applying procedure codes to non-admitted care activities which can then be incorrectly 'counted' in the admitted care arena[2].

The UK has been a relatively late entrant into the field of using resource groups as a means of prospective payment. As such the various inpatient HRG versions have seen progressive development and refinement. They heavily rely on the assumption of 'admitted' patient care and that all acute trusts are applying the NHS Data Standards relating to admitted care in a consistent way.

The equivalent systems in Australia and the USA appear to contain more advanced levels of discrimination to reject examples of non-admitted care attempting to masquerade as 'admitted' care and thereby attracting a higher level of payment.

One example is the code for 'removal of sutures'. Recall that this code originally existed to describe surgical procedures and as such this code should be accompanied by other surgical procedures to give a context for its use. Hence 'removal of sutures' in the absence of any other procedure codes should be regarded as an outpatient activity. By assuming that everything is a valid 'inpatient' admission the current HRG grouper does not flag this as a possible outpatient activity but simply assigns it to an inpatient cost group.

The NHS Data Definitions

Central to any system of healthcare remuneration are the data definitions and systems for review of compliance. In the UK the system of data definitions as codified in the Data Definitions Handbook was developed many years before the introduction of HRG's and PbR.

It has been assumed that the NHS Data Definitions and PbR are a compatible entity, however, the report called 'South Yorkshire Payment by Results Laboratory Project; Early Thinking – Early Learning' (July 2006) conducted on behalf of the DH in early 2005 came to the conclusion that:

"A payment system based on activity needs a "rock solid" system of activity measurement and recording….The finance and information worlds need to be brought closer together to establish a single "model of information". A national initiative on data definitions is urgently needed to provide clearer data standards….Considerably crisper and clearer definitions are required than have existed in the pre-Payment by Results environment as discussion has shown that the same term can be interpreted in different ways by different organisations or indeed by different professionals working within the same organisation….Working in combination with the other service

[2] Some 225 OPCS V4.2 codes (at the four digit level) appear to be able to code both inpatient and outpatient versions of procedures, i.e. removal of sutures, etc. This number has increased considerably with V4.3 and V4.4.

reforms, PbR represents very powerful chemistry. As such there is a need to guard against unexpected chain reactions."

An additional document emerging from this project which was aptly titled 'Warts and All' has the following comments. "*Warts and All" - The South Yorkshire Payment by Results Laboratory Project (October 2005)*

"Over the years, the financial and information world "models of information" have drifted apart**.** PbR has its roots in Reference Costs. Reference Costs has its origins in the information world "model of information" but has evolved independently: it has own language and terminology. This is perhaps best described as a dialect of information language. Financial divisions at the centre have introduced new terms, new derivations of words and meanings into this information language, which are only really understood by finance people. As a result, two national "models of information" have emerged. Collection of many items presents a major challenge – especially the further one moves away from inpatients - as the information world does not recognise many of these terms and definitions.

Neither model is thought to be currently right. Both models need to change and adapt to meet the needs of the modern 21st century health service but they need to do so together. There must be one single information model in the NHS. Moving towards a more integrated model must be a top national priority.

PbR definitions must in future be harmonised with mainstream information collections and vice versa. For PbR to stand any chance of working well, PbR definitions must be: -
• Consistent with "Connecting for Health" definitions;
• Embodied in the Data Dictionary;
• Supported by Enabling Data Set Change Notices with adequate lead in times for implementation.

This is by no means the case at present."

This was further emphasised several paragraphs later:

"Whatever new arrangements are adopted, it is essential that they are "fit for the future". It is recognised that some of the structures that have existed in the past have not been as effective as they might have been in resolving definitional issues and promoting data consistency. This is not for want of trying on the part of the many individuals working within them, who have demonstrated a very strong personal commitment to improving data quality. Previous structures have also seemed disconnected from mainstream general management. The centre needs to strike a careful balance between preserving the best of the past and making the new structures robust enough to support PbR.

The NHS needs national leadership and programmes on Data Definitions, which deliver results. The new arrangements must work; they must have "street credibility" with information professionals; they must have active support from top management at both the centre and the NHS; and they must have teeth**.**

The centre should also not underestimate the agenda it has to tackle. A radical review of the current model of information has not been undertaken for many years – it is a road along which people are reluctant to travel and the preference is to tinker at the edges. PbR is however bringing its limitations into increasingly sharper focus –

especially the further one moves away from inpatient collections. Action may not be able to be postponed for much longer."

It should be clear to any impartial observer that the Data Dictionary and PbR have evolved to the point where they can sometimes hold two fundamentally different world views.

The Data Dictionary still lacks the framework to place it at the centre of policy and the constraints placed by PbR. In its current form the Data Dictionary has no knowledge of concepts such as 'iso-resource' and the cost impact of a decision to allow a marginal situation to be counted as 'inpatient' rather than non-admitted care.

Indeed there is a strong case to be made that the Data Dictionary is capable of being used to advantage by Acute Trusts.

By this it is meant that a carefully crafted description of an activity can be constructed with the aim of using the Data Dictionary Definition to shift the apparent classification of an activity from the non-admitted care arena (i.e. ward attender, outpatients, regular day attender or even an A&E attendance) into the inpatient arena.

The following case study is a real life example of such an attempt to reclassify outpatient activities into the admitted care arena by means of the Data Dictionary. This example comes from the 'Frequently Asked Questions' section of the Connecting for Health web site[3]. The request on behalf of the acute Trust is carefully worded and elicits a response which could be interpreted as a justification for classification as 'admitted patient care'.

1. **The Request**

We currently treat children referred from their GP for the MMR vaccination where the child has a known allergy to egg which is one of the components. This involves the child being given a bed on the ward and monitored continuously for 2 to 3 hours after the vaccination to ensure no complications occur. As we are receiving more referrals for this type of activity we want to record this activity and are seeking guidance on whether it can be recorded as a day case as the patient is physically using a bed, nursing resources and is under the care of an allergy consultant.

2. **The Application of the Data Definitions**

If the bed is normally required as a result of the Patient's allergy, and a 'Decision To Admit the Patient' has been made by the allergy Consultant for the monitoring, the activity may be recorded as a day case. The NHS Data Dictionary definition of Ward Operational Plan states that *'A bed includes any device that may be used to permit a PATIENT to lie down when the need to do so is as a consequence of the Patient's condition'*.

[3] www.connectingforhealth.nhs.uk/systemsandservices/data/datamodeldictionary/help/faqs-07/day-case#5

3. The Medical Facts

The MMR vaccine is first given to children aged 12 to 15 months with a booster at 3 to 5 years.

There is a 1 in 100,000 risk of anaphylaxis among all children. Three combined studies gave only one allergic reaction in 752 cases including children with a previous convincing anaphylactic reaction to egg. (James,J.M, et al 1995; Baxter,D.N. 1996; Freigang,B et al 1994). All studies agree that administering the vaccine is justified and is relatively low risk.

Any anaphylactic reaction will normally occur within minutes but on most occasions will occur within one hour. The initial signs are swelling and itching of the area where the allergin has entered (in this case where the injection has been given). If allowed to progress these symptoms can be followed by a severe allergic reaction, respiratory difficulty and circulatory shock.

Such reactions are commonly encountered in A&E departments for persons showing allergic reactions to a wide variety of substances. The remmedy is an injection of adrenaline or epinephrine followed by antihistamines and cortisone tablets to prevent re-occurrence.

4. Suggested Application

It is obvious from the initial description and the medical facts that some form of supervision is required. However given the age of the children it is highly unlikely that they would stay on a bed for the full two to three hours stated in the request for a decision.

Note the reliance of the decision on the use of a bed. Also note that the patient is not unwell but simply requires monitoring in the possibility of an allergic reaction, i.e. per se they do not need a bed nor do they need a period of recuperation. Indeed the same service could easily be administered in an outpatient context where the patient is given the injection, sits down or plays in the outpatient area and is monitored at regular intervals by both the nurse and the parent/guardian (who will usually be an expert at monitoring for signs of an allergic reaction in their own child).

In those cases where it is required the administration of adrenaline or epinephrine could be regarded as a standard A&E attendance or simply a continuity of the outpatient visit. One assumes that the possibility of severe allergic reactions is normally catered for in any Allergy outpatient clinic given the nature of the work.

When the above description was shown to a GP they gave the following comments:

"The child does not need to be in bed or on a ward. They need to be in a place with immediate access to resuscitation facilities in the unlikely event of a significant anaphylactic response. If the child did have a significant anaphylactic response then a short term admission might be required."

The above description was also shown to representatives of the Australian Health System whose comments were as follows:

"These are normally done as outpatient presentations here. They'd be Type C's[4] and therefore not admitted. A hospital may claim that extenuating circumstances justified admission but it'd be pushing the envelope a little. Some of our specialist or major hospitals, such as the Royal Children's, I believe, have allergy clinics for these types of patients but they're run as an outpatient clinic."

Hence based on what may be termed an 'administrative or organisational' decision the same service can gain recognition as an 'inpatient' based on the seeming compliance with a Data Definition world view. This decision is in conflict with a PbR world view which primarily seeks to know if the care is roughly within the cost of an outpatient attendance or after assignment of diagnosis and procedure codes does it fall within the cost of the resulting HRG to which the 'admission' is grouped.

Indeed the decision to run this service in the manner described should have been made in consultation with the PCT. In times of competing demands upon resources it should be a joint decision whether to run a gold star service (as described in the request) or a satisfactory service that is both safe and cost effective (as per the outpatient based alternative).

In the above instance under the 07/08 HRG Tariff an outpatient Allergy attendance would be covered by local tariff and could be assumed to cost £152 under the indicative specialist services OPD tariff. The 'inpatient' version of this event would probably receive, depending on the quality of the coding process, a primary diagnosis of T784 (allergy, unspecified), T881 (other complications following immunization) or Z274 (need for MMR immunization). These would be grouped to HRG's P06 (£531), P14 (£532) or S33 (£370) respectively.

In this instance the hospital could argue that the particular event costs £250 which is far higher than the outpatient tariff and so it justifies the classification of 'inpatient'.

In this instance the concept of 'iso-resource' should be the guiding factor, namely, is the cost closer to the outpatient or the inpatient tariff. In this case the mid point between the two tariff values is (£152 + £370) ÷ 2 = £261 and hence the care lies closer to an outpatient attendance cost than to an inpatient admission.

It is for these very reasons that both the USA and Australia have seen the need to mandate which procedures are considered to be outpatient (Physician Office, Outpatient department), day case (Ambulatory Care Centre) or inpatient (Rehnquist 2003).

In Australia the decision on whether a procedure is inpatient or outpatient is based on a Commonwealth (Federal) document called the 'Day Only

[4] Australia uses a common system of classification for admitted patient care. Type C activities are most commonly non-admitted or outpatient but under exceptional circumstances could become an 'admitted patient'.

Procedures Manual'. Every procedure, inpatient or non-admitted, is given a Medicare Item Number. Each Item Number is classified as a Type A (procedures expected to be overnight admitted), Type B (admitted/inpatient procedure) or Type C (not normally admitted but may be with extenuating circumstances, such as a hemophiliac patient, etc). Anything else is considered non-admitted or outpatient.

Elective Inpatient Care

What Determines Inpatient?

From the above discussion it should be apparent that we need to get to the crux of exactly what makes an 'inpatient'.

There are two key factors:

1. A decision to admit
2. The patient needs a bed

The NHS Data Dictionary gives the following description of a decision to admit.

DECISION TO ADMIT

A record of the event that a clinical decision to admit a PATIENT to a particular Health Care Provider has been made by or on behalf of someone, who has the RIGHT OF ADMISSION. This decision denotes that the PATIENT is intended to be admitted to a hospital bed, either immediately or subsequently in the future.

The decision to admit may be as a result of a transfer of a PATIENT from a waiting list of another Health Care Provider.

The key point is that it is a 'clinical decision' made by someone who has the clinical 'right of admission' and that the person so admitted will require a hospital bed.

In essence, an inpatient is someone who is admitted to a bed due to need and not due to administrative convenience.

By the above it could be interpreted that clinical need is the key feature. Hence on this basis a PCT can question an 'admission' where the decision to admit is not medically necessary or where the decision to admit has been taken out of the hands of clinicians. This would include instances of where the hospital management has not provided the software tools (or the training) to allow anything other than an inpatient admission as a means of recording a patient contact. It would also include instances of administrative decisions to structure a service in such a way where the patient is admitted. In such instances the direction of government policy can be used to ask the question, has this service been designed to deliver care in the most cost effective way including how the contact is counted.

The definition of a bed can be found under the section of the Data Dictionary called ‘Ward Operational Plan’

This is a statement of the operational planning intent for a particular WARD, including intended time and bed availability, TREATMENT FUNCTION, BROAD PATIENT GROUP CODE and CLINICAL CARE INTENSITY.

Bed availability, in the above, is expressed as the WARD Total Beds Intended (Consultant Care, Nursing Care and Midwife Care) available for the use of PATIENTS. This should reflect the number of places available for patient care rather than just a count of physical devices that may be used as a bed.

A bed includes any device that may be used to permit a PATIENT to lie down when the need to do so is as a consequence of the PATIENT's condition rather than the need for active intervention such as examination, diagnostic investigation, manipulation/treatment, or transport. Cots should be included in statistics about beds where appropriate.

It should be noted that:

1. A couch or trolley should be considered as a bed provided it is used regularly to permit a PATIENT to lie down rather than for merely examination or transport. An example of such an arrangement is a day surgery ward furnished with trolleys
2. A PATIENT may need to use a bed, couch or trolley whilst attending for a specific short procedure taking an hour or less, such as an endoscopy. If such devices are being used only because of the active intervention and not because of the PATIENT's condition, they should NOT be counted as beds for statistical purposes
3. A PATIENT needing a lengthy procedure such as renal dialysis may use a bed or other means of support such as a couch or special chair. Whatever the device used it should be counted as a bed if used regularly for this purpose
4. Some procedures require narcosis. If this necessitates the PATIENT to lie down, the bed, couch or trolley can be counted as a hospital bed if used regularly for this purpose
5. A device specifically and solely for the purpose of delivery should not be counted as a bed if another device is normally reserved for antenatal and postnatal care. Details of the facilities available for delivery in a maternity ward should be included in a ward inventory

This description clearly states that the bed is provided because the patient needs ‘to lie down’ and this need is a consequence of the patient’s condition rather than certain types of intervention. It is at this point that much of what is called ‘day case’ for minor procedures and non-surgical conditions can be shown to lie outside of the definition of admitted patient care, i.e. if all that is required is that the patient lie down for a procedure then this does not constitute a need for a bed, i.e. point No 2 above.

There is also the assumption that the place where the patient stays in the bed is in what would commonly be recognised as a ward. The clinical care intensity for the ward is defined as:

The level of resources and intensity of care which it is intended to provide or is provided in a particular WARD.

National Codes:

For patients with mental illness
51 for intensive care: specially designated ward for patients needing containment and more intensive management. This is not to be confused with intensive nursing where a patients may require one to one nursing while on a standard ward
52 for short stay: patients intended to stay less than a year
53 for long stay: patients intended to stay a year or more

For patients with learning disabilities
61 designated or interim secure unit
62 patients intending to stay less than a year
63 patients intending to stay a year or more

For maternity patients
41 only for patients looked after by consultants
43 only for patients looked after by General Medical Practitioners
42 for joint use by consultants & General Medical Practitioners

For neonates
33 maternity: associated with the maternity ward in that cots are in the maternity ward nursery or in the ward itself
32 non-maternity: not associated with the maternity ward and without designated cots for intensive care
31 not associated with the maternity ward and in which there are some designated cots for intensive care

For the younger physically disabled
21 spinal units, only those units which are nationally recognised
22 other units

For terminally ill/palliative care
81 terminally ill/palliative care

For general patients
11 for intensive therapy, including high dependency care
12 for normal therapy: where resources permit the admission of patients who might need all but intensive or high dependency therapy
13 for limited therapy: where nursing care rather than continuous medical care is provided. Such wards can be used only for patients carefully selected and restricted to a narrow range in terms of the extent and nature of disease

Hence in cases of doubt the PCT is advised to request details of the ward operational plan and the intended intensity of care to see that these are consistent with the activities performed.

In conclusion, considerable amounts of care counted as a ‘day case’ appears to fall outside of the Data Dictionary definition of an ‘admission’ to a ‘ward’. PCT’s are therefore well within their right to insist that payment at an alternative tariff to the inpatient tariff is within the DH definition for PbR.

What is a Day Case?

The NHS Data Dictionary does not have a definition for a ‘day case’ other than they are a subset of an elective admission with patient classification of 2 = day case, i.e. admitted and discharged on the same day.

ADMITTED PATIENT ELECTIVE ADMISSIONS (DAY CASE)

This is a subset of ADMITTED PATIENT ELECTIVE ADMISSIONS of all the day case admissions within the REPORTING PERIOD. That is where the PATIENT CLASSIFICATION for the Hospital Provider Spell ACTIVITY GROUP is National Code 2 'Day case admission'.

The following are the recognised classes for admitted patient care.

Patient Classification

A coded classification of PATIENTS who have been admitted to a Hospital Provider Spell.

National Codes:

1. Ordinary admission.
A patient not admitted electively, and any patient admitted electively with the expectation that they will remain in hospital for at least one night, including a patient admitted with this intention who leaves hospital for any reason without staying overnight. A patient admitted electively with the intent of not staying overnight, but who does not return home as scheduled, should be counted as an ordinary admission

2. Day case admission.
A patient admitted electively during the course of a day with the intention of receiving care who does not require the use of a hospital bed overnight and who returns home as scheduled. If this original intention is not fulfilled and the patient stays overnight, such a patient should be counted as an ordinary admission

3. Regular day admission.
A patient admitted electively during the day, as part of a planned series of regular admissions for an on-going regime of broadly similar treatment and who is discharged the same day. If the intention is not fulfilled and one of these admissions should involve a stay of at least 24 hours, such an admission should be classified as an ordinary admission. The series of regular admissions ends when the patient no longer requires frequent admissions

4. Regular night admission.
A patient admitted electively for the night, as part of a planned series of regular admissions for an on-going regime of broadly similar treatment and who is discharged in the morning. If the intention is not fulfilled and one of these admissions should involve a stay of at least 24 hours, such an admission should be classified as an ordinary admission. The series of regular admissions ends when the patient no longer requires frequent admissions

5. Mother and baby using delivery facilities only.
Mother and baby using delivery facilities only and not using a bed in the antenatal or postnatal wards during the stay in hospital

For an elective admission having a ‘procedure’ to qualify as a day case it should fall within the Healthcare Commission definition of Day Surgery,

namely, requiring full theatre facilities. In essence these are genuine surgical inpatient admissions with a zero day length of stay.

Day surgery should ideally be carried out in separate dedicated units with their own dedicated operating theatres. But in practice, there are many alternative patterns of day surgery provision; for example:
• wards housing both day surgery and inpatients and operated upon in mixed day surgery/inpatient sessions in main theatres
• wards for day surgery patients, most of whom are operated upon in dedicated day surgery lists in main theatres
• patients admitted to a day surgery unit who may be operated upon within the unit but moved to another ward for recovery – this arrangement is particularly common for children
• dedicated day surgery theatres without associated wards (Healthcare Commission 2005)

All other elective 'procedures' labelled under the title of 'day case' should be subject to scrutiny as to whether they are outpatient procedures. Refer to the section dealing with outpatient procedures for a more detailed discussion.

Endoscopies

Upper and lower GI Endoscopies are part of a group of procedures which 15 to 20 years ago were considered to be a valid 'inpatient' admission. However they now occur in a minor procedures setting. To add to the confusion they occur both as an inpatient HRG and as an outpatient HRG. At present the inpatient HRG is typically more expensive that the outpatient equivalent.

Given the fact that the DH appears unwilling to stipulate which Tariff takes precedence then for the moment differential hospitals should be free to choose to count and bill by the inpatient or outpatient route. Strictly speaking they do not qualify as an 'inpatient' admission as they can be conducted in settings other than an acute hospital and do not occupy a bed.

The Data Dictionary has the following comment:

6. A PATIENT may need to use a bed, couch or trolley whilst attending for a specific short procedure taking an hour or less, such as an endoscopy. If such devices are being used only because of the active intervention and not because of the PATIENT's condition, they should NOT be counted as beds for statistical purposes

Regular Day Admission

The final category of elective admitted care is a regular day admission.

Table Three: OPCS procedure codes used to describe regular day admission in various hospitals servicing Berkshire residents.

OPCS	Description of Procedure	RDA	DC	%RDA
X40	Compensation for renal failure	86,582	13	100%

OPCS	Description of Procedure	RDA	DC	%RDA
X29	Continuous infusion of therapeutic substance	3,444	8,116	30%
X35	Other intravenous injection	992	1,809	35%
X36	Blood withdrawal	834	3,864	18%
X30	Injection of therapeutic substance	685	510	57%
X33	Other blood transfusion	510	5,099	9%
L91	Other vein related operations	315	946	25%
X70	Procurement of drugs for chemotherapy, band 1-5	302	257	54%
W36	Diagnostic puncture of bone	279	1,199	19%
W90	Puncture of joint	216	1,334	14%
A54	Therapeutic spinal puncture	149	245	38%
X71	Procurement of drugs for chemotherapy, band 6-10	125	102	55%
X72	Delivery of chemotherapy for neoplasm	76	116	40%
X37	Intramuscular injection	38	1,012	4%
X89	High cost immunosuppressant drugs	26	46	36%
X38	Subcutaneous injection	26	3,557	1%
S43	Removal of repair material from skin	18	84	18%
A55	Diagnostic spinal puncture	17	350	5%
M45	Diagnostic endoscopic examination of bladder	14	16,347	0%
G45	Diagnostic fibreoptic endoscopic examination of upper gastrointestinal tract	12	14,788	0%
T46	Other drainage of peritoneal cavity	11	371	3%
X90	High cost haematology and nutrition drugs	7	54	11%
H22	Diagnostic endoscopic examination of colon	7	10,325	0%
C75	Prothesis of lens	7	14,531	0%
X34	Other intravenous transfusion	6	117	5%
X59	Anaesthetic without surgery	6	427	1%
U26	Diagnostic testing of genitourinary system	5	8	38%
X39	Other route of administration of therapeutic substance	3	5	38%
W28	Other internal fixation of bone	3	985	0%
H25	Diagnostic endoscopy of lower bowel using fibreoptic sigmoidoscope	3	8,225	0%
T12	Puncture of pleura	2	60	3%
N32	Other operations on penis	2	66	3%
L99	Other threapeutic transluminal operations on vein	2	109	2%
C29	Other operations on lacrimal apparatus	2	201	1%
H23	Extirpation of lesion of lower bowel using fibreoptic sigmoidoscope	2	409	0%
T87	Excision or biopsy of lymph node	2	469	0%
H20	Endoscopic extirpation of lesion of colon	2	1,083	0%
A65	Release of entrapment of peripheral nerve at wrist	2	2,429	0%
X09	Amputation of leg	1	0	100%

The Data Dictionary defines a regular day admission as sub-category of admitted care within the patient classification section.

A patient admitted electively during the day, as part of a planned series of regular admissions for an on-going regime of broadly similar treatment and who is discharged the same day. If the intention is not fulfilled and one of these admissions should involve a stay of at least 24 hours, such an admission should be classified as an ordinary admission. The series of regular admissions ends when the patient no longer requires frequent admissions.

This definition assumes that they are an inpatient. No definition is given to what constitutes ‘frequent’. Hence a repeat procedure is probably not a

regular day admission. A suggested approach may be to look for three or more ‘day case’ admissions for the same patient in the same year.

A ‘regular day admission’ attracts a different (usually lower value) tariff to a ‘day case’ and so the distinction is of material importance.

Table Three gives details of OPCS procedure codes used to describe ‘regular day admission’ for Berkshire residents over the years 2003/04 to 2006/07.

This table shows ample evidence for confusion over the classification of ‘regular day admission’. For example, are repeat endoscopies (assuming endoscopies are an inpatient) a RDA or not?

There also appears to be widespread recording of events as a ‘day case’ which should be recorded as a ‘regular day admission’, e.g. X29, X39, X71, X72, etc.

There is also evidence that outpatient procedures are being counted as a day case, e.g. X37, X38, etc.

Lastly there are what appear to be data input or coding errors in the bottom 10 to 20 procedures in the table.

Table Four gives examples of ICD diagnoses recorded as a ‘regular day admission’ for Berkshire residents over the period 2003/04 to 2006/07.

The main conclusion from this table is that there appear to be a wide range of medical conditions which are counted as a ‘day case’ when ‘regular day admission’ or ‘regular day attendance’ would be a more suitable description.

Table Five gives a representative breakdown of the proportion of activity counted as a regular day admission (as opposed to day case) in 10 acute Trusts both from within and outside of South Central.
This table shows that the reporting of activity for patients with regular attendances is indeed in complete disarray!

Acute Trusts use between 1 and 57 procedure codes to record regular day admissions. The Trust (J) which uses 57 codes appears to have serious data quality issues since many of the codes are for procedures that would normally be day case procedures, i.e. there is a problem with the correct recording of admission method or in assigning clinical codes or both.

Table Four: ICD diagnosis codes used to describe regular day admission in various hospitals servicing Berkshire residents.

ICD	Description of Diagnosis	RDA	DC	%RDA
N18	N18 Chronic renal failure	86,903	2,281	97%
M06	M06 Other rheumatoid arthritis	981	4,530	18%
D56	D56 Thalassaemia	287	428	40%
E80	E80 Disorders of porphyrin and bilirubin metabolism	132	148	47%
D46	D46 Myelodysplastic syndromes	103	909	10%
D47	D47 Other neoplasms of uncertain or unknown behaviour	86	842	9%
Z13	Z13 Special screening examination for other diseases and disorders	77	807	9%
D69	D69 Purpura and other haemorrhagic conditions	77	581	12%
D64	D64 Other anaemias	37	1,841	2%
M32	M32 Systemic lupus erythematosus	33	75	31%
D45	D45 Polycythaemia vera	26	1,333	2%
E83	E83 Disorders of mineral metabolism	19	1,768	1%
D61	D61 Other aplastic anaemias	17	290	6%
D50	D50 Iron deficiency anaemia	17	970	2%
Z08	Z08 Follow-up examination after treatment for malignant neolasm	16	5,165	0%
Z04	Z04 Examination and observation for other reasons	14	167	8%
G35	G35 Multiple sclerosis	12	591	2%
T82	T82 Complications of cardiac & vascular prosthetic devices, implants & grafts	10	192	5%
M75	M75 Shoulder lesions	10	1,488	1%
D86	D86 Sarcoidosis	10	28	26%
D70	D70 Agranulocytosis	10	45	18%
D68	D68 Other coagulation defects	10	267	4%
B21	B21 Human immunodeficiency virus (HIV) disease resulting in neoplasms	10	4	71%
Z09	Z09 Follow-up examination after treatment for condtions other than neoplasms	9	2,094	0%
D89	D89 Other disorders involving the immune mechanism NEC	9	183	5%
Z51	Z51 Other medical care	8	1,038	1%
R18	R18 Ascites	7	240	3%
J84	J84 Other interstitial pulmonary diseases	7	52	12%
H26	H26 Other cataract	7	11,307	0%
Z12	Z12 Special screening examination for neoplasms	6	1011	1%
R59	R59 Enlarged lymph nodes	6	219	3%
D67	D67 Hereditary factor IX deficiency	6	6	50%
D59	D59 Acquired haemolytic anaemia	6	124	5%
D39	D39 Neoplasm of uncertain or unknown behaviour of female genital organs	6	10	38%
M70	M70 Soft tissue disorders related to useoveruse and press	5	116	4%
M34	M34 Systemic sclerosis	5	30	14%
M05	M05 Seropositive rheumatoid arthritis	5	130	4%

Of the full list of 115 procedures 73 (half of the total) occur at only one acute Trust and the bulk of these appear to be gross errors.

Code X40 Compensation for renal failure which should be 100% RDA in all Trusts only occurs at three Trusts. Indeed it is apparent that some trusts code the same activity using different codes to others!

Some of the procedures appear to be describing what may be minor outpatient procedures. The situation is so bad that the following recommendations could be considered.

1. PCTs should agree a list of procedures where regular day admission should be appropriate.
2. Any RDA submitted by an acute Trust for procedures outside of this list can be rejected as a gross error.
3. Trusts counting RDA activity as a DC should be asked to change their counting, i.e. those trusts which have zero RDA activity in the list.

Allowable diagnoses associated with RDA's should come from ICD codes C00 to D48 (Neoplasms) and N18 (Chronic renal failure). Code N19 (unspecified renal failure) should be rejected as poor coding. Codes B20-B24 (HIV) are an outside possibility although may be best considered as Regular Day Attender's.

Any RDA from ICD chapter A or B (viral or other infections); D50 to D89 (anemia's and diseases of blood); Chapter E (metabolic diseases) and chapter Z are probably more correctly Regular Day Attender's and the Trust should be asked to explain the exact nature of the attendance.

All other ICD codes can be rejected as gross errors.

In conclusion, PCT's are recommended to work with acute trusts to gain some measure of clarity in this area. Conditions with a mainly medical focus but currently counted as a 'day case' should be scrutinised to see if the activity is more correctly a 'regular day admission' or a 'regular day attendance'.

The next section on regular day attendance discusses an alternative approach which lies within the remit of non-admitted care.

Table Five: Proportion of <u>zero day elective</u> admissions which are reported as 'Regular Day Admission'.

If an acute Trust has no RDA activity (i.e. where the cell is blank) then it will be counting this activity mostly as a 'day case'.

Description of procedure	NHS Trust										
	A	B	C	D	E	F	G	H	I	J	Count
L91 Other vein related operations	4%	87%	50%	61%				55%	5%	95%	7
X29 Continuous infusion of therapeutic substance	1%	79%	45%	55%			2%	54%		78%	7
X33 Other blood transfusion	4%	57%	6%	9%			7%	56%		3%	7
X35 Other intravenous injection	7%	63%		47%			17%	85%		93%	6
A54 Therapeutic spinal puncture	17%	92%		30%			50%	95%			5
X36 Blood withdrawal		49%	13%	27%				28%		46%	5
X70 Procurement of drugs for chemotherapy Band 1	1%	100%	96%	88%				100%			5
W36 Diagnostic puncture of bone		66%		48%				58%		1%	4
X30 Injection of therapeutic substance		30%		17%					9%	7%	4
X71 Procurement of drugs for chemotherapy Band 6	9%	100%		89%				100%			4
X72 Delivery of complex chemotherapy for neoplasm	3%	100%		80%				100%			4
S57 Exploration of other skin of other site		4%		4%						33%	3
X40 Compensation for renal failure		100%			100%			100%			3
X59 Anaesthetic without surgery	9%	4%						4%			3
X89 Unspecified high cost immunosuppressant drugs		100%		93%						50%	3
A52 Therapeutic epidural injection			10%							5%	2
A55 Diagnostic spinal puncture		11%						21%			2
A65 Release of entrapment of peripheral nerve at wrist						6%				12%	2
A81 Other operations on sympathetic nerve			33%							18%	2
C75 Prothesis of lens						9%				1%	2
G45 Fibreoptic endoscopic examination of upper GI						4%				1%	2
H20 Endoscopic extirpation of lesion of colon						10%				1%	2
H22 Diagnostic endoscopic examination of colon						16%				1%	2
H23 Endoscopic extirpation of lesion of lower bowel						33%				2%	2
H56 Other operations on anus		2%								13%	2
L99 Percutaneous transluminal venous thrombolysis		86%		50%							2
M45 Diagnostic endoscopic examination of bladder						3%				36%	2
N28 Plastic operations on penis						100%				14%	2
S43 Removal of repair material from skin				48%						50%	2
S47 Opening of skin		7%								25%	2
S53 Introduction of substance into skin	5%	33%									2
T12 Puncture of pleura		2%		5%							2
T46 Other drainage of peritoneal cavity		15%								15%	2
U21 Magnetic resonance imaging NEC		5%						8%			2
U26 Glomerular filtration rate testing		15%						50%			2
W35 Therapeutic puncture of bone		100%						100%			2

Description of procedure	NHS Trust										
	A	B	C	D	E	F	G	H	I	J	Count
X34 Other intravenous transfusion		17%						40%			2
X37 Intramuscular injection	12%	20%									2
X38 Subcutaneous injection	6%	13%									2
X39 Oral administration of therapeutic substance		40%		75%							2
X96 Immunoglobulins band 1	7%	100%									2
A36 Other operations on cranial nerve										25%	1
A45 Other open operations on spinal cord		100%									1
A70 Neurostimulation of peripheral nerve			88%								1
A73 Other operations on peripheral nerve										9%	1
A76 Chemical destruction of sympathetic nerve										21%	1
A77 Cryotherapy to sympathetic nerve										13%	1
B28 Other excision of breast										5%	1
B32 Biopsy of breast										2%	1
C12 Wedge excision of lesion of eyelid						10%					1
C29 Other operations on lacrimal apparatus		7%									1
C33 Resection of muscle of eye		20%									1
C35 Other adjustments to muscle of eye		100%									1
C71 Extracapsular extraction of lens										13%	1
D15 Insertion ventilation tube tympanic membrane						14%					1
E36 Diagnostic endoscopic examination of larynx		9%									1
F10 Simple extraction of tooth										1%	1
G14 Endoscopic laser destruction lesion of oesophagus						33%					1
G43 Endoscopic extirpation lesion of upper GI										13%	1
G47 Intubation of stomach										2%	1
H25 Diagnostic endoscopic examination of lower bowel										1%	1
H48 Excision of lesion of anus										6%	1
H52 Destruction of haemorrhoid										17%	1
H59 Excision of pilonidal sinus										7%	1
J10 Transluminal operations on blood vessel of liver		100%									1
J12 Other therapeutic percutaneous operations on liver		100%									1
K63 Coronary arteriography NEC								8%			1
L19 Other replacement of aneurysmal segment of aorta		100%									1
L74 Arteriovenous shunt		12%									1
L85 Ligation of varicose vein of leg										5%	1
L94 Therapeutic transluminal operations on vein		33%									1
L97 Other operations on blood vessel		50%									1
M13 Percutaneous puncture of kidney		5%									1
M27 Therapeutic ureteroscopic operations on ureter										17%	1
M29 Other therapeutic endoscopic operations on ureter										5%	1
M42 Endoscopic extirpation of lesion of bladder										21%	1
M47 Urethral catheterisation of bladder										10%	1
M49 Removal of suprapubic tube from bladder								2%			1

Description of procedure	NHS Trust										
	A	B	C	D	E	F	G	H	I	J	Count
M76 Therapeutic endoscopic operations on urethra										18%	1
M77 Diagnostic endoscopic examination of urethra										20%	1
N11 Operations on hydrocele										7%	1
N17 Excision of vas deferens										2%	1
N30 Operations on prepuce										2%	1
N32 Other specified other operations on penis						20%					1
P05 Excision of vulva										8%	1
Q17 Therapeutic endoscopic operations on uterus										1%	1
S15 Unspecified other biopsy of skin				2%							1
S44 Removal of other inorganic substance from skin		4%									1
S52 Introduction of therapeutic substance into skin		5%									1
S60 Other operations on skin										40%	1
T20 Primary repair of inguinal hernia										1%	1
T52 Excision of other fascia										2%	1
T72 Other operations on sheath of tendon										4%	1
T86 Sampling of inguinal lymph nodes				14%							1
T87 Excision or biopsy of axillary lymph node				1%							1
U05 Computed tomography of head		2%									1
U08 Unspecified diagnostic imaging of abdomen								3%			1
U09 Computed tomography of pelvis		50%									1
U12 Diagnostic imaging of genitourinary system								5%			1
V48 Denervation of spinal facet joint of vertebra			5%								1
V54 Other operations on spine										9%	1
W06 Total excision of bone										3%	1
W28 Insertion of intramedullary fixation of bone						38%					1
W82 Endoscopic operations on semilunar cartilage										1%	1
W90 Puncture of joint										2%	1
X19 Correction of congenital deformity of shoulder		100%									1
X22 Correction of congenital deformity of hip		100%									1
X25 Other correction of congenital deformity of foot		67%									1
X28 Intermittent intravenous infusion		4%									1
X31 Injection of radiocontrast material		50%									1
X41 Placement of ambulatory apparatus for renal failure		33%									1
X42 Placement apparatus for renal failure		20%									1
X53 Extirpation of unspecified organ		100%									1
X73 Unspecified delivery of oral chemotherapy								50%			1
X90 Unspecified high cost haematology drugs				100%							1
Count of procedure codes used by each Trust	**13**	**54**	**9**	**21**	**1**	**13**	**4**	**22**	**2**	**57**	

Non-admitted Care

Day Care Attendance

Regular day attender's are a group of patients where both SUS and PbR guidance use confusing terminology which does not line up with the Data Dictionary[5]. Both sources appear to treat the two classes as if they were one and the same (one is an inpatient the other is non-admitted care). It would appear that both Regular Day Admissions and Regular Day Attenders are outside of the scope of PbR for 2007/08.

The class of 'Regular Day Admission' has already been discussed. The following extracts from the Data Dictionary give the relevant definitions for a day care attendance (also known as a regular day attender).

Day Care Attendance is a CARE CONTACT.

One attendance, or expected attendance, by a PATIENT at a particular Day Care Session. This will either be by a regular attender or by a PATIENT currently using a hospital bed (including Home Leave and Leave Of Absence for a period of 28 days or less).

If the PATIENT is currently subject to a Mental Health Care Spell and during attendance at the facility is in contact with the CARE PROFESSIONAL who is their allocated care programme approach care coordinator then a Face To Face Contact CPA Care Coordinator should also be recorded.

For Day Care Attendance, first attendance is the first of a series, or only attendance, at Day Care Facilities of an ORGANISATION by either a PATIENT using a hospital bed or a **regular day attender**. A re-attendance is any subsequent attendance at a Day Care Session of the same Health Care Provider by a PATIENT whose attender status has not changed since the previous attendance.

Day Care Session is a SESSION.

A Day Care Session under the control of a CARE PROFESSIONAL, run at a Day Care Facility. Sessions will generally last for half a day, an evening or a whole day.

PATIENTS participating in a Day Care Session will be recorded as Day Care Attendances.

Day Care Facility is a CLINIC OR FACILITY.

A Day Care Facility provided for the clinical treatment, assessment and maintenance of function of PATIENTS, in particular, though not exclusively, those who are elderly, mentally ill or have learning difficulties. They may be called Day Hospitals, Centres, Facilities or Units.

Day Care Facilities may be financed, planned and run solely by NHS organisations or solely by non-NHS organisations or jointly between NHS and non-NHS

[5] The NHS costing manual correctly identifies them as two separate entities; however, other guidance appears to confuse the two.

organisations. Jointly run facilities should still be managed by only one ORGANISATION.

The facilities specifically do not have hospital beds and function separately from any WARD.

Day Care Facilities are usually open during the five week days. In some places a service may be provided only once or twice a week and the service may take the form of evening or weekend Day Care Sessions.

The key point is that a day care facility provides for the clinical treatment, assessment and maintenance of function of patients in a setting which does not use a hospital inpatient bed, i.e. it may have beds and couches whose use is outside of the definition of an inpatient bed. Hence this type of treatment is most likely to apply to patients with a long term condition such as asthma, COPD, arthritis, IBS, etc where the severity of the condition can 'flare up' such that 'clinical assessment and maintenance of function' is required in a non-admitted care seting.

There is a high likelihood that much of what is currently described by the non-surgical HRG under 'day case' admission (i.e. 'day case' admissions for COPD, Asthma, etc) are in fact Regular Day Attender's.

The key point here is that the PCT is at liberty to request a review of such activities. Should they be considered to fall within the remit of a regiular day attendance then the PCT can request payment at a locally agreed price since the activity is outside the scope of PbR.

Before progressing to non-elective or emergency care we need to briefly discuss the final class of non-admitted care which is sometimes incorrectly presented as 'admitted' care.

Outpatient Attendance

The NHS Data Dictionary gives the following definition of an Out-Patient Clinic (Outpatient Clinic 2007)

Out-Patient Clinic is a CLINIC OR FACILITY.

An administrative arrangement enabling PATIENTS to see or be in contact with a CARE PROFESSIONAL at a Consultant Clinic, Nurse Clinic, Midwife Clinic, Family Planning Clinic, or at any other clinic.

Under this definition a ward, A&E facility, etc can classify as 'an administrative arrangement enabling patients to see or be in contact with a care professional'. Hence the reason that 'Ward Attenders' are regarded as an Outpatient Visit and why outpatient visits can occur at an A&E department.

The key issue here is that patients needing to be in contact with a care professional do so in the context of an 'outpatient' setting.

Outpatient Procedures

The ultimate aim of PbR is to have all similar procedures charged at the same price irrespective of setting. However it would appear that there were around 325 four digit OPCS 4.2 codes which could be used to code both an 'inpatient' and 'outpatient' version of the same procedure code. Use of the same code in an outpatient or A&E context will therefore have a different resource implication than use of the same code in a bona fide inpatient context. This list has probably expanded with the inclusion of additional OPCS 4.3 & 4.4 codes.

The Outpatient HRG's Definitions Manual 2001 (NHS Information Authority 2001) gave a useful set of outpatient procedures in its appendix section. This document was later superseded; however, the main point is that many of the procedures listed in the appendices to the Outpatient HRG's Definitions Manual are currently being (incorrectly) admitted as an inpatient 'day case'. See also DSCN 20/2000 which details outpatient procedures in Rheumatology, T&O and Surgery. These are listed in full in Appendix Three.

PCT's are advised to refer to these documents when conducting discussions with acute trusts over disputed outpatient vs. inpatient procedures. Note that the majority of procedures listed in the 'Outpatient HRG's Definitions Manual' document will have corresponding OPCS procedure code(s) and can therefore masquerade as an 'inpatient'.

For 2007/08 the following list of procedures has their own outpatient tariff. From 'Payment by Results Guidance 2007/08' (December 2006).

As can be seen all use OPCS codes (originally designed to cover inpatient surgical activities). The problem comes when a Trust seeks to bill for these items as an inpatient 'day case'. Which tariff takes precedence?

Table 2: List of outpatient procedures paid via tariff, with OPCS 4.3 codes

Procedure	OPCS 4.3 Codes
Colposcopy Hysteroscopy	P27.3, Q55.4 Q18.1,Q18.8, Q18.9
Flexible Sigmoidoscopy	H25.1, H25.9, H25.9
Rigid Sigmoidoscopy	H28.1, H28.8, H28.9
Epidural Injections (for Pain Services, specifically not to be used for Obstetrics)	A52.1, A52.2, A52.8, A52.9
Fine needle biopsy of breast	B37.1, B32.1, B32.3
Needle biopsy of prostate	M70.1, M70.2, M70.3
Laser Destruction of Lesion of Skin	S09.1, S09.2
Subcutaneous injection	X39.1, X39.2, X39.3, X39.4, X39.5, X39.6, X39.7,X39.8, X39.9

The PbR guidance for 2007/08 gives consideration to procedures conducted in an outpatient setting which are not covered by Table 2 (above) in the guidance and where the cost of these outpatient procedures is more that twice the value of the outpatient tariff for that specialty.

The detail of these exceptions is given in the following extract.

110. Where treatment is being delivered appropriately in an outpatient setting and the local cost of delivering this activity is more than twice the relevant specialty level tariff, the service can be funded at a locally negotiated rate. This is subject to the agreement of both the provider and commissioner. This will apply to outpatient procedures other than those for which there are published tariffs.

111. There may also be services that are either new or where the provider has been delivering the service in an outpatient setting. Where a provider is clearly delivering the service in a different setting compared with other providers and the local cost is more than twice the relevant specialty level tariff, the service can be funded at a locally negotiated rate. This can only happen with the explicit agreement of both provider and commissioner.

112. Should this approach be taken, the provider must record at least one diagnosis code and either an OPCS-4 procedure code or an outpatient HRG code (whichever best describes the procedure or investigation in question) in the Outpatient CDS record. This will ensure that commissioners can effectively monitor such occurrences and will help to inform both the next version of HRGs and future outpatient tariff arrangements.

PCT's should see this section as an opportunity to argue that the inpatient activity classified by Trusts as 'day case' which actually falls within the definition of an outpatient procedure can be paid at a locally agreed price.

The other alternative is to accept the proposed interim solution and use this as a simpler approach to the whole problem rather than having heated arguments over the exact definition of a whole range of activities.

Ward Attender

The NHS Data Dictionary defines a ward attender as:

Ward attenders are PATIENTS who come into a WARD to receive nursing care, but have not been admitted to hospital and do not stay in the WARD. They may need care because of diseases or injuries or other factors such as pregnancy that can affect their health. You need to record details about these PATIENTS since they use WARD resources, such as staff time and other facilities.

The 2005/06 NHS Costing Manual gives further clarification:

4.17 Ward Attenders / Ward Attendances / Regular Admissions

4.17.1 It remains important to correctly identify and cost different types of ward attenders. However, the requirement to separately identify this activity will only apply to the costing of 2004/5 data. From April 2005, this activity will be collected and recorded as outpatient activity, in line with the DSCN 32/2004.

4.17.2 The following definitions are taken from the NHS Data Dictionary, which can be found at http://www.nhsia.nhs.uk/datastandards/pages/default.asp.

Ward Attenders / Ward Attendances

Defined as "an attendance at a WARD by a patient for nursing care, where the patient is not currently admitted to that HEALTH CARE PROVIDER. If the attendance

is primarily for the purpose of examination or treatment by a Doctor, it is an OUTPATIENT ATTENDANCE (CONSULTANT) and not a WARD ATTENDANCE".

> 4.17.3 From a costing perspective, for patients attending for examination or treatment by a Doctor, this activity and the associated costs should be included and costed as outpatient activity within the relevant specialty.

It is clear from the above that most ward attendances are expected to be outpatient activity. The only (and usually rare) exception is when they pass the criteria laid out in the data dictionary to become an inpatient. Treatment delivered by a Nurse is still outpatient care but 'non-consultant'.

Emergency Care

Emergency admission has become the classic case of how the Data Standards have been by-passed by developments in policy implementation. The NHS Plan (released in July 2000) stated that 'by 2004 no-one will wait more than 4 hours in an A&E department from arrival to admission to a bed in the hospital, transfer elsewhere or discharge'.

In response the DH document 'Reforming Emergency Care' (October 2001) made wide ranging recommendations for change and in the 'Looking to the Future' section (p7) remarked:

To improve 'streaming', A&E departments could further separate services for patients with different needs.

This innocent statement appears to have opened the door for a massive increase in zero day stay 'emergency' admissions as the then Modernisation Agency interpreted this to mean that A&E activities could be 'streamed' to the point that they were no longer A&E but an emergency admission, i.e. by re-badging A&E activities as 'Assessment Units' or 'Observation Wards' the acute sector could avoid the four hour target. No thought was given to the unintended effects upon the inpatient tariff or if such a change was consistent with the Data Dictionary.

Accident & Emergency

Considerable confusion has arisen over what counts as an A&E attendance with some Acute Trusts regarding Assessment Units, Observation Wards, etc as outside the scope of A&E and hence qualifying as an inpatient emergency admission.

It would seem that prior to publication of the DH document 'A guide to Emergency Medical and Surgical Admissions' (October 2005) both DH guidance and the Data Dictionary were in agreement. This document, however, gave substance to the claim that patients can be admitted to both Medical & Surgical Assessment Units either via GP referral or by referral from A&E.

We will now look at the situation prior to October 2005 and the publication of 'A guide to Emergency Medical and Surgical Admissions'.

The NHS Data Dictionary gives the following definition of an Accident and Emergency Attendance (A&E Attendance Definition 2007) where **it is clear that all Assessment Units, Observation Wards, etc qualify as the equivalent to an A&E Department and hence activities should be reported as an A&E attendance and NOT an emergency admission.**

Accident And Emergency Attendance is a CARE CONTACT.

An individual visit by one PATIENT to an Accident And Emergency Department to receive treatment from the accident and emergency service.

Note that the accident and emergency service may be provided by staff from other MAIN SPECIALTY.

During an Accident And Emergency Attendance the PATIENT may temporarily leave the Accident And Emergency Department, e.g. for an X-ray, whilst still under the responsibility of the Accident And Emergency Department.

An Accident And Emergency Attendance may be as a result of a request from a GENERAL PRACTITIONER for help with a diagnosis or treatment.

Attendances at Out-Patient Clinic run in the Accident And Emergency Department should not be recorded as Accident And Emergency Attendance but should be recorded as Out-Patient Attendance Consultant or Clinic Attendance Non-Consultant depending upon the type of Out-Patient Clinic attended.

Any facility set up to receive and treat emergency cases is regarded as an Accident And Emergency Department for this purpose.

Accident And Emergency Attendance include both first and follow-up attendances. A follow-up attendance is any subsequent Accident And Emergency Attendance at the same Accident and Emergency Department for the same incident. All attendances for the same incident will constitute an Accident And Emergency Episode.

Each Accident And Emergency Attendance, which is a first attendance or an unplanned follow-up attendance, should be assigned an A+E STREAM.

Any patient diagnoses and interventions should be recorded using the A & E specific codes, see ACCIDENT AND EMERGENCY DIAGNOSIS, ACCIDENT AND EMERGENCY INVESTIGATION and ACCIDENT AND EMERGENCY TREATMENT.

For each Accident And Emergency Attendance the following times should be recorded: ARRIVAL TIME, A+E INITIAL ASSESSMENT TIME (first attendances and unplanned follow-up attendances), A+E TIME SEEN FOR TREATMENT, A+E ATTENDANCE CONCLUSION TIME and A+E DEPARTURE TIME.

For first attendances and unplanned follow-up attendances the A+E INITIAL ASSESSMENT TRIAGE CATEGORY and A+E STREAM need to be recorded.

The Data dictionary gives further clarification under the heading of 'Patient Classification' where it states that a non-elective admission applies to:

'a patient not admitted electively with the expectation that they will remain in hospital for at least one night'

It is clear from all of the above that the bulk of zero day stay 'emergency' admissions fell within the category of an A&E attendance.

While it did become apparent that there were valid clinical exceptions to the four hour target these were clearly spelt out in the document 'Clinical Exceptions to the 4 hour emergency care target' (December 2003). See Appendix Four for the full text.

This document states the following:

However, if patients have to spend a longer period being assessed then they should, if clinically appropriate, be accommodated in the emergency department clinical decision unit/observation facility where they should have a planned and productive period of clinical care.

The standard expected for all patients who are not clinical exceptions, including all patients with less serious injuries or illness, remains that set out in the NHS Plan. Breaches of the target should become increasingly rare as, for example, more appropriate use is made of good quality clinical decision units or observation units.

Note that the clinical decision unit/observation facility is clearly stated as being a part of the A&E department and hence the second paragraph does not mean that admitting the patient into the clinical decision unit is a valid option since they are still part of an A&E attendance which is subject to the particular exceptions to the four hour rule.

The following excerpt comes from the DH document DH_405077 'Reforming Emergency Care: Practical Steps' which appears to have been published in late 2003:

In hospitals, four kinds of service will be available to meet the needs of the four broad groups of patients attending or being referred to A&E departments. These four categories or streams are:

- Patients who require immediate resuscitation and those with major illness.
- Patients with less urgent, but potentially serious medical or surgical problems, who require detailed assessment before a firm decision can be made about their clinical management.
- Patients with moderate illness or minor injuries but who are unlikely to require admission to hospital.
- Patients with "primary care problems" – namely the range of conditions for which patients would typically visit their GP practice.

These streams of patients will be handled in different ways with staff and resources specifically dedicated to each stream. Children will receive care in part of the A&E department, which is separate from the main department and will effectively form their own stream; the resuscitation room will have a designated paediatric area. How each local emergency care system or network delivers this approach will vary according to local circumstances, but their response will need to include:

- Senior clinicians involved in the assessment of patients at an early stage. Accident and Emergency consultants will continue to fill this role, but there will be opportunities for joint working with specialists in general medicine, critical care and other branches of medicine. There is also the potential to bring together A&E observations areas and medical and surgical assessment units, and to identify who can be directed immediately to specialised units without delay in emergency departments.

For the patient, these streams within emergency care will bring an end to the need to wait in each part of the system. Patients in A&E with moderate and minor conditions will be seen by the group of staff dedicated to their stream of care who will not be diverted to attend to major cases which may arise. Effective integration between the different parts of the service will also improve the quality of care as patients pass from one part to the next.

The above indicates that up to the end of 2003 the 'medical assessment unit', 'paediatric assessment unit', 'surgical assessment unit', etc were all considered by the DH to be part of the extended A&E stream devoted to particular patients, i.e. patients sent to these units were not considered as an 'emergency admission' for the simple reason that their assessment has not been completed.

It would appear that at some point in late 2003 to early 2004 the Modernisation Agency began recommending the use of 'Assessment Units' as a way of achieving the four hour target. Interestingly the dramatic improvement in the percentage of patients achieving the four hour target seen from Q4 of 2003/04 onward correlates with the increase in volume of zero day stay emergency admissions. In some cases the remedies outlines in 'Transforming Emergency Care in England' (October 2004) and the undated document 'The Emergency Department: Medicine and Surgery Interface Problems and Solutions' (DH_4093157) were only been partially implemented and it was easier to admit patient via such short stay units.

The Modernisation Agency proposals were then codified by the pathway recommended in 'A guide to Emergency medical & Surgical Admissions' (October 2005). This document appears to give substance to an additional type of admission not covered by PbR or the Data Dictionary, that is, the short stay emergency admission. This document only reflected developing practice in emergency care which had been accelerated by the Modernisation Agency input. However, it gave the DH seal of approval that these were admissions in their own right.

The range of patients covered by the document outlining the 'Clinical exceptions to the four hour target' appear to be located in what are called 'Clinical Decision Units' which are said in 'A guide to emergency medical and surgical admissions' to be managed by the Emergency Department, i.e. they remain within the remit of A&E and should not be treated as a short stay emergency admission. PCT's should therefore refuse payment for any such activity reported as an 'emergency admission'.

The response of the PbR team was to attempt to modify the tariff to incorporate short stay emergency 'admissions', i.e. the sheer volume of short stay patients was leading to a significant distortion in a tariff which was originally intended to cover non-zero day stay emergency care.

At this point we need to take a very pragmatic approach. We are in a transition period where assessment units are growing in popularity as part of the wider view of the 'Emergency Department'. However, the important point

is that not all hospitals have a full range of Assessment Units, that 'admission' to such units is not to a uniform standard and that some hospitals still continue to treat such patients as an A&E attendance.

In such a confused situation a PCT is well within its remit to insist that it will not pay the inpatient tariff for the volume of zero day stays which are in excess to the national average for each HRG. Hence in 07/08 against the average for 05/06 and in 08/09 against the average for 06/07.

The DH and PbR in particular now have to modify the tariff and in the following quote we have details of the necessary interim measures until the situation can be sorted out. From the section dealing with emergency admissions in Annex B of Options for the Future of Payment by Results: 2008/09 to 2010/11 (2007).

Emergency admissions

B.18 The differential tariff applied to emergency admissions above and below the set threshold was introduced as an interim measure to share risk between commissioners and providers in a period of rapid growth in short-stay emergency admissions. As the transition period of PbR ends in 2007/08, it is appropriate to review this arrangement. We propose that, from 1 April 2008, commissioners will be able to choose from one of two options:

A. remaining in the current arrangement, where risk is shared equally at 50% between the commissioner and the provider, or

B. permanently withdrawing the differential tariff so that variations in activity are adjusted at 100% tariff.

B.19 To avoid doubt, we do not propose that a commissioner would be able to unilaterally decide to switch in and out of the differential tariff arrangement in order to manage financial risk. Moreover, commissioners would need to provide sufficient notice of the proposed change in line with the Code of Conduct and the terms of their contracts.

Paying for very short stays e.g. in observation/assessment or similar units

B.20 Many A&E departments have established observation units in which to assess patients for referral or discharge. The majority of patients should not be in an observation unit for longer than 12 hours and will be receiving quite different care from a patient admitted for a rapid intervention or procedure.

B.21 However, the current short stay adjustment to the tariff is designed to meet the costs of longer stays of up to 48 hours. As a result, the tariff does not reflect best practice and means the commissioner is not receiving value for money from the service.

B.22 We will look at options for overcoming this issue, including the definitional problems around admission, possibly including data collection of time stamps for admissions and discharges and using this to determine costs and price paid. We will look at this and other options in 2007/08 but the earliest a specific tariff could be introduced for very short stays is 2009/10.

B.23 We would be interested to know if any health economies have already begun to develop local strategies for dealing with this issue.

At no point does this excerpt refer to the Data Definitions (which appear to be in urgent need of modification) and there is no clarity about whether the category of short stay patients refers to the 'clinical exceptions' identified by the DH December 2003 document or to the wider definition in 'A guide to emergency medical and surgical admissions'.

The Data Definitions must be placed within the context of PbR such that the two forms a single entity rather than the DH issuing conflicting messages as policy and practice develop over time.

A&E Attendance Followed by Admission

The Payment by Results Guidance 2007/08 (December 2006) is clear that any admission subsequent to an A&E attendance will attract both the A&E attendance cost and the cost of the inpatient admission.

> 29. A&E attendances are reimbursed at the same rate regardless of whether a patient is subsequently admitted. The additional costs of those A&E attendances that lead to an admission have been added to the admitted patient care non-elective HRG tariff in proportion to the numbers of patients admitted through A&E. Patients who have died, or were admitted, are identified by the odd numbered V codes. Patients admitted through A&E should be reimbursed both for the A&E attendance and the relevant admitted patient HRG tariff.

DH guidance always assumes that counting is fair and as such PCT's which suspect that a Trust is admitting patients to avoid four hour breaches are at liberty to withhold payment for the suspect activity pending independent review of the management of patient flows within A&E.

The Emergency Short Stay Tariff

The emergency short stay tariff was introduced as a result of the rapid growth in short stays arising from the increasing use of assessment units and observation wards. It has undergone various modifications over time and for 2007/08 applies different proportions depending on the average LOS for the HRG. See extract from Payment by Results Guidance 2007/08 (December 2006).

As can be seen from the table the short stay tariff assumes that short stay patients will stay for an average of 24 hours.

The short stay tariff still seems to be out of line with the actual cost incurred for the majority of short stay patients who only stay less than 12 hours.

Once again we come back to our central argument that DH guidance assumes national average behaviour and the recommended interim solution

given in this report remains a valid way of correcting for gross examples of divergent counting practice.

Short stay emergency tariff

54. Short stay emergency tariff cases apply to certain HRGs where actual length of stay is less than two days.

55. The level of reduction depends on the national average length of stay of the HRG as follows:

Table 6: Level of reduction applied to tariff

HRGs with average length of stay	Short stay tariff (% of tariff applied)
0-1	100% - ie. full tariff applies
2 days	50%
3-4 days	35%
5 or more days	20%

56. Details of this at HRG level are provided with the 2007/08 national tariff.

57. The short stay tariff applies when;

- the emergency admission has admission code 21-24 or 28
- the assignment of the HRG is based on diagnosis rather than procedure code.
- the spell is not for a child (aged <17 on date of admission)

58. If these criteria are met then the short stay tariff applies regardless of whether the patient is admitted under a medical or a surgical specialty. The reduction applies to all elements of the tariff including specialised top-ups.

PCT's should also be aware that the 2005/06 reference costs (applicable to 2007/08 tariff) do contain indicative HRG specific tariffs for activities conducted in medical and surgical assessment units. 2005/06 was the first year that this data was collected and as a result some of the indicative prices are surprisingly high; however, on the whole prices should be compared with the short stay tariff to get a basis for reasonable comparison.

Emergency Readmissions

The 2007/08 tariff guidance gives PCT's the right to negotiate adjustments to the total cost for the volume of emergency readmissions which are higher than an expected level.

107. PCTs and providers should agree as part of SLA discussions what level of emergency readmissions are to be expected in the coming year. This estimate will take account of the specific services noted above and any other local services where open access arrangements are a feature. Historical levels of readmissions should be reviewed along with the reasons for the existing levels. Any emergency readmissions above this locally agreed rate can be considered for adjustments to the level of reimbursement by PCTs at year end.

Once again a national average approach is strongly recommended as the starting point for discussion.

Maternity

There has been considerable inconsistency in the application of the clinical codes to the events involved in pregnancy and child birth. In particular what qualifies as a valid HRG N12 and to which babies is it valid to apply codes for minor or major diagnoses (HRG N02 to N05), i.e. what is the definition of a well baby and what range of minor conditions are acceptable for a well baby to have before they are regarded as a separate admission in their own right?

The following is a copy the section dealing with maternity services Annex B - Options for the Future of Payment by Results: 2008/09 to 2010/11 (2007)

B.53 At present, the tariff covers most types of deliveries and outpatient clinics. Community midwifery in people's own homes, home deliveries and clinics for which a consultant is not clinically responsible are not presently in scope.

B.54 *Our health, our care, our say* committed us to ensuring that PbR supports the choices women make during pregnancy. Bringing current exclusions within scope would ensure that maternity services are rewarded based on activity and encourage more home births and community midwifery activity.

B.55 We have already signalled our intention to bring non-consultant clinics within scope of outpatient commissioning datasets and from October 2007 activity data from midwife-led clinics will be included. This means that from 2008/09 all midwife-led clinics can be recognised in the outpatient dataset, whether held in hospitals, children's centres, GP premises or elsewhere. This is important because it enables national currencies to be applied to attendances at midwife-led clinics. Furthermore, standardised data on midwife-led activity will enable more accurate costing and comparative analysis at national level and this is essential to determine an appropriate tariff for this activity.

B.56 In 2008/09, we expect that national currencies will be applied to midwife-led clinics, with funding agreed locally. In line with the principles established by the PbR Code of Conduct we do not propose to mandate application of the obstetrics outpatients tariff to midwife-led clinics until 2009/10 (i.e. at least 12 months after implementing the change to counting practices), although there will be a final decision on this in summer 2008.

B.57 Given our commitment to paying a tariff based on activity not setting, it is anomalous that home births do not have a national price and so we intend to introduce one from 2008/09. Before this, we will test out whether the same prices can, or should, apply for home birth as for hospital-based birth. This is because although the event is the same, the resource use varies with setting.

Local innovation

South Devon has already implemented a system for funding home deliveries based on a local price for activity – a system they are calling 'PbR plus'.

Regarding so-called admissions to HRG N12 the data definition for a 'ward attendance' includes the words:

'They may need care because of diseases or injuries or other factors such as pregnancy that can affect their health.'

It could therefore be argued that the bulk of N12 can be questioned by a PCT. Regarding 'well babies', PCT's are advised to assume that a baby is a 'well baby'; until it is admitted to a specialist ward.

Renal Medicine

Renal medicine is currently covered by local agreements and is moving toward a national tariff. Part of the problem is consistency of counting with some hospitals counting the multiple attendances as outpatient, regular day admissions or day case.

The correct classification is most definitly 'regular day admission' since the Data Dictionary makes the following statement under the definition of a bed:

7. A PATIENT needing a lengthy procedure such as renal dialysis may use a bed or other means of support such as a couch or special chair. Whatever the device used it should be counted as a bed if used regularly for this purpose

DSCN No: 21/2007 gives details of the additional information reqired to support the national renal data set, however, it is useful to have clarity over the admission type.

The National Renal Dataset defines the information required to support the implementation of the National Service Framework for Renal Services:

1 Part 1 Dialysis & Transplantation (Department of Health, January 2004)
2 Part 2 Chronic Kidney Disease, Acute Renal Failure and End of Life Care (DH February 2005)
3 Renal Services Information Strategy (DH June 2005) which specified national action under the heading of Information for Secondary Purposes, including the National Secondary Uses Service (SUS) and the National Renal Dataset (National Actions 3.1 and 3.2).

Commissioning Using HRG

Reforming NHS Financial Flows Annex One states the following:

Furthermore, this system will avoid the transaction costs of the internal market. Firstly, every PCT and Trust will not be negotiating prices. Secondly, the system will **not** require line by line commissioning at an individual level for every HRG. HRG's are will be used as a mechanism for adjusting more aggregate cost-and-volume contracts for case mix. Only in certain key priority areas will more detailed agreements be made. The simultaneous development and implementation of the NHS IT strategy with new technologies like electronic patient record and booking systems will also reduce transaction costs.

It would seem that commissioners are now in a position of almost having to scrutinise every HRG line given the ambiguity in the application of the data standards. It is for this reason that the pragmatic solution suggested in this report is offered as a viable alternative to getting bogged down in the detail.

References

Rehnquist, J. Payment for Procedures in Outpatient Departments and Ambulatory Surgical Centers. Office of Inspector General. Department of Health and Human Services, USA. JANUARY 2003, OEI-05-00-00340

Baxter,D.N. 1996 Measles immunisation in children with a history of egg allergy. Vaccine, 14(2), 131-134

James,J.M. et al. 1995. Safe administration of measles vaccine to children allergic to eggs. New England J. Med, 332(19), 1262-1266

Freigang,B. et al. 1994. Lack of adverse reactions to measles, mumps and rubella vaccine in egg-allergic children. Ann. Allergy, 73(6), 486-488.

A&E Attendance Definition 2007
http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/a/accident_and_emergency_attendance.asp?shownav=1

Outpatient Clinic 2007
http://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/o/out_h_patient_clinic.asp?shownav=1

Healthcare Commission 2005. Acute Hospital Portfolio. Day Surgery. July 2005 ISBN 1-84562-043-7

Office of Population Censuses and Surveys (1990) Tabular list of the classification of surgical operations and procedures. Fourth Revision, London HMSO. ISBN 0-11-691295-2

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