GETTING THE BEST FROM HOSPITAL PATIENT INFORMATION

Dr Rod Jones (ACMA, CGMA)

Statistical Advisor

Healthcare Analysis & Forecasting

Camberley, Surrey

hcaf_rod@yahoo.co.uk

For further reports, discussion documents and published papers please go to:

http://www.hcaf.biz

TABLE OF CONTENTS

1. Introduction

2. Outpatient Information

3. GP Referral Processes
3.1. Referrals other than by a GP
3.2. Patient not ours/transferred out
3.3. Temporary residents
3.4. No record of referral
3.5. The national GP file

4. The Outpatient Visit
4.1. Overlap between acute and community
4.2. Outpatient attendance or test?
4.3. Joint consultant clinics
4.4. Treatments similar to inpatient procedure
4.5. DNA and cancelled appointments
4.6. Deceased patients
4.7. Private patients
4.8. Babies

5. Confirming The Attendance
5.1. Consultant letter vs minimum data set
5.2. Data input errors
5.3. Attendance classification
5.3.1. Casualty clinics
5.3.2. Ward attenders
5.4. In/Out of PCG's

6. Unexpected Referral Outcomes
6.1. Patient admitted direct from clinic
6.2. Patient by-passes outpatient appointment
6.3. Direct referral to inpatient waiting lists

7. Inpatient Information
7.1. The discharge summary
7.2. Use of fund report 12

8. Fundholder Training

9. Mutual Problem Solving

10. Conclusions

Appendix One: Information Transfer Supporting PCG's

Appendix Two: Paperless Information Flows

Appendix Three: Key Outpatient and A&E Definitions

Appendix Four: Example of Outpatient Clinic details and PCG's status

Appendix Five: Guidelines For Discharge Forms

Appendix Six: Guidelines for Outpatient Information

Appendix Seven: Examples of Documentation for Patients, GPs & Medical Secretaries

© Dr Rodney Jones, Healthcare Analysis and Forecasting, 1996

1. Introduction

This workbook seeks to highlight the major problem areas in both inpatient and outpatient information flows and to suggest how to make the task more manageable.

2. Outpatient Attendances

While inpatient stays represent the greatest proportion of a hospital budget it is the management of outpatient & related appointments which represents the greatest challenge by virtue of sheer volume (over 90% of all patient contacts) and complexity (a typical hospital having up to 20 specialties and over 100 sub-specialties).

Tables one lists the most common queries raised by GP's and this will be a good indication of where most effort will be required both in terms of dealing with the problems and in resolving their root causes.

Table One: Typical GP outpatient attendance queries

Category	Percent of Queries
Apparent Duplicate	1%
Private Patient	1%
Temporary Resident	2%
Attendance was not DNA	4%
Other (date, clinic, etc)	9%
Attendance not recorded by hospital	23%
Not our patient, i.e. patient has moved or incorrectly allocated to wrong GP	23%
No clinical letter to back attendance	28%

The following sections are designed to highlight the root causes behind these errors and/or omissions and to present strategies for their resolution.

© Dr Rodney Jones, Healthcare Analysis and Forecasting, 1996

3. GP Referral Processes

The GP referral process is the first step to the success or otherwise of many of the ensuing information transactions.

Key to success is the integration of the medical and administrative processes within a practice such that there is minimal time delay in the internal transfer of information and in the dispatch of the referral letter. A study of the time delay between the date on the referral letter and the date on which the letter is first opened within a hospital shows that 5% of letters are received over five working days after the patient has seen the GP, i.e. potentially up to nine week days after the appointment.

Less appreciated is the fact that around 20% of these letters contain one or more omissions of essential information, i.e. previous surname or address (if recently changed), correct DOB, home address and registered GP for temporary residents, overseas address and telephone number for overseas visitors, etc. These errors/omissions lead to further errors and time delays which are potentially preventable. An effective referral process is therefore fundamental and helps to ensure that patient communication is correct and timely.

3.1. Referrals other than by a GP

Since 2001/02 all referrals from the practice primary health care team are grouped into PCG's. This has removed some of the confusion from previous years, however, unless all referrals are via a fully documented letter (processed within the PCG's system) using practice headed paper then confusion will be the inevitable consequence.

In addition to referrals from members of the primary health care team there are numerous other referral routes. These routes and their associated problem areas are given in Table 2.

Certain specialties are multidisciplinary and hence require a broader approach. Areas of particular difficulty are Ophthalmology/Orthoptics and Oral Surgery/Orthodontics.

Referrals to Opthalmology/Orthoptics come from either the GP or Optician. An Optician referral to Orthoptics can lead to a cross-referral to Ophthalmology. Hospitals do not as yet have access to a national file of Opticians and so the attendance is most likely to be incorrectly linked to the patient's GP.

Referrals to Oral Surgery/Orthodontics come usually from a Dentist but sometimes from a GP but the attendance may be incorrectly linked to the GP rather than the dentist. A Dentist referral to Orthodontics may lead to a cross-referral to Oral Surgery. A national file of Dental practitioners became available in 1995 (although as yet not widely used).

© Dr Rodney Jones, Healthcare Analysis and Forecasting, 1996

Table Two: Sources of referrals and proposed solutions to some of the problem areas.

Source of Referral	Problems	Solutions
Consultant cross-referral	Letter not copied to GP	Letter to be sent to GP
Tertiary referrals	Letter or PU1 form not sent to GP	Letter or PU1 form to be sent.
Referral commenced when patient was with previous GP	Patients notes may take months to arrive from previous GP. Patient seen before new registration.	GP to ask FHSA to expedite notes and registration. National rules are now in place.
Referral by other GP	Occurs for temporary residents and others with multiple residences. Documentation may never reach the registered GP	Patient to be given copies of all documentation. Referring GP to take responsibility for specifying registered GP on referral letter.
Telephone referral	Occurs in urgent cases. GP may forget to keep an internal record.	Written referral to be sent to provider marked 'Confirmation of telephone request'.
School Medicine	GP may not be informed.	Relay reasons to GP
Physiotherapist	GP may not be informed.	Relay reasons to GP
Dentist (to Oral Surgery or Orthodontics)	GP may not receive a copy of the letter, cross-referral between Oral Surgery and Orthodontics may occur.	Dentist to send copy of referral to GP or refer patient to GP. Consultant letters to indicate 'referred by'.
Optician (to Orthoptics or Ophthalmology)	GP may not receive copy of referral, cross-referral between Orthoptics/Ophthalmology may occur.	Optician to send copy to GP or refer patient to GP for referral.
Community visits by consultants (also domicillary visits)	Mainly in Paediatrics, Elderly Care and Renal Medicine. Consultant letter may not be sent to GP	Consultant to document all community visits with letter to GP
Community Nursing (also domicillary visits)	GP may not be informed of referral	GP to receive copy of all correspondence.
Letters in response to a community or domicillary visit.	Most likely that an m.d.s. will be absent.	Consultant letter to indicate community or domicillary visit and referrals arising.
Incorrect letterhead (mostly for consultants with multiple clinic types)	Confusion over non-receipt of an m.d.s. for those clinics which are out of PCG's.	Individual letterheads to be used with an indication of In/Out of PCG's

© Dr Rodney Jones, Healthcare Analysis and Forecasting, 1996

3.2. Patient not ours/transferred out

Transfers in and out of a district range from 3 to 14% of the registered population (6% being the national median value). A further 5% change their address but not their GP. This combined percentage is so high that the task of keeping track of the address and registered GP is a key operational requirement. For instance, an appointment can be made before a patient moves and although asked if they have moved the patient may not give the new address and GP. This is compounded by the fact that not all hospital systems (i.e. radiology, pathology. PAMS, etc) are linked to a common patient index.

Experience of patient details queried as either 'not our patient' or 'transferred out' shows that in 30% of the occurrences there is no record on the FHSA data base (i.e. the transaction has not been processed, incorrectly processed, or the patient does not live within the boundary of the FHSA).

If there is any doubt as to the most recent details please contact ……..

3.3. Temporary Residents

If 'Temporary Resident' is not clearly marked on the referral letter then it is the responsibility of the practice to pay for the treatment (as an ECR). Even when told that a person is a 'Temporary Resident' it is often an impossible task to find the real address and registered GP. Hospitals can furnish numerous examples of so-called 'temporary residents' living in almost every country of the world.

In reality these are 'Overseas Visitors' for whom special rules apply. Failure to inform a hospital of the fact that a patient is an 'Overseas Visitor' will mean that they will lose rightful income (usually via the Department of Health) and will therefore carry the cost of any patient treatment out of the allocated mobneys for local residents.

.

One solution is for the GP to attach a copy of the Temporary Resident Form to the referral letter, however, these forms were designed before the introduction of contracting and contain insufficient detail. Re-design of these forms by the FHSA is required.

There is also a proportion of people who for various reasons wish to remain 'anonymous'. A further proportion will be ignorant of the implications of contracting and will give different addresses and GP's when living in different places (i.e. students, people with two homes, etc).

In some overseas countries there is no surname and so the patient can give different 'names' to the hospital and the GP. Likewise women who marry or re-marry may well not see the need to update their previous surname with a GP and/or hospital. Patients may also feel that to disclose a change of address may jeopardise the continuity of their treatment.

© Dr Rodney Jones, Healthcare Analysis and Forecasting, 1996

The last situation is where a patient has moved but still remains registered with their old GP up to the point where they decide to register with a new GP. They may have on-going care and attend hospital appointments. The new address may be on the m.d.s. and as it will not match the details on the PCG's system the PCG then responds with - 'not our patient'.

3.4. No record of referral

There are many routes to an outpatient appointment (see Table seven) and in many instances the GP is not always informed.

This raises the issue of the 'self referred' patient. One instance may be a patient verbally told by their GP to visit a chiropodist/dietician who then arrives at a provider with no referral letter but insisting that their GP told them to come. Although the ruling is clear, i.e. no letter no liability to pay, the outworking is not always so transparent.

Patients with on-going care (i.e. diabetes, cardiology, congenital orthopaedic problems, etc) do create problems especially when the initial referral was at some point in the past. Since 94/95 referrals from every member of the primary health care team are in PCG's and as such should be sent in conformance to the national standards expected of a referral letter. Urgent telephone referrals should also be followed up by a referral letter clearly stating that it is in confirmation of a telephone request.

3.5. The national GP file

This is the file from which all hospital computer systems obtain their base details. Table six presents the major limitations and their consequences. These deficiencies are not the fault of the provider or the GP and there is very little that can be done except to keep raising these issues with those who distribute this file.

Table three has been included to alert PCG's to the root cause of apparent inability on the part of your provider to get your details correct - the truth is it is not their problem as they are left to struggle with the deficiencies inherited from use of the national GP file.

© Dr Rodney Jones, Healthcare Analysis and Forecasting, 1996

Table Three: Limitations of the national GP file and the consequences arising from these limitations/errors.

Deficiency	Consequences	Solutions
Nominally updated every quarter (but not at regular times)	Amended GP details must often be added as GP unknown - m.d.s. is therefore not sent.	Regular Monthly update discs.
New Fundholder contract codes do not arrive until after May.	Activity assigned to DHA contract, details have to be amended.	Provisional codes to be provided in advance.
No provision for GP's to operate from more than one practice. Main practice listed.	GP details are not recognised and must often be entered as GP unknown - m.d.s. is therefore not sent.	Provision for multiple surgery locations.
Inconsistent address details, i.e. surgery name is often omitted.	Different practices can operate from the same address. Confusion and m.d.s. sent to wrong contract.	Surgery name to be given along with full address.
Old and new address remain for GP's who change practice.	Wrong practice can be selected. Patients from the previous address may still give the name of the GP who has left.	Flag previous practice. Automatic check against date left field. GP and patient postcode cross-matched.
No link between old and new address for practices who change name or address.	Details sent to a redundant address.	Automatic re-routing to current address or name.
Incorrect GP details, i.e. initials or surname.	Wrong GP can be selected or GP cannot be located.	Better Q.A. of file. First name of GP a possibility.
Incorrect fundholder or practice codes.	Old practice and contract code against new practice code.	Better Q.A. of the file.
Change of Surname	Both names on the file.	Flag and a link to the new name.
Hyphenated names	National file has difficulty with hyphenated names. Doctor listed under either part of their name.	Allow for hyphenated names but cross-match individual parts to the full name.
Identical surname and initial(s)	Dr Smith, Dr Jones or Dr Patel - which?	Require the ability to define a local version of the national file
Retired/Deceased GP's	Details remain on file.	A flag and link to the replacement GP. Names culled from the file after 2 years.
Trainee GP's, Locums, Retainers and Assistants	Not listed on National GP file	Provision for local updating to allow for these exceptions.

© Dr Rodney Jones, Healthcare Analysis and Forecasting, 1996

4. The Outpatient Visit

After the initial referral comes a first and sometimes ensuing follow-up attendances. What information problems may we expect here?

4.1. Overlap between acute and community

This occurs where a Community Trust runs a series of community hospitals and pay for the services of consultants from a hospital. The activity (and responsibility for correct information) rest with Community Trust but the consultant letter may be go out on a letterhead of the acute hospital. PCG's may not have been informed as to who is responsible for recording the attendance.

A reverse situation can also apply where the acute hospital pays for clinic space at a community hospital. In this case the activity are the responsibility of the acute hospital. The transfer of administrative details between the two sites is often a weak point. The responsibility for the transfer of administrative details needs to be clearly defined. Transfer of administrative details can also be a weak point in the case of outreach clinics conducted at a GP practice and responsibilities must therefore be clearly defined.

4.2. Outpatient attendance or test?

Confusion can arise when a consultant letter indicates that a 'test' or diagnostic procedure is required. Often the test will be done on the spot, sometimes as a ward attender or even as an inpatient/daycase. Entries onto the PCG's system may therefore be made which are for non-outpatient 'tests' or that are bundled into the outpatient price.

Consultant letters can also arrive upon receipt of a test result even when the patient has not made a further attendance. This can lead to the incorrect expectation of an outpatient appointment. There do not seem to be simple solutions to these problems as this would require each consultant firm to have a full knowledge of the complexities of PCG's.

4.3. Joint consultant clinics

Usually conducted where a patient has some form of cancer or is a diabetic. Joint (oncology, radiology, haematology) clinics can be held in ENT, Urology, Oral Surgery, Paediatrics, Breast, etc, while joint diabetic clinics can be held in ophthalmology, ante natal and paediatric settings.

You will need to clarify with your provider the status of such clinics and which consultant writes the letter. There also appear to be different splits between In/Out of PCG's, i.e. the joint breast/oncology clinic may be In while the joint ENT/radiotherapy is Out, etc.

© Dr Rodney Jones, Healthcare Analysis and Forecasting, 1996

The national guidelines for the patient m.d.s allows for shared care consultants but not all computer systems are able to achieve this objective.

4.4. Treatments similar to inpatient procedure

Given below are three instances in this category but there are probably others. These are:

- Bilateral YAG iridectomy (Ophthalmology) - one form is via major surgery while the other is a simple outpatient procedure.

- Colposcopy (Gynaecology) - one form is via a day case procedure while the other is an outpatient procedure.

- Lithotripsy - an attendance where the lithotripsy procedure is not carried out becomes an outpatient attendance.

In addition to the above there are a range of so-called 'significant outpatient procedures' which have in many hospitals been transferred to the category of a day case. The confusion arises where different providers have different definitions of the split between when a significant outpatient procedure becomes a day case. In the absence of clearer guidance from the NHS Executive this confusion will continue.

4.5. DNA and cancelled appointments

With a national average of 10% of patients who DNA it is not surprising that PCG's find it difficult to close their end of year position. Experience indicates that a further 10% of appointments are cancelled by the patient (including the arrangement of a new date) - such 'cancellation' sometimes occurring a mere hour before the appointment. This adds up to one fifth of all appointments - the reality of the situation is far from the assumed accountancy precision built into PCG's software and of the unfortunate omission of the ability to record a DNA as a non-attendance.

You will need to work closely with your provider over this matter, as to receive a copy of every new appointment and every change to an appointment may well be an administrative nightmare.

4.6. Deceased patients

Information for an attendance will arrive after a patients decease (i.e. patient notes recalled to FHSA) and hospital information indicating a DNA may also arrive for appointments scheduled after the point of decease, i.e. the provider is told of the decease some time after the event. The problem is compounded where not all clinics are computerised (i.e. they run using manual appointment books) and hence the appearance of DNA attendances may be created.

4.7. Private patients

© Dr Rodney Jones, Healthcare Analysis and Forecasting, 1996

The main problem here is that a patient will go private to jump the queue in outpatients and then revert to NHS for the operation and/or follow-up attendances. It is often difficult to pick up the point of transition as the consultant will often retain the notes of his 'private' patients. Recent moves to improve the outpatient waiting times should reduce this problem considerably.

4.8. Babies

Babies are born without a name or a registered GP and can be called by their mothers name while in hospital only to be later registered under their fathers name. Twins can simply be called boy or girl and hospital numbers can be associated with the wrong twin as they are later given names.

To compound the problem, at the GP practice no computer entry can be made until the baby becomes a registered patient, which may be weeks after the birth.

5. Confirming The Attendance

Having attended for their appointment the patient returns home unaware of the administrative complications which can ensue.

5.1. Consultant letter vs minimum data set

Due to pressure from auditors most PCG’s are using the consultant letter as the basis for their data validation. While auditors may have valid reasons for this insistence it does cut across the intent of the m.d.s. as the unit of currency for invoicing. In addition it is not without shortcomings as a consultant letter is not always associated with a patient attendance and it is often unclear when the patient attended and to which clinic they actually went. Table four lists various problem areas and their potential solutions.

One additional solution is to transform the consultant letter into an m.d.s. by making the top portion of the letter 'administrative' and the bottom portion 'clinical'. This would save the duplication of effort in the production of both the m.d.s. and the consultant letter - which share much common information.

© Dr Rodney Jones, Healthcare Analysis and Forecasting, 1996

Table Four: Problems arising from the reliance on consultant letters as a source of contracting data.

Problem	Occurrence	Outcome	Solutions
No m.d.s. but a letter	Mainly when patients are slipped into a clinic at short notice or when attendance details are misplaced.	Provider to locate details of attendance and raise m.d.s.	Patient notes to be checked to see if attendance documentation has been left there by mistake.
No letter	Mainly from follow-up appointments	Provider m.d.s. is questioned by fundholder	Standard format letter where there is no medical information to be conveyed.
No letter from internal cross-referral	Frequent	Provider m.d.s. is questioned by fundholder.	Copy of letter to be sent to GP
Date of clinic does not match with date of letterhead	Frequently depending on consultant	Possible double counting of attendance or incorrect division between in/out of PCG's, or wrong PCG's year.	Standard layout for letters giving date typed and date of clinic.
Name of clinic is not given	Frequently depending on consultant and clinic type	Confusion regarding clinics which are in/out of PCG's.	Clinic name to be given in standard letter format. In/Out of PCG's stated on letterhead.
Letter in response to a DNA	Potentially up to 10% of volume	Potential counting of a nil-attendance.	Fundholder to screen letters. Consultant letter to include 'RE: DNA of appointment'
Letter in response to test results but not relating to an attendance	Infrequent	Potential counting of a nil-attendance.	Fundholder to screen letters. Consultant letter to state 'RE: Receipt of test results/ no attendance'
Letter in response to a GP's request for an opinion on a test result.	Infrequent overall but fairly frequent where GP claims m.d.s. has not been sent.	Potential counting of a nil-attendance	Fundholder to screen letters looking for phrases such as 'I have now been given a family history', 'reviewed test results', etc.
Letter in response to 'inpatient' procedure	Mainly where significant outpatient procedures have been reclassified as day case.	Potential counting of a nil-attendance.	Fundholder to check with provider regarding definitions.

© Dr Rodney Jones, Healthcare Analysis and Forecasting, 1996

5.2. Data input errors

This error type occurs within the data of both provider and fundholder. Table five lists the main error types and their consequences.

This type of error is unavoidable as it is related to human fallibility. In the long term it will only be minimised by the introduction of 'expert' software with cross-validation and error checking steps (e.g. are clinic and consultant consistent, 'Kones' is a mis-key of 'Jones', males referred to Gynaecology, although in rare instances men can be referred to a breast clinic, etc).

Table Five: Main data input errors and the consequences arising from these errors.

Data Type	Outcomes	Solutions
Date	Potential double counting and mis-match with consultant letter, or wrong month/year.	Automatic date stamp using computer technology, but would fail for retrospective data entry.
Name and initials	Confusion between patients and potential wrong hospital number	NHS number plus automatic validation based on name, D.O.B. and postcode.
Hospital Number	Confusion between patients and potential double counting	Automatic validation based on name, D.O.B and postcode.
Consultant Code	Letter does not match m.d.s.	Take letter as the true consultant firm
Clinic Name/Code	Letter does not match m.d.s.	Consultant letterheads are not always comprehensive. Refer to patients notes to cross-check.
GP Code	Wrong practice will receive the m.d.s.	Inform provider that consultant letter has been received. National GP file also creates problems.
Contract Code (i.e. in/Out of PCG's)	The m.d.s. will be sent to the incorrect purchaser (i.e. District vs fundholder)	Short term establish cross-validation software. Long term abolish distinction between In/Out of PCG's.
Attendance type (i.e. first vs follow-up)	Creates appearance of a missing attendance	Check patient attendance record with dates.

© Dr Rodney Jones, Healthcare Analysis and Forecasting, 1996

5.3. Attendance classification

All hospitals are bound to operate within the scope of the NHS Data Dictionary. The people who set up PCG's appeared to have developed their own set of rules which did not match with the rest of the NHS. We are all aware of the difference between an episode start and finish date (GPFH software to change from April 1996), however, a more trivial example is that any patient who waits over six months for a follow-up appointment becomes a first attendance and that an outpatient attendance following an emergency admission is a 'first' rather than 'follow-up'.

Fortunately most of us ignore the obvious mismatches but it does sometimes create problems. Please discuss with your provider the reasons for apparent discrepancies before launching a scathing broadside. Further outpatient definitions and related problems are given in Appendix Three.

5.3.1. Casualty Clinics

The NHS definition of a casualty clinic is vague and allows for 'casualty' type clinics to be run in departments such as ENT and Ophthalmology (see Appendix Three). A patient may also be assessed in the main casualty clinic and cross-referred to another clinic. Strictly speaking such cross-referrals become in-PCG's (i.e. Consultant initiated) outpatient attendances. Fundholder perceptions may be different (as discussed above and below under In/Out of PCG's).

5.3.2. Ward Attenders

Ward attenders are a class of patient who for various reasons are seen on a ward by someone other than a doctor (see Appendix Three). They may be out of PCG's depending on the Provider/Region. The confusion arises in that some consultants conduct outpatient clinics on a ward or see occasional urgent cases on a ward. Both of these are true outpatient attendances although the way the information is collected may obscure the exact position.

6. Unexpected Referral Outcomes

Certain outcomes are expected from a referral letter. The following are some of the unexpected outcomes and the problems which they cause.

6.1. Patient admitted directly from clinic

The rule that no one can have an outpatient visit on the same date as an inpatient visit does not always hold. The direct admission of a patient from clinic does result in an outpatient visit and an inpatient admission on the same date. The possibility exists that one or both will then be questioned. Likewise patients can have a booked appointment for an outpatient visit on their day of discharge, although usually in a different specialty.

© Dr Rodney Jones, Healthcare Analysis and Forecasting, 1996

6.2. Patient By-passes Outpatient Appointment

This situation occurs for particular specialties where a consultant receives the GP referral letter and places the patient directly onto a waiting list (mainly for endoscopic procedures). Occurrences appear to be restricted to Gynaecology, Urology and Gastroenterology although it is possible for Orthopaedics/Rheumatology (Arthroscopy), General Surgery (Endoscopy).

A second occurrence of this type of route lies between Gastroenterology and General Surgery where following Endoscopic or other examination the patient is placed directly onto the inpatient waiting list of a General Surgeon (i.e. the General Surgeon does not see the patient for a 'first' appointment but only as a follow-up after usually 'urgent' surgery).

6.3. Direct referral to inpatient waiting lists

This situation occurs mainly for open access endoscopy but may occur in other instances. The confusion will arise if the consultant letter does not clearly state 'Open Access Endoscopy' or where it is not clear that this was a day case or other inpatient procedure. Further confusion arises if the patient is cross-referred to another consultant due to the findings of the procedure. In this case the fundholder may question the source of the referral.

Confusion can arise where a fundholder's administrative staff are unaware that a GP referral to open access procedures will not involve an outpatient attendance, i.e. the referral is logged as awaiting an outpatient attendance.

7. Inpatient Information

While the area of inpatient information represents the least significant investment in time it does however represent the greatest impact upon budgets. Should an inpatient admission be necessary the collection of inpatient information will involve the typical queries given in Table six.

Table Six: Typical GPFH inpatient queries

Query Type	Percent of Queries
Emergency vs Elective	1%
Private patient	3%
No discharge summary	7%
Overnight vs daycase	8%
No m.d.s. (inc discharged next month)	21%
Not our patient	26%
Not coded yet	28%

© Dr Rodney Jones, Healthcare Analysis and Forecasting, 1996

Queries relating to 'Not coded yet' and 'No dischage summary' relate to the processes surrounding the flow of information within a hospital. Process deficiencies in this area will lead to a reasonable proportion of the 'No m.d.s' type of queries. These processes are discussed in more detail in section 7.1.

Comments from sections 2.2. to 2.4. are applicable to the 'Not our patient' category of query.

7.1. The Discharge Summary

The source of the inpatient information to both the hospital and the fundholder is the discharge summary. Some understanding relating to the cause of particular problems (timeliness and quality) in this area is essential.

Table seven lists the common error types found on discharge summaries. To the GP the patient name, DOB and address are the most critical while not admitted/discharged on PAS will imply the absence of an mds.

Table Seven: Common error types on discharge summaries

Error Type	Percent
Incorrect/missing hospital number	0.3%
Not admitted/discharged on hospital computer	0.5%
Incorrect name or date of birth	1.0%
Incorrect address	1.2%
Incorrect/missing consultant	1.7%
Variant admission or discharge dates	3.1%
Range between wards	0% to 50% error rate
Best 25% (30% of patients)	2% of all errors
Worst 25% (15% of patients)	45% of all errors

More revealing is a breakdown of source which reveals that 45% of the errors come from only 25% of the wards dealing with as little as 15% of the patient volume. Furthermore theses wards will usually be overnight rather than daycase and tend to be surgical rather than medical, i.e. medical specialties are more used to recording patient information. Errors also tend to be greatest for emergency admissions.

Timeliness and error rates appear to be linked such that high dependency and daycase wards have a high proportion of discharges completed on the day of discharge (90 to 100%) while medical and surgical overnight wards show completion rates of 40 to 90% and 20 to 80% respectively. Discharge forms outstanding for more than one week show the same trends.

Armed with this knowledge PCG’s can locate those wards causing the greatest problems and relay this information back to hospital management for action. If no

© Dr Rodney Jones, Healthcare Analysis and Forecasting, 1996

action ensues there is always next years contract with the potential for specific clauses relating to information quality.

9. Mutual Problem Solving

While the above lists may give due cause for despair there needs to be a spirit of co-operation to enable progress to be made. PCG's will need to recognise that the delivery of outpatient services by any provider is a complex and highly multidisciplinary process. As with any process where there are many departments involved in delivering the final product the delivery of solutions to problems will not always be straightforward.

The first step is to prioritise the importance of the problems (listed above). A local informal group of PCG's and providers is probably the best forum for this exercise. The next step is to address each problem one at a time. The internal negotiation/coercion/change management involved is considerable due to the numerous parties involved. To expect that your provider will be able to address more than one problem at a time will create frustration on your own behalf.

The problem solving process will also require some discussion (on your behalf) with various parties from within your provider as to how best to use your leverage as a fundholder. Several telephone conversations to gain an insight into the complexity of a problem are probably more beneficial than an official letter.

A polite request addressed personally to a consultant explaining (simply and clearly) why you need a certain piece of information and how it effects you if it does not arrive is more likely to be favourably acted upon than exasperated letters to the Chief Executive. For more generic problems a GPFH/Provider group is probably the best place to start although exceptions can be addressed back to individual consultants.

The solution to many of the above problems involves increasingly sophisticated computer programs to sort out the attendance types and purchaser codes. Differences between Regions, the sheer volume of patients, the diversity of clinic types/locations and the differences between purchasers (cost per case, block, block with some cost per case, etc) make the task almost beyond the attainment of perfection. Suppliers of computer software to providers and GPFH are obviously unable to meet every subtle difference across the country. Until there are sets of national standards there will remain this confusion and lingering inability to resolve all the issues.

10. Conclusions

The aim of this workbook has been to provide information and encouragement to mutual co-operation in an area where there appear to be many (understandable) problems. Open communication between both parties is to be encouraged and there needs to be an acknowledgement that all problems cannot be solved immediately and that progress will only be made as problem areas are mutually

© Dr Rodney Jones, Healthcare Analysis and Forecasting, 1996

prioritised. Providers and GP's are encouraged to form small working parties to tackle those problems which are generic.

© Dr Rodney Jones, Healthcare Analysis and Forecasting, 1996

APPENDIX ONE

INFORMATION TRANSFER SUPPORTING GP'S

Key Information To Be Validated Before 1st April

- Outpatient Waiting Lists (for computerised clinics)
  - First Appointment (inc number waiting by consultant)
  - Follow-up Appointment (inc number waiting by consultant)

- Inpatient Waiting List
  - Overnight and Daycase (inc number waiting by consultant)
  - Verify position regarding endoscopies (Bronchoscopies, Laparoscopies, Arthroscopies, Cystoscopies, etc)

Key Information To Obtain From Providers

- List of all consultants with consultant code and specialty/specialties

- List of all abbreviations used on m.d.s.

- List of all clinic and specialty codes including any locally defined codes

- Contact names and telephone/fax numbers
  - Consultants and their secretary
  - Business Managers and their secretary
  - Information department, Clinical coding, Waiting list officers

- List of all off-site clinics and who is responsible for the m.d.s. - see Appendix 4 for an example document.

- List of all outpatient clinics with day and time (in- and out-of-PCG's) - see Appendix 4 for an example document.

- List of wards and their usual specialty

- Activity multipliers for elective overnight, daycase and outpatient activity

- Price book with cost bands and procedures

Key Information For a GP Practice to Give To The Provider

- List of all registered GPs and their national GP code

- Direct dial number for PCG's department including the names of staff and their areas of responsibility

© Dr Rodney Jones, Healthcare Analysis and Forecasting, 1996

Highly Recommended

- Visit Medical Records, Clinical Coding and the Information department.

Never Ever Do These

- No referral letters by GP trainees and Locums (the referral must be in the name of a registered GP from your practice).

- No 'Temporary Residents' without full details of registered GP and home address.

- No 'Overseas Visitors' without details of home country address, telephone number and post code.

- **Waiting Lists**

  At month end compare patients on hospital and fundholder waiting lists. This will resolve/flag the following:

  - Patients who have recently transferred out of the practice
  - Temporary residents
  - Patients not yet on the hospital waiting list (allow for some time lag)

- **Outpatients**

  At month end compare hospital m.d.s. against PCG's. This will resolve the following:

  - Patients who have recently transferred out of the practice (best dealt with via validation of the outpatient 'waiting' list prior to attendance).
  - In and out of PCG's
  - No correspondence received by practice

Be Kind To Your Provider

- When dealing with a query

  - always quote hospital number

  - attach a copy of
    the consultant letter
    the discharge form

- Transfer of information

  - best on a disk rather than printed paper

© Dr Rodney Jones, Healthcare Analysis and Forecasting, 1996

APPENDIX TWO

PAPERLESS INFORMATION FLOWS

This section provides the necessary information for you to receive all inpatient information in the form of a floppy disc download direct from the provider Patient Administration System (PAS).

The usual process involves delivery of a printed m.d.s. containing an abstract of the information from the Provider PAS. There is usually one piece of paper (m.d.s.) per patient.

The suggested alternative is to take the full download of information from the PAS and use the following data definitions (as defined by 'The NHS Data Dictionary', Vol. 2 - Definitions., Data Standards Team, IMG, 15 Frederick Rd, Edgbaston B15 1JD) to decipher the information.

All patient information is downloaded to floppy disc for transfer to the practice where the data is manipulated in a spreadsheet. Both in- and out-of-PCG's, coded and un-coded episodes are downloaded and are easily sorted in a manner suited to the needs and work processes of each practice.

Missing patients, i.e. those expected as in-PCG's, can be easily located by a search based on 'Name' using the 'Find' facility - in most instances they will either be uncoded or out-of-PCG's. Likewise patients discharged in the following month will be identified by admission and discharge dates in different months or by no discharge date, i.e. an on-going episode.

You will find that more problems will be resolved more swiftly using this method of paperless information transfer.

All relevant patients can then be selected and printed out on a one patient per line basis giving an environment friendly alternative to the one patient per page m.d.s. normally delivered as part of the contracting process.

Use the following data definitions to decipher the Provider download and to more fully understand what has happened to each patient. Simply use the function key facility in any spreadsheet to change all occurrence of NHS code to a corresponding description, i.e. admission method 21 becomes 'emergency', etc.

© Dr Rodney Jones, Healthcare Analysis and Forecasting, 1996

Useful Admission and Discharge Codes

1. Source of Admission (ADMIT_SRCE)

19	Home
29	Temporary Residence
39, 49	Prison, Special Hospital
51/52/53/54	NHS Hospitals, etc
65/66	Local Authority
79	Born on the way to hospital
85/86/87	Non-NHS Hospitals, etc

2. Admission Method (ADMIT_METH)

11/12/13	Elective
21/22/23/24	Emergency
28	Emergency transfer from other sources or hospitals
31/32; 82/83	Maternity and Births respectively
81	Transfer from other hospital (NOT emergency)

3. Intended Management (INTEND_MGT) - for elective patients only

1	Overnight
2	Day Case
3/4/5	Planned sequence of admissions, i.e. chemotherapy

4. Patient Class (PAT_CLASS) - the actual as opposed to intended management

1	Overnight
2	Day Case
3/4	Regular overnight, Regular day case

5. Elective Admission Type (ADMIT_TYPE)

11	Waiting List
12	Booked
13	Planned (usually for a sequence of care)

6. Patient Category (PAT_CAT)

10	NHS
20	Private
30	Amenity bed

7. Discharge Method (DISCH_METH)

1	On clinical advice/consent
2	By self or relative
3	Legal reasons, court order, etc
4, 5	Deceased, Stillbirth

© Dr Rodney Jones, Healthcare Analysis and Forecasting, 1996

8. Discharge Destination (DISCH_DEST)

19	Home
29	Temporary Residence
39	Prison
45	Special Hospital
52/53/54	NHS hospitals, etc
65/66	Local authority
79	Deceased/Stillbirth
85/86/87	Non-NHS hospital, etc

Key Differences between Consultant Episode and Hospital Spell

Consultant Episode: Time spent in the continuous care of oneconsultant (EP_START_DTE & EP_END_DTE)

Hospital Spell: medical — Total continuous stay of a patient with one provider where care is the responsibility of one or more consultants (ADM_START_DTE & ADM_END_DTE)

A *Hospital Spell* starts on admission and continues through one or more *Consultant Episode(s)* and finishes on discharge at the end of the last Consultant Episode. The change of care from one consultant to the next is via a *Transfer* and **not** a *Discharge.*

Consultant Episodes within a Spell can be the cause of several problems particular to a fundholder:

- Discharge summary is only completed by last Consultant thus the episode containing the PCG's procedure may not be mentioned on discharge summary

- For some specialties (i.e. Rheumatology) the patient is admitted by Consultant Rheumatologist, transfers to Orthopaedic Consultant for procedure and is transferred back to Rheumatologist, Elderly Care or Rehabilitation consultant for eventual discharge, i.e. 3 consultant episodes with the PCG's procedure not connected with the expected specialty/consultant.

Other Common Problems:

- Incorrect admission method (i.e. emergency instead of elective) - the episode is assigned to the wrong purchaser.

- Emergency admission for expected elective patient (not common) - discharge summary may not state emergency/elective admission.

- Actual procedure is slightly different to expected procedure and hence becomes out-of-PCG's - should be less common from April 1996.

- Intended Day Case where patient stays overnight - episode then becomes overnight and will fall into a different price band.

© Dr Rodney Jones, Healthcare Analysis and Forecasting, 1996

APPENDIX THREE

Useful Outpatient and A&E Definitions

- **Accident and Emergency**

Any facility set up to receive and treat emergency cases. It may not deal with emergency ambulance cases. This service offers care to patients who arrive with urgent problems and ***who have not usually been seen previously by a General Practitioner****.*

The situation regarding women who bleed, etc during pregnancy is not clear as many arrive after seeing their GP and have a written GP letter. In this case the attendance may be regarded as 'Urgent' outpatient attendance. Individual clarification will be needed from different providers.

- **Written Referral Request**

A written request for health care service as a consultant out-patient episode or elective admission list.

This definition does not however clarify the question of urgent gynaecology referrals where the majority of women arrive with a written GP referral letter (which has often bypassed the PCG's department).

- **Consultant Outpatient Episode**

An episode of care comprising a series of outpatient attendances in respect of one referral. The episode ends (discharged) when the patient is not given a further appointment or the patient has not attended for 6 months (i.e. by repeated cancellation or non-attendance). If after discharge the condition deteriorates and the patient returns this is a new episode (referral).

Self-referral (i.e. the patient iniates the attendance) is out-of-PCG's, however, local agreement needs to be reached over certain disease conditions where the patient is given leave to attend at any time.

- **Outcome of Outpatient Attendance**
    1 Discharged
    2 Another appointment given (i.e. follow-up)
    3 Appointment to be arranged

Locally defined outcomes of an attendance may include codes for Direct admission (as emergency), Admission To waiting list and Booked admissions.

© Dr Rodney Jones, Healthcare Analysis and Forecasting, 1996

- **Ward Attendance**

Attendance at a Ward by a patient for nursing care. If the attendance is primarily for the purpose of examination or treatment by a doctor it is an out-patient attendance.

Some consultants hold their clinic on a ward and the ward name may appear in the name of the clinic. The attendance is outpatient.

- **Consultant Written Referral Request**

A written request by a consultant for health care services for a patient.

A Consultant referral request commences a new consultant outpatient episode. For instance attendance at A&E (out-of-PCG's) may prompt a referral to a consultant of another specialty which may commence a new (in-PCG's) episode.

Common Problems

- The distinction between tests and attendances are not always clear, i.e. attendance for a treadmill test in Cardiology. Clarify with your provider.

© Dr Rodney Jones, Healthcare Analysis and Forecasting, 1996

APPENDIX FOUR

Example of Outpatient Clinic details

This clinic list has been produced by the Information Directorate of the ..... NHS Trust. It is intended to be used as a guide and not as an authoritative document since details can change from year to year.

Clinics held in the community are under the ownership of either the Trust or the Priority Care Trust. Ownership (i.e. the organisation responsible for delivery of the m.d.s.) needs to be determined on an individual basis and from year to year.

If you have any queries regarding this document please contact your Account Manager.

Allergy specialty code 331 Outpatient cost £xx

Clinics are held on Tuesdays and Fridays on the second floor of main outpatients.

This clinic also covers skin allergy (Dermatology). An associated clinic for inhaled allergy is conducted in the ENT department on Wednesdays.The Specialist is Dr .....

Anaesthetics specialty code 190 Outpatient cost £xx

The pain clinic is held 3 times a week at ..... in the day bed unit and once a month at ..... The consultants are Dr .....

Ante-Natal specialty code 510

Ultrasound scanning is dedicated to Obstetrics and Gynaecology, led by Dr .....

There are 4 consultant led clinics held at ..... and one at ..... district hospital

Patients can be treated on Labour Ward (when not admitted) on an outpatient basis, seen by the midwives.

Community bases are at ..... Hospital, the ..... and ..... led by midwives.

A community midwife service operates throughout the district, midwives share ante-natal care with GPs and provide post-natal follow up for the patients from those practices, in their own homes until at least the 10th day post partum.

Midwives cover the hospital and community services.

The consultants are Mr .....

Additionally Parent Craft classes are held in the Maternity Block at RBH, Mon a.m teenagers/unmarried mothers (midwives (M) & physio (P)), Tues a.m Asian parents (M

© Dr Rodney Jones, Healthcare Analysis and Forecasting, 1996

& P & Translator), Tues p.m 1st Baby (M & P), Wed p.m as Tues a.m. Additional classes are held in the evenings and Sunday afternoon.

Anticoagulant clinic specialty code 823 Outpatient cost £xx

Clinics are held at ..... on wednesday and Friday.All clinics are led by Dr .....

Audiology specialty code 884 Outpatient cost £xx

Various Hearing Aid (HA) clinics operate all week.

- Diagnostic Audio-Vestibular (DAV)
- Hearing Therapy (HT)
- Joint ENT/Audiology/Speech Therapy are listed under ENT

Breast Care spec code 1001 Outpatient cost £ xx (as gen surg)

The breast care nurse and clinic work with the general surgery clinics (Mr .....). When the patient visits the clinic as part of a surgery clinic there is **no** separate cost.

BCG Clinic specialty code 995 Outpatient cost £xx

Clinics are held in the Respiratory Medicine department. BCG vacinations for employment and holidays are paid for by the patient (out of PCG's). Other inoculations are In-PCG's. The Consultant is Dr .....

© Dr Rodney Jones, Healthcare Analysis and Forecasting, 1996

APPENDIX FIVE

Sample Guidelines For Discharge Forms

This form is vital to GP communication. It must be completed as part of the discharge arrangements. Any delay beyond the point of discharge results in a break in our communication with the patients GP and reflects poorly on our commitment to patient care. Hospital policy is that all patients be discharged with a fully completed discharge form.

The form is made up of four sheets and does require you to 'Press Hard' to allow the information to be legible on all sheets. The top sheet is sent to the coding office, the next sheet to the GP (to let them know what has happened - a prompt dispatch is mandatory), the third sheet is filed in the case notes and the final sheet can be given to the patient as a record in case of emergency.

This form is also vital to our well-being as a hospital providing services to our local community. Information on the form triggers the recovery of income from an inpatient visit. No form - no money. We cannot function without income and to miss income is unfair on patients and staff as it means that we are trying to treat more patients without funding for the staff to treat them.

The information from this form is added to a computer to deliver what is known as a minimum data set (m.d.s.). The m.d.s. contains everything added to the Hospital computer upon admission and discharge plus additional information regarding the 'Diagnosis' and any 'Procedures'. These are added by the Coding Department using internationally agreed medical terminology. Absence of coded information means that our purchasers (Health Authorities and GP PCG's) do not pay for any work we have done and we have not contributed to the UK-wide analysis of health needs via the diagnosis and procedures.

The m.d.s. must be sent to purchasers no later than 6 weeks after the month in which the discharge occurred. We have agreed even tighter deadlines with our GP PCG's, i.e. an m.d.s.10 working days after month end. Completion on the day of discharge means this is an achievable target as there is a one day turnaround time within the coding office.

Following is a description of each section on the Discharge Form and the consequences that will arise if the information is wrong or missing. Every mistake will end up costing the hospital money either in lost income or as the cost of putting the error right.

We are aiming to achieve right first time by moving responsibility for corrections back to the ward. All details on the discharge form should match with those on the hospital computer. Where they do not the form will be returned to enable discrepancies to be reconciled. Incorrect information costs us money, to get it right first time costs very little. How we go about completing these forms may need to change. Should you have any ideas for improvement please discuss these with your Business Manager, Nurse Manager, Clinical Director or Head of Firm.

Sections 1 to 8 are commonly completed by ward staff while sections 9 to 18 are usually completed by a doctor. Sections 9 to 18 may be completed by ward staff depending on the policy of the business unit or firm.

© Dr Rodney Jones, Healthcare Analysis and Forecasting, 1996

1. **Hospital (multiple site locations)** - this information is not critical but it can help resolve queries.

2. **Dear Dr** (Do not leave blank - this is a key piece of information)

Insert the name of the patients registered GP including initials. Dr Smith could be any one of twelve local GPs. The incorrect GP can mean that the Discharge Form is sent to the wrong Practice. If an emergency should develop this could cause a difficult or embarrassing situation.

Due to the fact that there is usually more than one GP of the same name it is best to add a short practice name, i.e. Dr C.J. Hughes, Loddon Vale; Dr C.P. Hughes, Wallingford; etc.

For patients who do not have a registered GP put 'Not Registered' and for patients who do not know or cannot tell you, put 'Not Known'.

For 'ECR' patients (i.e. anyone living outside of our health commission) prior authorisation must be obtained from the ECR help line on ext 8647. If in doubt ring! We lose over £250,000 per year on unauthorised ECR patients. In fact most 'Temporary Residents' will fall within the category of ECR. Some GP PCG's are also ECR (i.e. they do not have a contract with the hospital).

Dear Dr (Special Cases):

Boarding Schools - Here the patient may be referred by a school doctor who is not the registered GP. Contact the school for assistance they will have details of the registered GP on file.

Nursing Homes - The patient may have been referred by the home doctor. In this case the patients permanent residence may be the nursing home but the registered GP may be elsewhere with a registered address different to the nursing home (i.e. that of a relative). If necessary contact the nursing home for assistance.

Prisons - The patient will be referred by the prison doctor, the registered GP is the one prior to detention.

Mental Institutions - The patient will be referred by one of the Institution medical staff. The registered GP will be the one prior to being institutionalised. Patients resident before 1971 have the institution as their home address.

Temporary Residents - A temporary resident is anyone staying at a location other than their permanent home. Examples are: people with holiday homes, students visiting home on vacation, visiting friends or relatives, away on holiday, boarding schools, etc. In all cases it is important to obtain the registered GP since all medical correspondence should be housed in the patients GP medical file. Where necessary copy any correspondence to the referring GP.

Overseas Residents - Overseas patients do not normally have a registered GP and may be referred under the guise of a 'Temporary Resident'. All clinical correspondence will go to the referring GP. Contact Sue Grindrod (ext 7820) for advice. Overseas Students are usually exempt from these rules and the referring GP will substitute as the registered GP.

The UK has reciprocal agreements with many countries so the person may not have to pay for the treatment. For those countries having no reciprocal agreement the rule is - if they can afford to travel to the UK they should be covered by travel insurance. If the hospital treats people without charge it will deprive our local area of the care it deserves. Contact the Overseas patients helpline

© Dr Rodney Jones, Healthcare Analysis and Forecasting, 1996

Incorrect (or no) GP means a lot of time wasted in trying to determine where the patient is registered and more often than not this means the total loss of income. It is vital to determine from the patient - who is your registered GP or which GP did you last register. The reason for this is that the patients GP medical file will be located with their registered GP. Their medical file is transferred when they register with a new GP.

3. Hospital Number (Must be inserted - write in bold)

The entire hospital computer systems and medical records library runs on the hospital number. To omit this number means that time is wasted checking the hospital computer to match the name, DOB and address with a number. There is the potential for error in this step.

4. Consultant, Department & Ward (Insert the name of the consultant firm & ward)

The discharge form should more accurately be called a 'Transfer Form'. Every time the patient changes consultant there should be an individual discharge form. The hospital gets paid for finished consultant episodes (FCEs). Ten consultant episodes and only one discharge form equals nine lost opportunities for income. A discharge form needs to be completed for each FCE when the patient is 'transferred' to the new consultant (and ward). **Put transferred to Consultant X, Ward Y on the form.**

Any endoscopies conducted by the members of another firm fall within this category, however, for endoscopies it is not necessary to complete an additional form. Simply put endoscopy on the list of procedures and give the correct date.

Department is that of the consultant firm (e.g. Respiratory Medicine, Surgery, Urology, etc).

The ward is that at the end of that consultant episode. Patients can change ward without changing consultant and a new discharge form is not required. Only when a patient changes consultant has the equivalent of a 'discharge' taken place and so a new form is required.

5. Surname & Forename (Must be inserted)

Must be those recorded with the registered GP. If the surname is different to that recorded with a GP fundholder the details are rejected as 'not our patient'. In this case the only cross-check is via the date of birth and address. For recently married women put the pervious name in brackets.

6. Address & Postcode (Must be inserted)

15% of the population change their address or GP every year. This gives ample opportunity for the information in the patients notes to be out of date. Patients on an elective waiting list will travel long distances to avoid having to go through the waiting all over again with a new GP and hospital. The address therefore needs to be the one recorded with the registered GP. For 'Temporary Residents' the referring GP will be different to the registered GP. For Overseas patients we need both a home country address and a UK contact address. For assistance contact .....

Postcode is vitally important and should be the same as on the hospital computer. If not please confirm with the patient or request confirmation from the postcode data base. Our computers run on postcode rather than 'address' and it is the postcode which determines in which health authority the patient lives. Our computers also use the postcode to detect ECR patients. An ECR is any patient attending from somewhere which does not have a contract with this hospital (e.g. neither the PCG's nor the health authorities in Birmingham have a contract with us to treat their patients). We have to request special authorisation for ECR patients so that we can get paid. For assistance with ECR's contact.....

© Dr Rodney Jones, Healthcare Analysis and Forecasting, 1996

Special Cases:

Boarding Schools - 'Home' address is that of the parents (sometimes the school) - check regarding the location of the registered GP - the school will be able to assist.
Nursing Homes - Is the nursing home the home address - check with nursing home.
Prisons - Home address is that prior to detention.
Mental Institutions - Home address is prior to the institution. If not known put the institution.

7. Date of Birth (A correct DOB must be added)

Date of birth is a key field since the GP computer systems rely on DOB to verify if the patient belongs to them. This is a logical check since 'Surname' and address can change.

The DOB is also important since it gives the age of the patient and can affect the clinical code given to the diagnosis (i.e. juvenile diabetes) or the procedure (i.e. hip replacement with or without cement is dependant on age).

8. Admission & Discharge Date (Dates must be correctly recorded)

The admission date must be correct. The discharge date is the actual date of discharge (to leave the hospital) or the date of transfer to a new consultant. Correct recording of these dates is very important as they determine the length of stay (LOS). The LOS has an enormous impact on the running costs of the hospital and incorrect recording of this figure can lead to incorrect conclusions and flawed projections for future needs.

For medical (as opposed to surgical) management the income received is often determined by the LOS. In this case correct dates determine the correct income.

9. Diagnosis (A comprehensive diagnosis of the condition must be added)

The diagnosis is a key field and is used both to inform the patients GP and in the field of public health medicine. In the latter arena it is used to determine the planning and delivery of healthcare needs and for international epidemiological studies. A vague or incomplete diagnosis will correspondingly give poor data regarding the healthcare needs of the population. If a complete diagnosis cannot be determined give as much detail as is possible. This information is coded within the hospital and is available internally for medical audit and externally via the NHS to whom the data is relayed.

For example, a diagnosis of 'ulcer' could be an external ulcer or an ulcer of the stomach or duodenum. A 'gastric ulcer' can likewise be more appropriately described as gastric ulcer with or without bleeding, perforated or unperforated, chronic or acute. In fact there are 300 possible codes for 'ulcer' giving a rich description able to enhance any type of medical audit.

10. Relevant Investigations (A legible list of investigations is required)

Relevant to this section would be Nil (for none), ultrasound and radiological investigations including CT scans, various types of blood test, microbiological and other pathology tests, etc.

11. Management (A description of *non-routine* management is given here)

Nil (for nothing special), conservative (for non-surgical intervention), intravenous antibiotics, blood transfusion (10 units), etc.

© Dr Rodney Jones, Healthcare Analysis and Forecasting, 1996

12. Procedure/Operation(s)

An accurate description of any procedures is essential. For all surgical intervention we get paid according to the most important procedure. Be specific and descriptive. For example, there are 20 variants of an Oesophagoscopy costing £400 to £650. A non-specific description will go to the lowest figure. Give details of any biopsy as this moves the procedure to a higher price band.

13. Complications

Complications may relate to a specific *medical* problem or a *mechanical* problem, i.e. post surgical hyperthyroidism or displacement of cardiac pacemaker electrode. The description should be complete enough to determine if it is postoperative, i.e. postoperative wound infection & increased blood pressure, clot retention, vomiting following gastrointestinal surgery.

14. Destination after Discharge

Home, nursing home, with relatives, deceased, other ward, etc.

15. Aftercare Needed

Nil (for none), removal of sutures by....., GP to check ....., etc. This is important secondary information for the GP.

16. Outpatient Appointment

Give the clinic name and date (or interval, i.e. 5/52 for 5 weeks, 6/12 for 6 months).

17. Discharge Drugs

Complete in full with dose. The hospital only gives a seven day supply. The GP needs to have this form within seven days in order to give repeat prescriptions. To achieve this target the form virtually needs to be in the post the day the patient is discharged. To get this communication right assumes that the registered GP is correct.

18. Signature and Date

On completion sign the form and give the date it was signed (no cheating please!).

Parts of the form completed by others: There is no legal reason for someone other than a doctor to complete the discharge form - other than the section on drugs. Whoever signs the form gives their assent to the fact that the information on the form is correct. Where other sections are completed by members of the ward team they may initial their contribution. Check regarding the policy of your firm/specialty on this matter.

Deceased Patients: Here drugs are no longer required on the discharge form and the form may be completed in full by someone other than a doctor. Each specialty will need to determine their policy on this. **The results of the coroners investigations do not have to go onto the discharge form.** *Immediately* upon decease the form must be sent to the GP and a copy to the coding office. Failure to send a copy to the coding office will often result in total loss of income. By the time we get the notes back from the coroner we have long passed the six week deadline for the recovery of income.

Transfer to another consultant: In this instance a copy of the form must be sent immediately to the coding office to recover the income for the completed consultant episode. This 'transfer' form does not need to be signed by a doctor and does not need to contain drugs.

© Dr Rodney Jones, Healthcare Analysis and Forecasting, 1996

Example Material Explaining The Uses Of Discharge Forms

1. An explanation of the key uses of the discharge form

A. For Seamless Care

Here the patients GP needs to have details from all boxes on the letter including 'Aftercare Needed' and 'Out-Patient Appointment'. For the Outpatient Appointment an interval is sufficient, i.e. 2 weeks. The omission of a key diagnosis could put the patient at risk of receiving inappropriate care. **It is for this reason that the hospital requires these forms to be completed on the day of discharge.**

B. National & International Epidemiology

Diagnostic Coding via ICD 10 codes is used for **national and international** Epidemiology. The information is derived from the 'Diagnosis' section on the Discharge Letter. All diagnosed conditions from which the patient suffers should be included. Omission of this information means that healthcare planning is not possible. The patients GP also collects diagnostic information using the Read coding system.

D. Medical Audit

The recorded diagnosis and procedures are coded and entered onto the hospital data base. Stastical analysis for the purpose of medical audit can be conducted using this data thus avoiding the laborious task of locating and reading the patients notes.

D. The Funding of Patient Care

Procedure/Operations coding via OPCS codes is used to determine the cost of an inpatient procedure. The information should be entered in the 'Procedures/ Operation(s)' section on the Discharge form. Every procedure should be clearly detailed with dates. **Omission of operations may lead to the hospital running at a loss! Forms lost or mislaid can lead to a loss of up to £3,500 for a single (but major) procedure.**

YOU DO NOT HAVE SIX WEEKS TO COMPLETE A DISCHARGE FORM/SUMMARY!

The misunderstanding seems to have arisen where clinical & nursing team members believe that there is a six week window of time in which to complete a Discharge Form.

Our GP's are insisting that their patients receive seamless health care, namely, a correct and unabbreviated Discharge Form sent to the GP on the day of discharge.

The six week period is to do with NHS imposed time scales for sending out invoices. Invoices for Inpatient episodes are all raised from a Discharge Form. The absence of a discharge form or delayed completion means we do not get paid for the patient care we have delivered.

Patient Care is to do with a seamless service and has a more demanding time scale of 'On The Day Of Discharge'. If you were a GP would you settle for less?

2. Procedure for completion of discharge form when the patient has died

© Dr Rodney Jones, Healthcare Analysis and Forecasting, 1996

- Forms must be completed for deceased patients
- Do not send the Form with the notes to the Coroners office
- Insert the Diagnosis for which the patient came in for treatment
- Insert any relevant procedures that have occurred up to the point of decease (if you don't we won't get paid)
- Send copy to GP and copy to Coding office, leave other copies in the notes.
- You do not need to record the reason for death as this is done by the Coroner.

3. Procedure for completion of forms upon change of consultant

- Forms must be completed for any patient who has a change of Consultant
- Insert Diagnosis for which the patient came to your ward for treatment
- Insert any relevant procedures that have occurred up to the point of transfer (if you don't we won't get paid for your hard work)
- Record Consultant's name to which the patient has been transferred on the top left hand corner of the form.
- Send the copy to the Coding office
- Do not fill in Drugs and there is no need for a doctor to sign (optional) as this is an internal transfer.

4. Examples of background information for hospital doctors

A number of issues arise from this seemingly tiresome form.

1. Our GP's have difficulty in providing seamless patient care due to the lateness and poor quality of the information. The patient arrives back at the GP without any information regarding diagnosis, procedures, complications and drugs.

2. A discharge prescription lasts only 7 days; so the GP must know the required drug regime within 7 days of discharge.

3. Every change in consultant (except for on-take transfers) requires a new form.

4. A discharge form must be completed even on a patient's decease, otherwise procedures already completed will **not** get paid for.

5. Multiple procedures must be recorded - the most expensive procedure is paid for.

6. It is easier to fill out the form as you go along, or dictate procedures, diagnosis, management, investigations & complications to the named nurse (if appropriate). This prevents a depressing backlog of forms building up, ending up relying on your memory should the notes be required elsewhere.

7. Each form is worth around £1,000 which is required to continue patient care.

8. Every patient must have a discharge form at the point of discharge.

© Dr Rodney Jones, Healthcare Analysis and Forecasting, 1996

APPENDIX SIX

Guidelines For Outpatient Information

Following is a description of each item of information required for an outpatient visit and the consequences that will arise if the information is missing or incorrect. Almost every mistake will end up costing the hospital money either in lost income or as the cost of putting the mistake right.

1. Consultants Name

A name is required to link the attendance to a Consultant Firm. The workload of each firm will be incorrect if this is wrong.

2. Clinic/Ward

If the patient is seen on a ward by a doctor put the name of the clinic and not the name of the ward. A ward name means that the hospital not able to recover any income for the attendance since it becomes a 'ward attender' and the cost is supposed to be part of ward costs. *The only time that a ward name should be used is when a patient is seen by someone other than a doctor, i.e. counselling by a nurse or removal of sutures, etc.* The only exception to this rule is for Pre-Op Clerking where the ward name should be inserted.

3. Date seen in ward/clinic

No date/incorrect date means the attendance will be questioned. In both cases considerable time will be spent resolving a fairly trivial matter.

4. District Health Authority of residence

The code to be added relates to where the patient lives, i.e. Berkshire, Oxfordshire, etc. It is enormously important for the recovery of income and is automatically assigned by computer, however, is totally dependent on the correct POSTCODE.

For 'Temporary Residents', 'ECR' & 'Overseas' patients - to locate these patients always ask for a patients 'home' address and their 'Registered GP' - if required explain what is a registered GP. For O/S patients we need the home country address as well as a UK contact address. *If we do not determine the patients registered GP and home address the attendance will be rejected by our purchasers and we will lose the money for the attendance.*

5. Patient Details

Hospital number All hospital computers run on hospital number and so an incorrect number will cause total confusion. No number will waste a lot of time as someone has to find it.

Date of birth is critical since GP Fundholder computer systems rely on this date to verify that the patient belongs to them.

Surname is critical and needs to be the surname under which the patient attends at their GP. An incorrect surname means that the attendance will be rejected by a Fundholder as 'Not our patient' and we will not get paid for the attendance.

© Dr Rodney Jones, Healthcare Analysis and Forecasting, 1996

Permanent address is relevant for 'Temporary Residents', i.e. someone away from home such as on holiday or students home on vacation. The permanent address is the address which has been given to the patients registered GP. Most 'Temporary Residents' are also ECR's (see below).

Permanent or Home Address is vital for 'ECR' patients (ECR means someone from somewhere that does not have a contract with this hospital). All ECR patients need to have prior authorisation from their purchaser before we can see them. Without this authorisation we do not get paid. Hospitals lose a lot of money from unauthorised ECR's. If in doubt contact ..... Please put 'ECR' in bold letters at the top of any forms. For suspected overseas patients we need both home country and UK details, contact ..... for assistance.

Post Code is so **very important**! Computers use the postcode as one of several key fields to allocate the attendance to the correct purchaser and to automatically locate ECR's. You would be amazed at the number of very wrong or absent postcodes. Hours are wasted trying to find them at considerable cost to the hospital.

Around 15% of the population change their address or GP every year! Ask the patient for their postcode. If it is the same as the computer or case notes. If different, update the computer and Case Notes and that the old sticky labels have been discarded. Does their telephone number also need to be updated?

Nearly 30% of people who change their address become an ECR. This means that up to 5% of a follow-up clinic have the potential to be ECR's. People will travel long distances to keep an appointment if they think that they will have to wait all over again at their new hospital.

6. GP's Details

Always give full name and initials. There are many Dr Smiths, hence the need for initials. The practice post code is not usually needed unless you are not able to give a GP code. A correct GP code allows the computer to automatically allocate a Practice code. Use the 8 character national code beginning with a G, i.e. G3390926. When a GP code is not given hours of time are spent allocating them within the Information department - at a substantial cost. *An incorrect GP means we will probably lose the income.*

7. NHS Number

The new NHS number is being introduced from March 1996 and will eventually become the common identifier for all patients.

8. Unique referral number

This was one of those bright ideas from the NHS which never worked for a variety of reasons as a means of common identification between GP and hospital.

9. Date referred

Insert the date given on the referral letter. This date is important because it allows the PCG's to cross validate the attendance and it allows the hospital to calculate the length of wait experienced by patients for their appointment.

© Dr Rodney Jones, Healthcare Analysis and Forecasting, 1996

10. Reason for Referral (Only for New Referrals)

For GP PCG's this is usually given on their referral form.

11. Consultants priority (Only for a New Referral)

Priority is usually assigned by the consultant after reading the referral letter. Some urgent referrals will arrive with a letter in hand.

12. Appointment Type

New referral:- anyone with a letter from a doctor, consultant or other health professional.

Consultant initiated:- referred by another consultant

Re-attendance:- re-attendance for the original reason the person was referred.

Unscheduled:- usually someone who has referred themselves

Warning: Keep a watchful eye for 'New referral' patients booked into follow-up clinic slots (usually at a consultants request). Likewise look out for follow-up patients booked into new clinics. Patients can also be attending for more than one clinic at a time.

13. Referred by

GP, A&E, Consultant are self explanatory. For a cross referral from A&E ensure that the Appointment type is 'Consultant Initiated'. If you don't the attendance will be questioned by the GP fundholder and valuable time will be wasted verifying the attendance. 'Self referred' will usually be linked to an 'Unscheduled' appointment type. There are several immediate conditions (i.e. IBD, diabetes, etc) where the consultant will tell the patient to re-attend at any time. For these patients put referred by 'Consultant' and for appointment type 'Re-attendance'.

15. Outcome

DNA should be ticked if the patient did not attend. It is important that the GP knows this. If a patient decides to become Private for further attendances tick 'Private Patient'

Insert the date of the next appointment (if known) or insert an appropriate time interval on the next line, e.g. 5/52 for five weeks or 3/12 for three months, in the 'Further app. f/u interval' box. This information is used by the GP PCG's as a key field. **Addition of the date of next appointment should trigger automatic authorisation for follow-up ECR visits.**

Put discharge if the patient no longer needs to attend. '4th & subsequent app.' is to be left blank. This was another bright NHS idea based on the false assumption that for all medical conditions a patient had one first and two follow-up visits. 'Cross Referral' is very important due to 'Tertiary Referrals'. Insert the name of the consultant to whom the patient has been referred. A 'Tertiary Ref.' means another hospital - insert the name of the hospital or an appropriate abbreviation. All Tertiary referrals need to receive authorisation. Admission direct from clinic/ward is usually relevant to urgent referrals. Booked admissions are those where the patient is given a date there and then while 'On the waiting list' is as stated. **Completion of this box triggers automatic authorisation for ECR patients.**

© Dr Rodney Jones, Healthcare Analysis and Forecasting, 1996

APPENDIX SEVEN

Examples of Documentation to Patients, GPs and Medical Secretaries

1. Outpatient Poster

Ever wondered why you are asked your address and GP every time you attend? If you had thought it was just because we couldn't get it right, here is the answer:

Every year over 15% of the population change their address or GP!

Often we are the last to hear. If your address (or telephone number) has changed and we have to re-schedule a clinic or operation due to unforeseen circumstances your notification will be sent to the wrong address and you may make an unnecessary visit to the hospital.

If our details regarding your GP are wrong your GP could miss out on some vital piece of information regarding your treatment needs.

So when we ask for your address and GP - please let us know because it is important to ensure good all round communication.

If you have moved and are not registered with a new GP let us know, if you don't it can cause total confusion.

2. Leaflet for distribution at an outpatient visit

What to do whenever you change your address, telephone number or GP

Every year over 15% of the population change their address or GP! Often we are the last to hear. If your address (or telephone number) has changed and we have to re-schedule a clinic due to unforeseen circumstances your next appointment details will be sent to the wrong address and you will arrive for a clinic that is not running.

If our details regarding your GP are wrong, your current GP could miss out on a vital piece of information regarding your treatment needs. Whenever you change your address or GP please let us know by writing to :-

Alternately you can telephone on .....day between x a.m. and y p.m.

You will need to supply the following:

- full name
- date of birth
- old GP
- hospital number (if known)
- old address
- new address (postcode is important)
- new GP with initials and address

It is important for you to tell us ahead of your appointment as this will save us the time of changing the details when you arrive for your appointment. At your appointment you will be asked to confirm the changes. Our sincere appreciation for your assistance in this matter.

3. Letter with offer of appointment

© Dr Rodney Jones, Healthcare Analysis and Forecasting, 1996

Did you know that almost 10% of patients do not attend for their appointment. This causes us incredible problems. For instance, if the first person in a clinic does not attend then the consultant can be left sitting around for 30 minutes waiting for the next patient to arrive. We have even had rare occasions where a whole department have seen virtually no patients during a clinic session!

Probably half of these non-attendances are due to patients who have changed either their address or GP. You may not be aware but over 15% of the local population change their address or GP each year. We are often the last to hear of these changes and as a result vital medical information can go astray.

In this instance the appointment details will have been sent to the wrong address. To help us can you please write (FREEPOST) to the hospital department to which you have been referred and give the name and address of your new GP and your new address and postcode (postcode is essential).

Should you change your GP your medical notes get transferred to the new practice at the point when you register with a new GP. If we are not informed of your new GP we will send the clinical information to your old GP who will no longer have your notes and will not know your new address! This is one reason why you should register with your new GP as quickly as possible and should likewise let us know as soon as a change is made to your details.

If you have to cancel an appointment please contact the clinic and arrange a new appointment date. This allows us to offer your vacant slot to another person. Since most appointments are made weeks in advance we would request the courtesy of at least five days notice as this gives us the greatest opportunity to fill the vacant slot.

Lastly, late arrival for an appointment also causes us considerable problems. Imagine if the first person in a clinic arrives late then we are then expected to see that person and at the same time not make everyone else late. You will appreciate that one late person ends up making everyone else after them late as well.

Your assistance in these matters would be greatly appreciated and will allow us to give you a prompt and efficient service.

© Dr Rodney Jones, Healthcare Analysis and Forecasting, 1996

4. Letter from Hospital to surrounding GPs

To all GPs using hospital services

RE: Temporary Residents and Overseas Patients

We urgently need your help. Temporary Residents and Overseas Patients are displacing the care of local patients. Why?

The answer is straightforward. If they are referred to hospital with a local address and on a GP's headed paper then we can only assume they are a resident and registered with that GP. While this sounds very innocuous there is a catch. Their attendance then gets paid for by the local Health Authority thus depriving local residents of their rightful care.

The information we need on every referral is as follows:

- The patients home address (as recorded with their registered GP)
- The referring GP (yourself)
- Full details of the patients registered GP.

This information allows us to send the bill to the patients respective Health Authority thus leaving that money to treat another of your registered patients.

For Overseas Residents we need a clear indication, preferably at the top of the letter

'This person may be/is an Overseas Resident'

Many countries have reciprocal agreements with the UK and so the patient may not have to pay themselves. In these cases we receive payment via the DOH. Treatment delivered by the N.H.S. only deprives one of your own patients.

Your assistance in this matter is greatly appreciated.

© Dr Rodney Jones, Healthcare Analysis and Forecasting, 1996

5. Letter to Medical Secretaries Regarding Telephone Referrals

Subject: Telephone requests for Urgent outpatient visits

Dear Secretaries,

From time to time you receive telephone calls from GP's requesting urgent appointments for particular patients.

Often the GP only gives you minimal information regarding the patient and often the patient is not even registered with that practice. The end result is that we are losing income for some of these visits and the relevant clinical communications never get to the patients registered GP.

Whenever you receive a telephone request can you please ask the GP the following questions:

- Is the patient registered with their practice
- If not registered with them, who is the registered GP and what is the home address of the patient as well as the temporary address (we must know all of these)
- If not registered with them, is the patient from overseas (we need to know the overseas home address as well as a UK contact address)

Can they also provide the following:

- Patients full name (as recorded with the registered GP)
- Patients date of birth
- Patients home address (as recorded with the registered GP)
- Patients post code - this is a vital piece of information as our computers use this
- Referring GP details
- Registered GP details

If they are unable to supply any of the above can you please explain why the information is needed and request that they write with the missing details as soon as possible.

Can you then pass all this information on to ..... in Medical Records. This will allow us to get paid for the attendance and ensure that the patients clinical information is channelled to their registered GP.

© Dr Rodney Jones, Healthcare Analysis and Forecasting, 1996