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Improving data quality to deliver more accurate reimbursement

An NHS Foundation Trust in the East of England that provides acute hospital and community care services to around 280,000 people has taken steps to deal with significant financial pressures and a requirement to maximise value for money with the available resources. 3M's Health Information Systems (HIS) business enjoys a strong working relationship with the Trust's clinical coding team, which uses 3M™ Medicode™ Clinical Encoder as its primary clinical coding tool.

Project requirement

Complete, accurate clinical coding is essential in NHS Trusts. The Payment by Results framework means that a Trust's revenue is dependent on its coding quality. The Trust had previously engaged an external firm to review the quality of its coded clinical data, however this had resulted in a significantly increased workload for the senior coding team, as the suggested changes were often inappropriate and had to be reviewed carefully. The Trust's Clinical Coding Manager contacted 3M's HIS team to see how it could help the Trust to better use its resources to improve data quality.

Identified needs

3M's HIS team quickly recognised three key insights.

Firstly, it was important to build on the coding team's existing knowledge of Medicode clinical encoder. Secondly members of the existing senior coding team were best placed to identify and assess anomalies in their own data. Thirdly it was necessary to reduce data to a manageable quantity by screening out activity that did not require review.

The addition of three new 3M Medicode modules was proposed to improve the coding process, optimise data quality and maximise the capacity of both the clinical coding auditor and clinical coding trainer:

One of the modules was the 3M™ Data Quality Analytics Solution (DQA) which reviews all coded episodes and reports against the national clinical coding standards, alerting the user to potential errors. Target review areas are identified effectively and efficiently at episode level. DQA fits into the daily coding process where alerts can be reviewed by people trained to recognise the impact of errors.

The results

Financial benefit

A more accurate data submission has led to an income improvement of £148,000 in the first six months, meaning an average of £24,000 per month increase in appropriate reimbursement.

Increased data accuracy

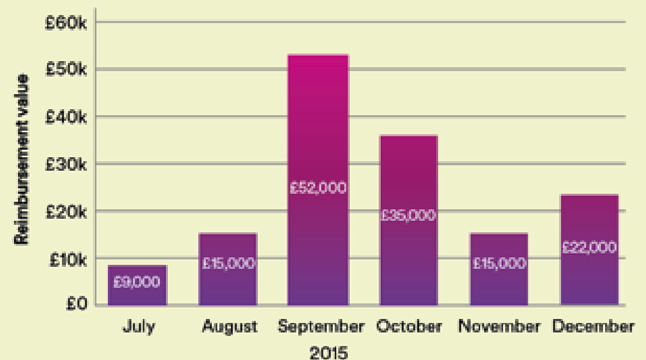
The new modules have led to improved accuracy and quality of data for both internal and external use.

Increased capacity for audit

The introduction of the new modules has meant that all coded data can now be audited internally using existing resources.

Development of people skills

DQA has allowed the existing team to optimise its efficiency and initiate a cycle of continuous learning and development.



First six months all saw improved reimbursement results, with £52,000 generated in September 2015 alone. Data on file with the Trust's Clinical Coding Department 2015.

"Twice-weekly running of DQA means that the coding team has immediate feedback, in more detail. Our month-end checks are fewer and completed nearer to the time of coding, meaning that we are able to quickly correct errors and feed back to the coders."

Clinical Coding Manager

For more information on the 3M DQA Solution:
Freephone **0800 626578** or email **help.his.uk@3M.com** or visit **www.3M.co.uk/his**

Financial results were produced by processing six month's data and amending codes, i.e. using a more specific code and also adding codes where DQA highlighted a potential error and on further investigation where extra codes could be added. Data on file 3M and Medicode are trademarks of the 3M company. © 3M 2016.

Carrying on

Continuing healthcare demand and costs are increasing and commissioners are feeling the strain. Seamus Ward examines why

It is fair to say that continuing healthcare (CHC) has not always had the highest profile in the NHS. In the past, it may have been regarded as a small, if contentious, element of commissioners' budgets, a hangover from primary care trusts or, in NHS acute providers' case, largely an irrelevance, because the care is delivered either in patients' homes or in privately run nursing homes. Yet its profile is rising.

Several times in the last year NHS England has highlighted how underspends in provisions for legacy CHC claims – for care delivered before April 2012 – have helped increase the overall commissioner underspend and offset provider sector deficits.

Providers are increasingly worried about delayed transfers of care – some of which are caused by slow assessment of patients' eligibility for CHC. With new claims seemingly on the rise and a deadline looming to process legacy claims, CHC looks set to play a bigger role in the national conversation on finance and the services that are delivered by the NHS.

CHC is a package of health and social care commissioned and funded solely by the NHS. This covers patients who are over 18 and require physical and/or mental healthcare outside hospital – which could be in their home or a nursing home – as a result of a disability, accident or illness. To be eligible, the patient must be assessed as having a primary health need. This is assessed using a framework, which was first introduced in 2007 and includes an initial checklist to see if a patient may be eligible for CHC, followed by a more detailed decision-support tool (see box right). A fast-track tool can also be used for those in the final stages of life. If a patient is deemed eligible, a review should take place after three months and annually thereafter.

It is a complex and emotive area, and the waters are muddied by the fact that there are new claims (those made since the inception of CCGs) and legacy claims (those passed on by PCTs when they were abolished).

Retrospective claims, also known as previously un-assessed periods of care (PUPOC), cover the period from April 2004 to March 2012, and are made by patients hoping to be reimbursed for the care they paid out of their own pockets. With many patients now dead, these claims are often made by relatives.

PUPOC payments should restore the patients to the financial position they would have been in if CHC had been funded at the time. The settlement should not result in the individual or the CCG gaining a financial advantage. Nationally, about 59,000 PUPOC claims were made and by March 2015, 27,500 were waiting to be processed.

The health and parliamentary ombudsman has complained about the slow speed of progress and NHS England expects CCGs to make an initial assessment of all claims by March 2017 at the latest. It has asked CCGs to complete outstanding assessments by September to allow a six-month contingency. This does not include time for appeals.

While CCGs have the legal responsibility for the legacy claims and must make provisions in their accounts, NHS England holds the funds. The funds are gathered through a risk pool to which all CCGs contribute each year – it is these funds that have been

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underspent in recent times, with NHS England returning a proportion of CCG contributions. In 2014/15, the underspend on the risk pool meant that all CCGs were given back about 50% of their contribution – £156m was returned nationally. According to the latest NHS England figures, at year end in 2015/16 the underspend against expected legacy claims was £192m.

While the return of a proportion of contributions has been helpful, it's not all positive. As NHS England chief finance officer Paul Baumann has pointed out, this is merely deferred spending and the funds will be needed in the next few years as claims are settled.

CCGs say the remaining legacy settlements could be higher than those already processed because outstanding claims tend to involve patients who needed more complex care.

The assessment of a PUPOC claim is similar to that outlined in the box, but can be complicated by the fact that the patient may be dead and it can be difficult to get hold of the care records needed to complete the review. In addition, claimants must prove how much they paid for their care. One CCG estimates that the cost of reviewing its PUPOC claims will be more than £200,000. This is paid by CCGs and is not offset against the contribution to the risk pool, which is typically between £1.5m and £2m a year.

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According to Health and Social Care Information Centre figures, just under 22,000 patients were newly eligible for CHC at the end of the first quarter of 2013/14. Over the next 10 quarters the number of newly eligible patients rose and by the end of the third quarter of 2015/16 it stood at more than 25,000.

In the same period, the overall number of patients eligible for CHC increased from just under 57,000 to 62,000. Although a relatively modest increase, costs can soon add up. Needs vary, of course, with an individual with significant health needs perhaps costing £5,000 to £6,000 a week while an older person who perhaps needs a little support through regular nurse visits could cost a few hundred pounds.

Increased pressures

Kernow Clinical Commissioning Group ended 2015/16 with a £17m deficit against a planned surplus of £500,000. A spokesperson for the CCG told *Healthcare Finance* that it overspent its CHC budget by just over £11m. The CCG says pressures on CHC are mainly due to the increased population of over-65s living in Cornwall and the Isles of Scilly and increased life expectancy. It is working closely with NHS England to develop robust plans to improve its financial position. It is also working with its CHC providers as part of the recovery plan.

'Continuing healthcare is a big issue for the NHS and it has grown massively over the last 10 years,' says Ray Hart, managing director of Valuing Care, a consultancy that helps NHS bodies establish the true costs of the care they are commissioning. In some cases, he says, it has saved 10% to 20% on the cost of individual care packages.

'The growing area is around older people who are eligible for CHC, taking up quite a proportion of people in care homes,' says Mr Hart. 'Most people think social services pay for this population, but a proportion – 10% to 20% in any given area – could be CHC clients. It needs to be commissioned based on the cost of the placements, but it is not always seen as a priority.' He believes that there is a greater awareness of CHC, adding that in the past many of these patients would have been cared for in cottage hospitals, which are now largely gone.

Commissioners are looking at different ways of solving that problem and getting better value from ever-increasing demand, he says.

'For older people, CCGs have on the whole used council rates and added extra services on top. But providers are questioning council rates. Some commissioners have used banding and not always accurately. We have seen huge variation around bands, with some providers claiming they don't cover their costs, while others are quite happy. Bands speed up the process and make billing easier. 'On the flip side of that, if you are trying to cost every single assessment and placement – looking at how many staff are needed per shift, for example – that's a lot of work.'

One CCG told *Healthcare Finance* that it had introduced more consistency into the assessment process it had inherited from its predecessor primary care trust. Instead of assessments being undertaken by district nurses, there is now a dedicated nursing team for this purpose and a more rigorous assessment process. It has also commissioned 'discharge to assess' beds for hospital patients. There was a recognition that an assessment undertaken at the 'direct discharge' stage could lead to under- or over-estimating a patient's needs, but the initiative allows clinicians to get an accurate assessment of the support that will be required when they leave hospital. Patients are moved to these beds for a week or more, until they are stabilised, and then an assessment is made.

The CCG has seen a 12% fall in the number of patients being funded for CHC, funded nursing care or joint packages of care. And within this overall reduction, there has been a shift away from CHC towards joint funding and funded nursing care. The CCG attributes this to its better and more consistent assessment, but the savings have been counterbalanced by rises in nursing home costs and care costs in other sectors – driven in part by the rising cost of staff in these services.

CHC is a complex area and in many parts of the country it is becoming a pressing financial matter not only in terms of legacy claims, but also new claims as the population ages.

The CHC process

Initially, a health or social care worker will identify a patient with a potential need. In some areas this can involve the completion and submission of a checklist to the CCG.

At the next stage, a decision support tool is used to determine the patient's eligibility. This is a document with more than 50 pages and is filled in by a nurse assessor.

Once gathered, the information is discussed by a multidisciplinary team, which assesses the level of need across multiple domains to decide if there is a primary health need in an individual's care needs. This covers areas such as breathing, mobility and whether they need help with eating and drinking.

The assessment has four possible outcomes:

- **The patient is eligible for CHC** – the cost of all their care, including accommodation if appropriate, is picked up by the CCG.
- **The patient requires funded nursing care** – this care is delivered only in nursing homes and is funded by the CCG. In one CCG spoken to by *Healthcare Finance*, this amounts to around £113 a week, with the balance possibly funded by social services. If a patient decides that they want to be in their own home and their needs can be met in the community, no payment is made, because universal services such as district nursing can provide this level of nursing care.
- **The patient needs a joint care package (health and social care)** – the CCG and the local authority agree to contribute to the cost of the patient's care, which can be delivered in a care home or the patient's own home. As is often the case with local authority social care funding, CCGs would typically cap the cost of services delivered at home at a point close to the cost of supporting that patient in a care home.
- **The patient has only social care needs.**

New role with HFMA - Policy and technical assistant

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The HFMA is looking to second a Policy and Technical Assistant to support the work of the technical editors. For more information about the role visit jobs.hfma.org.uk

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