

# **An Evaluation of Three Years of the PbR Data Assurance Framework**

January 2011

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# Summary Report

**1** The Payment by Results (PbR) Data Assurance Framework (the Framework) has been in operation since 2007/08. It was set up with two objectives:

- to drive improvements locally in the quality of data that underpins PbR; and
- to provide national assurance of sufficient data quality for the PbR system to function robustly.

**2** To do this, the Commission developed three core components to the Framework:

- an independent audit programme of admitted patient care and outpatient data, examining national themes and targeted clinical areas, covering all acute NHS trusts in England;
- develop benchmarking indicators to target audits and for wider use online by primary care trusts (PCTs) and trusts; and
- national research, briefings and reporting on issues emerging from the audit programme and benchmarking analysis.

**3** In response to their 2010 consultation, the Commission undertook to conduct a formal, independent evaluation of the first three years of the Framework, from 2007/08 to 2009/10, to assess its impact and effectiveness over that period and to inform its future development. The evaluation sought to answer two main questions:

- Have the core components of the Framework been delivered effectively and has it met its stated aims?
- To what extent, and in what ways, has the Framework driven change in the behaviours and improvements in data quality of assessed bodies and local health economies?

**4** This report contains the findings of that evaluation. They are that:

- The Framework has achieved its aim of improving data quality. Over the three years, clinical coding accuracy has increased by 5 per cent as a national average, although significant local variation remains.
- The Framework has achieved its aim of providing national assurance. Key national stakeholders, such as the Department of Health, Care Quality Commission and NHS Connecting for Health, can demonstrate how they have relied on the findings of the Framework.
- It is the clinical coding audit programme that has been most visible and had most impact, both locally and nationally.
- Many respondents were aware of the National Benchmarking, but few were able to demonstrate how they had used it themselves as part of their clinical coding assurance.

- The Framework has delivered value for money in relation to the total value of errors found and represents a very small (0.03 per cent) investment of total PbR expenditure. However, PCTs and trusts had differing perceptions of this.
- Respondents both locally and nationally voiced their concerns over what, if anything, would replace the Framework in the future. Changes to the Audit Commission, NHS commissioner arrangements and responsibilities for tariff setting create opportunities to rethink how any future assurance framework is structured.

# Detailed Report

## Background to the PbR Assurance Framework and the Evaluation Text

**5** The Payment by Results (PbR) Data Assurance Framework (the Framework) was established with two objectives:

- to drive improvements locally in the quality of data that underpins PbR; and
- to provide national assurance of sufficient data quality for the PbR system to function robustly.

**6** To do this, the Audit Commission (the Commission) developed three core components of the Framework:

- an independent audit programme of admitted patient care and outpatient data, investigating national themes and targeted clinical areas, covering all acute NHS trusts in England;
- the development of benchmarking indicators to target audits and for wider use online by primary care trusts (PCTs) and trusts; and
- national research, briefings and reporting on issues emerging from the audit programme and benchmarking analysis.

**7** Between 2007/08 and 2009/10, all NHS acute trusts received an annual external clinical coding audit of admitted patient care and at least one outpatient data assurance review. The inpatient audits were conducted by professional clinical coding audit firms, contracted by the Commission. During this time, the Commission also undertook pilot reviews of Accident and Emergency (A&E) data and Independent Sector (IS) providers.

**8** The output of the audit process was a local report for the PCT, shared with the provider. From 2009/10, Strategic Health Authorities (SHAs), PCTs and providers were also supplied with summary reports that placed individual providers' performance in a local and regional context. From 2008/09, reports became available online, through the PbR Portal on the Commission's website.

**9** These local reports were intended to provide local NHS bodies and national stakeholders with an assessment of the quality of acute provider data and give a clear indication to commissioners and providers of the areas for improvement.

**10** Originally available in written reports, the benchmarking indicators were developed into an online tool, the National Benchmarker freely available to the NHS. Data from the Hospital Episode Statistics (HES) database was used to update the National Benchmarker quarterly and there were annual updates to the indicators, methodology and presentation of the National Benchmarker.

**11** From 2009/10, the National Benchmarker began to be developed with a dual purpose: both to inform the selection of areas for the clinical coding audit programme and as a tool in its own right, to assist PCTs and providers improve their efficiency. Guidance, training and case studies were made available to the Commission's own staff and the NHS.

**12** Each year, the Commission has published an annual report on the Framework's findings at a national level. From 2008/09 onwards, this has included a year on year comparison of performance. In addition, the Commission published various shorter reports, into the two pilots already mentioned, as well as a pilot study on assuring Reference Costs, and a research project, conducted with the Royal College of Physicians (RCP).

**13** Commission staff, working on the Framework, have presented at numerous regional and national events on data quality, clinical coding, PbR and financial management.

**14** In response to their consultation in 2010, the Commission undertook to conduct a formal, independent evaluation of the first three years of the Framework, from 2007/08 to 2009/10, to assess its impact and effectiveness over that period and to inform the future development of the programme.

**15** The original intention was to commission this work externally. However, shortly before the evaluation was due to start, the Commission's abolition was announced. To save public money, the Commission decided to appoint an in-house team, using staff who had not previously worked on the Framework. The evaluation brief issued to the in-house team remained exactly the same.

## Methodology

**16** The evaluation sought to answer two main questions:

- Have the core components of the Framework been delivered effectively and has it met its stated aims?
- To what extent, and in what ways, has the Framework driven change in the behaviours and improvements in data quality of assessed bodies and local health economies?

**17** The evaluation team comprised of a team leader and three further core team members, drawn from Commission staff who had worked on performance reviews and inspections in the public sector, but who had not previously been involved with any aspects of the Framework.

**18** Data to inform the evaluation was secured through a number of means.

## Surveys

**19** Two surveys were sent out on October 2010. The first was to 307 PCTs and NHS providers (NHS survey), and the second to 320 individuals directly involved in the delivery of the Framework (staff survey). Both surveys asked respondents how they rated the Framework overall and how it could be further improved. Feedback was sought about the effectiveness of the audits in identifying areas for improvement, and what had improved as a result. Both groups were asked how they had received updates about the development of the assurance Framework, such as through the PbR portal and annual reports, and how effective these had been.

**20** In the NHS survey, respondents were asked how helpful the recommendations in the clinical coding audit reports had been, and what issues had prevented their organisation in fully implementing any recommendations. A question sought to identify what additional costs, such as staff time and financial cost the Framework had placed on their organisation.

**21** Respondents were also asked whether their organisation had used the National Benchmarker and what the barriers had been if they had not used it. Those who had used this tool were asked if they found it easy to use and navigate and what changes had resulted.

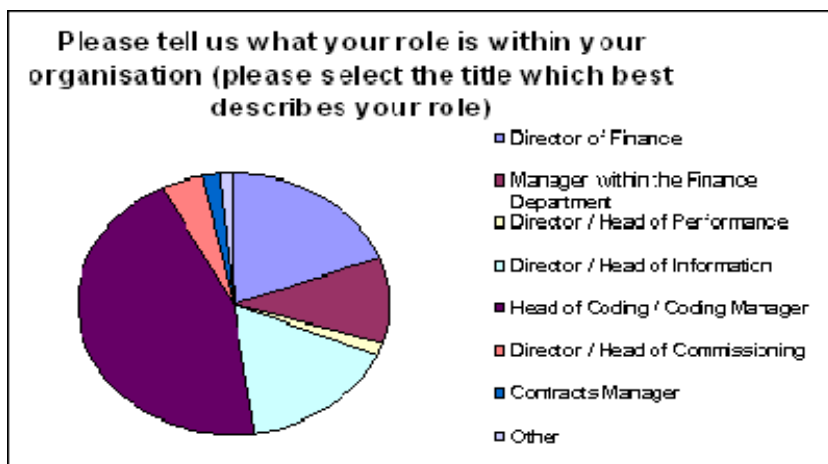
**22** The staff survey asked for views on the effectiveness of the processes for delivering the audits. The training and support available to them was explored and they were asked how effective they felt that this had been.

**23** Full details of the questions asked in both surveys are contained in Appendices 1 and 2.

**24** There was a 24.4 per cent response rate the survey of PCTs and NHS providers, with a total of 75 responses. Of these, 23 responses (30.7 per cent) were from PCTs and 49 (65.3 per cent) from NHS providers. The remaining respondents did not indicate which bodies they represented.

**25** 30 (40 per cent) of the responses were from coding managers, with a further 13 (17.3 per cent) from directors of finance and 11 (14.7 per cent) from directors of information. Of the remaining responses, 7 (9.3 per cent) were from finance managers. Directors and managers in commissioning, contracts and performance made up the remainder. (Figure 1)

Figure 1: Breakdown by job title of respondents to the NHS survey



Source: Audit Commission

26 36 (48 per cent) of the responses related to both inpatient and outpatient audits. A further 35 (46.7 per cent) were for inpatient audits alone and three (4 per cent) related solely to outpatient audits.

27 The staff survey had a 24.1 per cent response rate with a total of 77 responses. Of these, 35 responses (45.5 per cent) were from auditors managers with a further 17 (22.1 per cent) from PCT Appointed Auditors, and 13 responses (16.9 per cent) from performance specialists. The Commission's own staff and the staff of the financial audit firms were represented in the sample. There were also five responses (6.5 per cent) from clinical coding auditors. (Figure 2)

Figure 2: Breakdown by job title of respondents to the staff survey



Source: Audit Commission

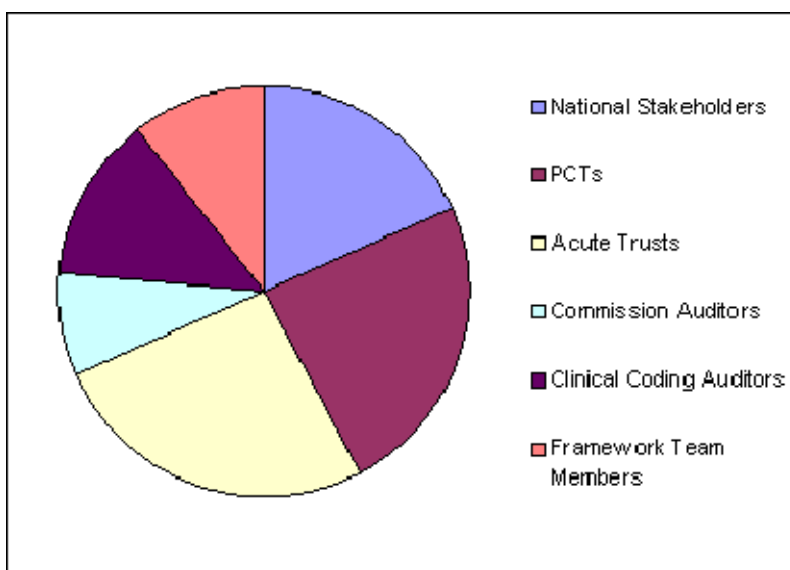
28 The small sample sizes means that, in some cases, the data needs to be treated with caution.

29 The Framework team had also collected post-audit questionnaire data between February and July 2010, on the 2009/10 programme and between November 2008 and October 2009 on the 228/09 programme. The evaluation team have occasionally drawn on this material for comparison.

## Interviews

The evaluation team conducted 38 face-to-face or telephone interviews with representatives of a wide range of stakeholders. This group comprised of seven stakeholders at national level, such as CQC, Monitor and the Department of Health (DH); nine PCTs; ten hospital trusts; three Commission auditors; five clinical coding auditors and four members of the Framework team. (Figure 3)

Figure 3: **Breakdown by organisation type of interview participants**



Source: Audit Commission

30 For PCTs and NHS providers, these interviews followed a similar format to the survey: investigating views about the effectiveness, impact and value for money secured by the Framework. The interviews allowed for further exploration of issues that had been raised by the survey responses. The outcomes of the interviews and the surveys were then tested in questions to individuals involved in the delivery of the Framework and discussed with national stakeholders.

31 Full details of the questions asked are contained in Appendix 3.

## Document reviews

32 This consisted of analysis of the three annual reports and related documents and other sundry material.

## Quantitative data

33 Quantitative data relating to the audit results and subsequent analysis was supplied by the PbR team and is the same as that used to produce the 2009/10 Annual Report. The evaluation team did not generate any further audit data nor undertake any additional quantitative analysis.

## Findings

34 The review found that, in general, the PbR Assurance Framework has met its stated aims and that the core components have been delivered effectively. The DH stated in interview that:

**‘The reduction in errors over the last three years is testimony to the effectiveness of the approach and benefits are evident in other areas, such as programme budgeting.’**

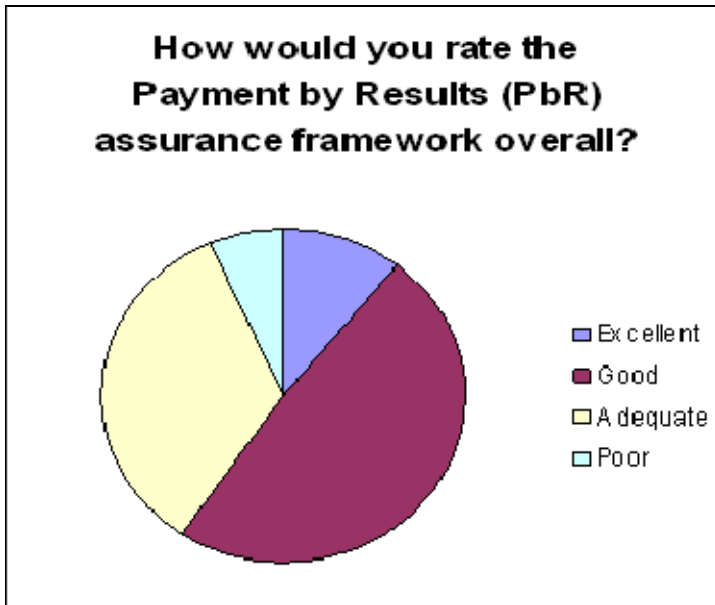
35 And a Commission Auditor reported that:

**‘The Framework has been effective in identifying areas for improvement and as a lever for the PCT to have a more robust dialogue with the acute trust around activity and coding accuracy. The Framework has also been a lever for improving contract management.’**

36 It is seen by respondents and interviewees, especially national stakeholders, as an independent, comprehensive and consistent way of providing assurance and highlighting issues. By enabling comparisons and benchmarking, it acts as a major driver for investment and improvement in clinical coding.

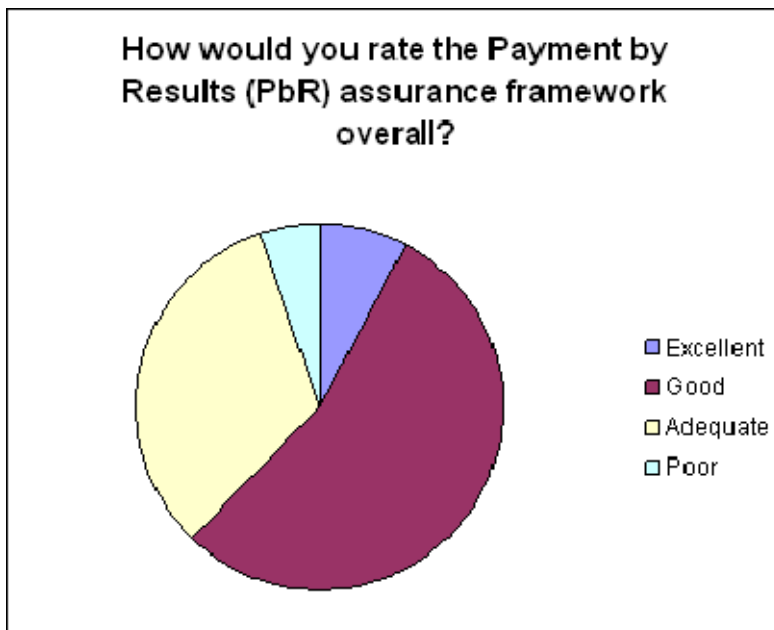
37 In the survey nearly 65 per cent of trusts and 48 per cent of commissioners who expressed a view on the Framework overall described it as ‘good’, or ‘excellent’. (Figure 4) When the Framework team conducted their post-audit questionnaire of the 2009/10 programme, over 65 per cent of all respondents rated most aspects of the Framework as good or excellent. For the 2008/09 programme, the results were similar at over 63 per cent of all respondents.

Figure 4: NHS survey overall views of the Framework (NHS survey)



Source: Audit Commission

Figure 5: Staff survey overall views of the Framework (staff survey)



Source: Audit Commission

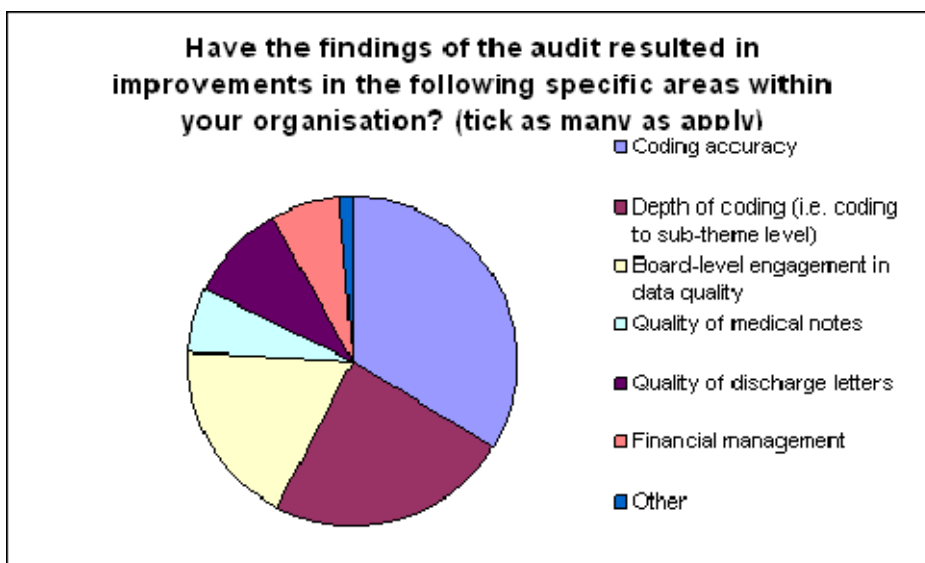
**38** The views of the NHS were shared by three quarters of Commission staff and contractors who had directly delivered the clinical coding audits. (Figure 5)

## Has the Framework met its main objectives?

**39** The first of the Framework's two main objectives is to drive improvements locally in the quality of data underpinning PbR. As the 2010 annual report notes, accuracy of clinical coding has improved year-on-year. At the start of the programme the average rate of clinical coding errors at trusts was over 16 per cent. This reduced to just over 11 per cent by 2010. Approximately £9 million worth of financial errors have been identified. The gap between the best and the worst trusts has narrowed and error rates in HRGs have also decreased.

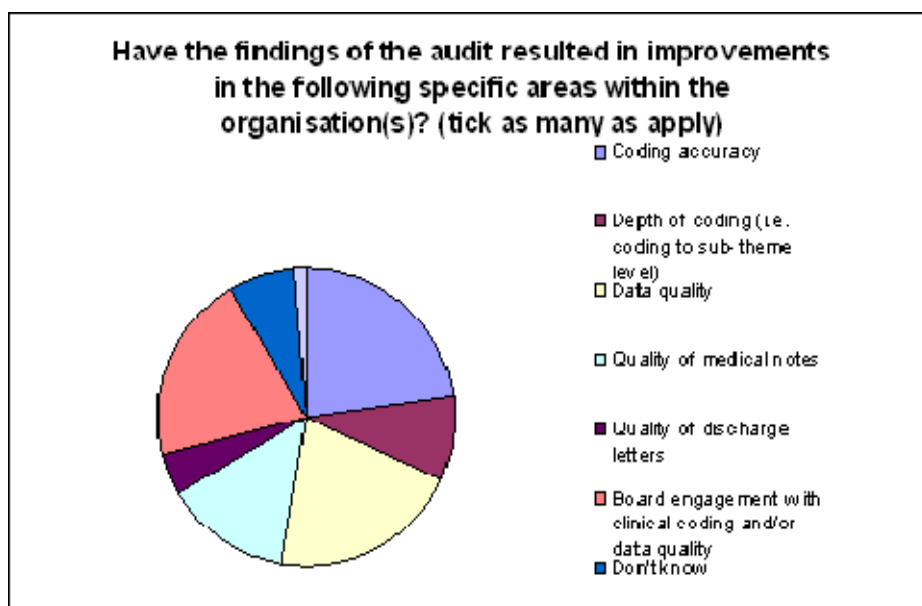
**40** Improvement in clinical coding accuracy was cited by over 73 per cent of respondents to the survey of PCTs and NHS providers as a consequence of the Framework. (Figure 6) Half of them noted improvements in the depth of coding and forty per cent noted increased engagement at Board-level in data quality. Improvements in the quality of discharge letters, and improved medical notes were also identified by survey respondents and interviewees. Commission staff and clinical coding auditors reported broadly similar areas of improvement. (Figure 7)

Figure 6: **The kinds of improvements the Framework has identified (NHS survey)**



Source: Audit Commission

Figure 7: **The kinds of improvements the Framework has identified (staff survey)**



Source: Audit Commission

41 In interview, one trust stated that ‘the audit has been effective in improving the quality of discharge letters in the trust’. Another stated that ‘the reports have led to an increased awareness of data quality, both a Non Executive Director (NED) level, as well as at data entry level’.

42 However, one PCT stated that:

**‘The Framework has had quite limited impact. The PCT wanted the validation that they are being charged effectively [...] but the sample size is too small. The programme is therefore of limited use to commissioners’.**

43 The Framework’s second objective is to provide national assurance of sufficient data quality for the PbR system to function robustly. This objective is more complex to achieve and to assess. Firstly, because there is no definitive point at which data quality can be said to be sufficient for payment purposes. And, secondly, because any such point can change, dependant on the classification system used. The Commission observed the effect of the change from HRG3.5 to HRG4 in the 2009/10 Annual Report.

44 In comments in interview, supported by Monitor and the NHS Information Centre (NHS IC), the DH stated that:

**‘In other countries, the tariff has been reduced on the assumption that this up-coding is happening. The assurance that the Framework has given has prevented this happening’.**

**45** National stakeholders reported that they mainly drew their assurance from the national reports and analysis. CQC reported how the Framework had become more responsive to the assurance needs of national stakeholders over time. The example they gave was of ‘unsafe to audits’, which were not an important area for the Framework in its first year but, after CQC flagged this as a significant issue, the Commission provided the data to them in subsequent years.

## **Have the core components of the Framework been delivered effectively?**

### **Audit Programme**

**46** The evaluation found that the audit programme was the highest profile component of the Framework with client organisations and the area on which most comments were received. There was broad agreement amongst survey respondents and interviewees that these audits are valuable and producing demonstrable improvements. Post-audit questionnaires, conducted by the Framework team, have indicated a consistent level of satisfaction with over 60 per cent of respondents rating the audits as good or excellent.

**47** Delivery of the audits is generally perceived as being a smooth and successful operation by those involved in conducting them, with all respondents agreeing that the overall process was effective. Audits have been useful in providing assurance, confirming what needs to be done, forming a basis for discussion and additional work and identifying areas for further investigation. Improvements are evident in organisations which the CQC has visited as a result of issues being highlighted by the Framework.

**48** However, some PCTs and providers felt the approach was simplistic, with small sample sizes and non material financial changes. Similarly some organisations did not find the approach helpful in tackling certain issues, such as increases in costs whilst activity remains constant.

**49** The Framework Team, the Professional Association of Clinical Coders (PACC) and some trusts commented on the variability in the approach and competency of some coding auditors.

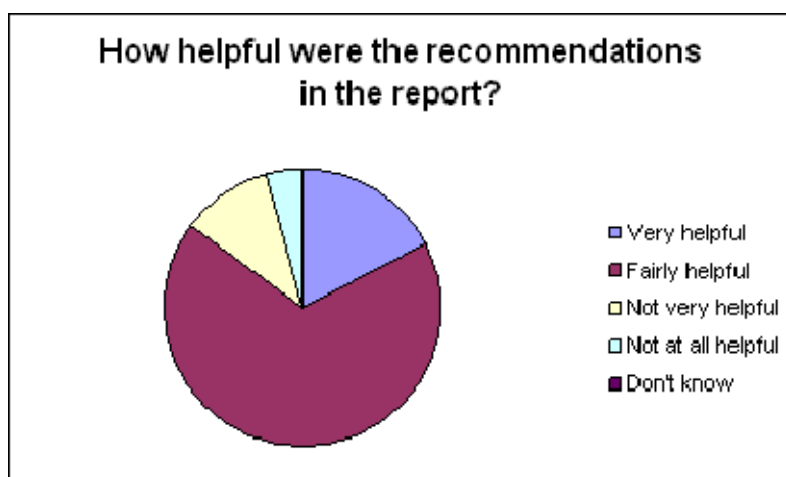
**50** Local reports are generally regarded by the NHS as being useful and supportive of further improvement. (Figure 8) However, one national stakeholder felt the local reports could be more clearly written to be more accessible to non specialists. But, as one Trust respondent added, ‘precision is more important than accessibility’.

Figure 8: How useful were the audit reports (staff survey)



Source: Audit Commission

Figure 9: The value of the audit reports' recommendations (NHS survey)



Source: Audit Commission

**51** The large majority (84 per cent) of the respondents to the survey of commissioners and trusts agreed that the recommendations in clinical coding audit reports were helpful. (Figure 9) However, a few comments were made by respondents and interviewees that recommendations sometimes need to be better tailored to the needs of the organisation. The 2009/10 Annual Report shows that more providers had a higher number of outstanding recommendations than in 2007/08.

Figure 10: How much is the NHS using the Benchmarker? (NHS survey)

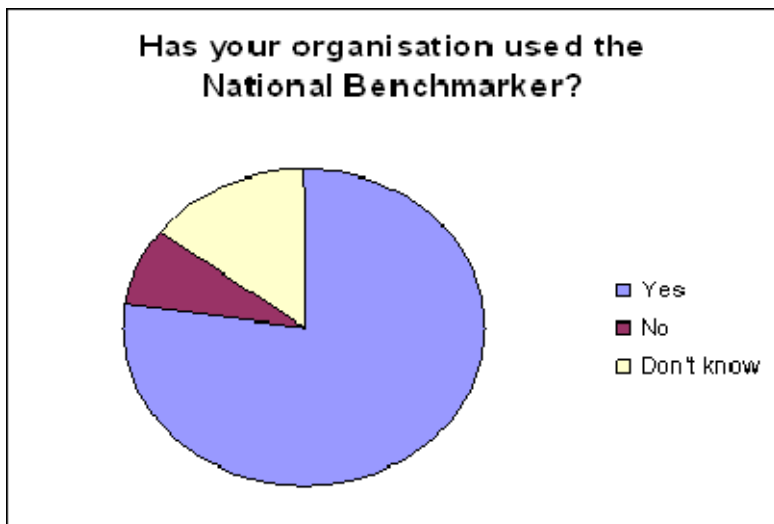
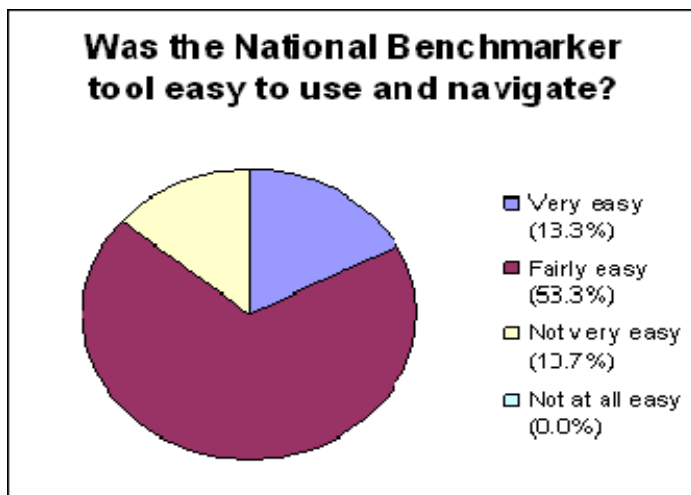


Figure 11: How easy is the Benchmarker to use? (NHS survey)



Source: Audit Commission

52 There were 21 replies to the question, 'What changed as a result of using the Benchmarker?' Of these, about half felt nothing had changed or that they could not identify any impact and, when asked, few interviewees could provide concrete examples of its application to assurance in their organisation. However, one trust respondent was able to give a clear example of using the Benchmarker for wider purposes:

**'The trust has used the National Benchmarker to inform its planning process. It has been useful to operational managers to question where they vary from the norm and it has been particularly useful to provide responses to challenges from the PCT, to have counter-arguments to their claims backed up by findings from the National Benchmarker'.**

53 This disconnect seems to be, in part, because some Commission staff were not skilled or proactive in using and promoting the Benchmark. As one Audit Manager said:

**‘This can be damaging to the reputation of the Commission, if health organisations realise that internal staff do not know how to use our own products’.**

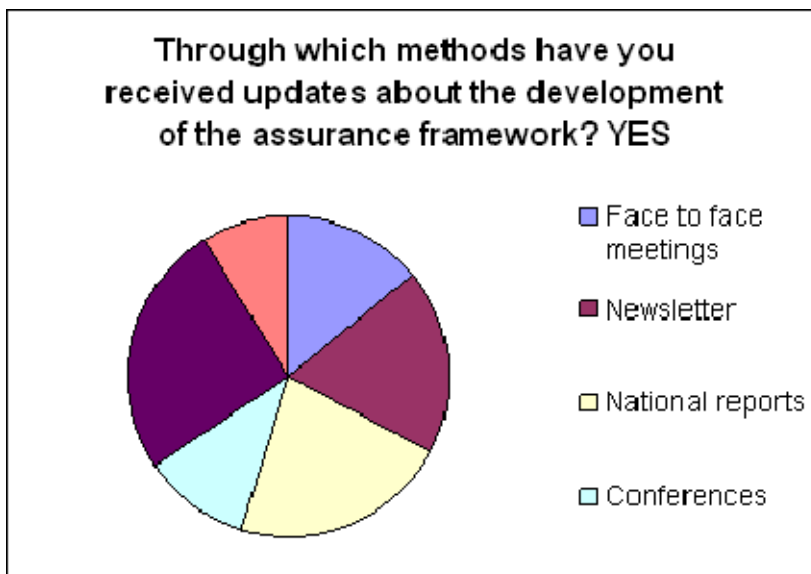
54 There were other comments from auditors and from NHS bodies that the Benchmarker needs to be better promoted. A trust respondent stated:

**‘I was unaware of it [but I] have now signed up for access to this useful tool’.**

### National research and publications

The national reports and analysis are well regarded, especially by national stakeholders, for whom the highlighting of key issues is particularly helpful. The ways in which updates about the Framework are provided were mostly regarded as effective. National reports and the Commission’s website were the most cited information channels, followed by the Assure newsletters. (Figure 12)

Figure 12: **Methods for receiving updates on the Framework (NHS survey)**



Source: *Audit Commission*

55 The greatest discontent expressed in the survey of users was with the Commission’s website, but only eight respondents described this as ‘not very effective’.

## Value for money and additional costs

56 Between 2007/08 and 2009/10, the Commission audited £200 million pounds of inpatient activity. £9 million (4.4 per cent) of this activity was assigned to the wrong HRG. During the same period, PCTs have collectively been charged £15.5 million for the PbR Assurance Framework. This represents approximately 0.03 per cent of total PbR expenditure. For this level of investment, the Framework has contributed to a five per cent reduction in clinical coding errors. (Table 1)

Table 1: **PbR expenditure, assurance fees and gross error values**

Year	Total PbR Assurance Framework Fee (£millions)	Total Value of Episodes Checked (APC only) (£millions)	Total Gross Value of Errors Found (APC only) (£millions)	Total Value of PbR Expenditure, excl. A&E and OPs (£millions)
2007/08	5.4	73.0	3.5	17,400
2008/09	5.0	66.0	2.6	17,900
2009/10	5.0	60.4	2.7	18,300
Total	15.5	199.4	8.8	53,600

Source: Audit Commission

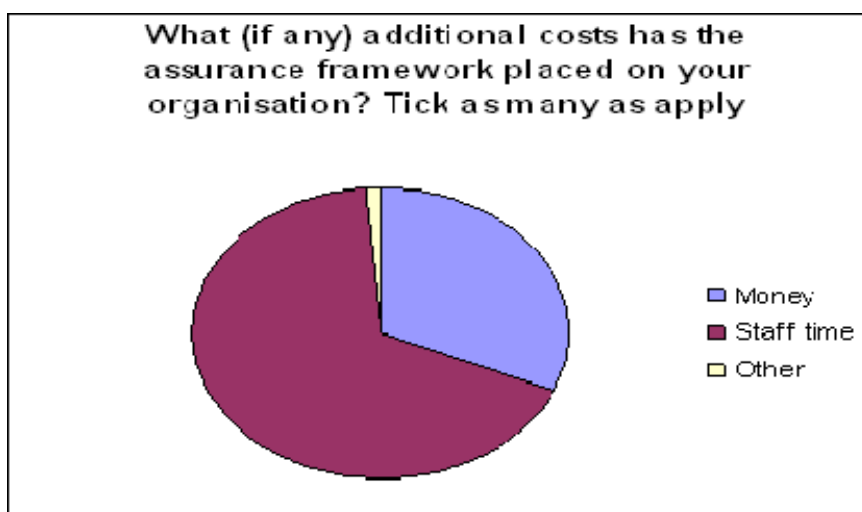
57 National stakeholders expressed concern that it would be costly and difficult to replicate this system-wide approach and to achieve consistency if the work is undertaken by separate organisations in the future.

58 The evaluation was also interested in exploring what, if any, additional costs were incurred by PCTs and NHS providers as a result of the Framework; specifically, the coding audit programme and what local NHS bodies' perception of the value for money of the Framework was.

59 This question was variously interpreted in the survey and this affected the comparability of the cost estimates given. But, generally, NHS bodies perceive that they have incurred some increased costs due to the Framework. The majority (60 per cent) of respondents felt that the Framework incurred additional staff time, while 28 per cent indicated that there had been extra financial costs.

60 Comments about the additional staff time were generally inexact; for example, 'overtime required to pull case notes', although, there were some more precise measures, such as 'six hours and employment of two additional coders'. The extra financial and staff costs were generally identified as related to the conduct of the audits, rather than to the implementation of the resulting recommendations.

Figure 13: **What additional costs has the Framework placed upon the NHS?**



Source: Audit Commission

**61** PCTs, especially, had mixed views about whether the audit fees that they paid represented value for money, with a few feeling that they could have spent the money better in other ways to drive improved performance in the trusts.

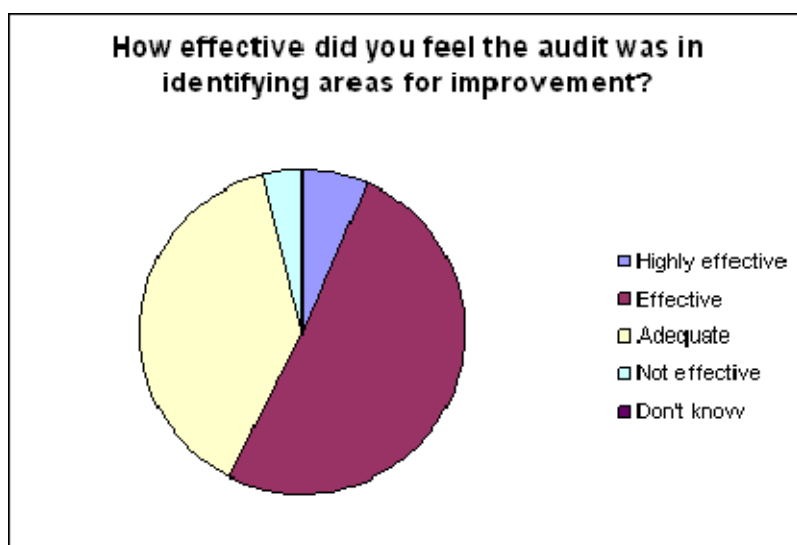
**62** However, providers generally indicated that the clinical coding audits were useful and the extra staff time incurred was acceptable. One trusts stated that, 'the trust invested in more staff as a result of the audit. They had always felt this was needed but the audit provided the impetus'. The Foundation Trust Network reported that some trusts had commented to them that they would be willing to pay for the audits themselves in the future.

### **How has the Framework driven change?**

**63** The recommendations from clinical coding audits and within national reports, together with benchmarking data, have been useful to the NHS in managing and driving up performance. (Figure 14)

**64** Clinical coding audits have promoted improvements in accuracy and in the depth of coding. They have effectively identified strengths and weaknesses in processes and infrastructure. This has mostly enabled a constructive dialogue between PCTs and providers and has provided area-wide data to inform SHA planning.

Figure 14: **NHS views on the improvement value of the Framework (NHS survey)**



Source: Audit Commission

**65** In the main, respondents cited the recommendations contained within the local audit reports and impact on the contractual relationship between PCTs and providers and the most significant ways in which the Framework has driven change at a local level.

**66** One trusts stated that:

**‘Year one and year two produced good recommendations, which the trust acted on. As a result of the year one audit, the management of coders was improved [and] clinicians are now far more aware of the importance of accurate coding’.**

**67** Respondents from trusts cited changes in behaviour or awareness amongst not only clinical coding staff, but managers, clinicians and board members, including NEDs. A Commission Auditor reported that, ‘NEDs have become more informed on clinical governance in relation to data quality as a result [of the Framework]’.

**68** Specialist trusts, which had performed comparatively poorly as a group in 2007/08, responded positively. Their coding accuracy is now at least as good as at other trusts.

**69** However, there is still a significant gap between the best and the worst-performing trusts and overall progress in implementing recommendations has been slow. Only 13.7 per cent of all trusts audited in 2009/10 had completed all their recommendations from the last two years. These recommendations tend to be the more wide-ranging ones, such as improving the quality of documentation or clinician involvement, which cannot be resolved quickly and need to be supported by high-level commitment and addressed corporately.

**70** SHAs are able to detect trends and issues across their areas and plan accordingly. The data provided by the Commission enables comparisons and pinpoints areas where improvement is needed. This helps SHAs to request prompt action, or to consider concerns raised by PCTs about the performance of individual providers on the basis of robust data.

**71** The high quality data and reports generated by the Framework are valued by other regulators. For example, over the three years, Framework reports and analysis have increasingly provided the data that CQC needs to identify issues that need tackling, such as the quality of the clinical records.

**72** The Framework has provided NHS Connecting for Health (CfH) with the opportunity to look at historic data quality. As consequence, the clinical coder training programme and support to working clinical coders has been improved. For example, CfH are now able to better target the guidance they send out.

## Conclusions and issues for further discussion

**73** The conclusions of the evaluation are quite clear. The PbR Data Assurance Framework has met both of its stated aims: to improve local data quality and to provide national assurance. Clinical coding accuracy has improved over the three year period, although some significant, unexplained variation between organisations remains. Many organisations are reporting a proactive engagement with the Framework. Similarly, national stakeholders not only report but can illustrate how they are deriving value from the work the Framework.

**74** Of the three components of the Framework, it is the clinical coding audit programme that has been the most visible and had the most impact on local bodies and national stakeholders. And, in particular, it is the recommendations made in the local audit reports that appear to have the most impact. However, this is not universally the case.

**75** The other two components of the Framework – the benchmarking indicators and the national research – appear to have played less of a role, particularly at the local level. This is not necessarily a surprising finding, as local organisations are more passive recipients than active participants in these two components. However, what remains unclear is whether this is a genuine form of selection by NHS bodies, or that these components were overlooked or misunderstood.

**76** The National Benchmarker is most interesting in this regard. A majority of respondents were aware of the Benchmarker, but most were not able to provide examples of how they had used it effectively for clinical coding assurance. This could be because there was not sufficient technical support available for many organisations to take advantage of the Benchmarker's capabilities. Certainly, there are organisations that can provide good examples of how it can add value.

**77** Most organisations reported that the Framework was generally well managed and delivered. Interestingly, some of the more critical comments came from the Commission's own staff. This probably reflects the complex and evolving delivery chain for the Framework and serves as a reminder that continuous improvement should apply to processes as much as outcomes.

**78** A wider message that emerges from the evaluation is the different ways in which the Framework is viewed, not by local and national bodies, but by PCTs and Trusts. PCTs are proportionally underrepresented in the survey data but their lower levels of engagement and satisfaction with the Framework still come through. Again, this is not a surprising finding, given that most of the work of the Framework is conducted at trusts, but it is the PCT which pays.

**79** A number of both local and national stakeholders expressed concerns about what, if anything, will replace the PbR Assurance Framework in the future. Given the genuine improvements that can be observed and the significant value that national stakeholders and, particularly, trusts have reported, thought needs to be given to how to hold on to and improve on the gains made in clinical coding accuracy and continue to provide independent assurance of data quality, both locally and nationally for providers, commissioners and tariff setters.

**80** As the both PCTs and the Audit Commission will be abolished and the PbR Assurance Framework will come to an end in its presents from, there will be an opportunity to restructure the way in which any future assurance framework is funded. Some trusts have reportedly said that they may be willing to pay for clinical coding assurance. National stakeholders have also reported significant benefits, and so a central funding mechanism may also be appropriate.

# Appendix 1 NHS Survey Questions

## **General**

Do you work for a Trust or a Commissioner?

Please tell us what your role is within your organisation (please select the title which best describes your role)

Are you completing this questionnaire with regard to the in-patient or outpatient audit?

How effective did you feel the audit was in identifying areas for improvement?

Have the findings of the audit resulted in improvements in the following specific areas within your organisation? (tick as many as apply)

How helpful were the recommendations in the report?

If your organisation has not fully implemented the recommendations, what has been the issue preventing this?

## **The National Benchmark Tool**

Has your organisation used the National Benchmarker?

Was the National Benchmarker tool easy to use and navigate?

If your organisation has used the National Benchmarker what has changed as a result?

Please tell us why you do not use the National Benchmarker tool

## **Communication of findings and changes in the PbR Assurance Framework**

Through which methods have you received updates about the development of the assurance framework?

How effective have these methods been?

## **Overall Payment by Results Assurance Framework**

What (if any) additional costs has the assurance framework placed on your organisation? Tick as many as apply.

How would you rate the Payment by Results (PbR) assurance framework overall?

How would you improve the PbR assurance framework for future years?

# Appendix 2 Staff Survey Questions

## **General**

Please tell us what your role is within your organisation (please select the title which best describes your role).

To which organisation(s) do your comments refer?

Are you completing this questionnaire with regard to the in-patient or outpatient audit?

Did you directly deliver the audit?

## **Delivery of the audit**

### **Overall delivery**

Overall I thought the PbR audit was a worthwhile piece of work.

I found the methodology helpful in identifying the key issues for the PbR audit.

### **Set up meeting**

I found the set-up meeting a useful way of gaining an overview of the key issues for the organisation I would be auditing.

I found the set-up meeting a useful way of gaining an overview of the key issues for the commissioner.

### **The audit**

I found the testing process straightforward and easy to perform.

The client found the process for agreeing identified errors valuable.

### **The report**

The template report provided me with a high quality starting point for drafting my own report.

The report was effective in delivering the key messages and assurances.

## **Training and support**

How effective was the training in helping you to deliver the audit?

Did you use the following means of support to help you deliver the audit?

- Regional support.
- Support from national assurance team.
- Guidance.
- PbR online portal.
- Other means of support.

How effective were these means of support?

How effective was the overall process for delivering the audit?

Please give your reasons for the previous answer.

## **Impact of the audit**

How effective did you feel the audit was in identifying areas for improvement?

Have the findings of the audit resulted in improvements in the following specific areas within the organisation(s)?

## **Communication of findings and changes in the PbR Assurance Framework**

Have the following methods been used to update you about the development of the methodology and the results of audits?

- Face to face meetings.
- Newsletter.
- PbR online portal.
- National reports.
- Conferences.
- Other methods of communication.
- How effective have these methods been?

## **Overall Payment by Results Assurance Framework**

How would you rate the Payment by Results (PbR) assurance framework overall?

What do you think are the strengths of the current assurance framework approach?

How would you improve the PbR Assurance Framework for future years?

## Appendix 3 Interview Questions

Theme/main question	Detailed questions
<p>Impact of the PbR Assurance Framework</p> <p>The stated purposes of the PbR Assurance Framework are to provide assurance to key national stakeholders (DH, IC, CfH, CQC, Monitor etc) and to supporting improvements in clinical coding and data quality in local NHS organisations.</p>	<p>How effective has the Assurance Framework been in identifying areas for improvement?</p> <hr/> <p>What has been the impact of the work overall?</p> <p>Please explore whether organisations have undertaken any additional clinical coding audits or data quality investigations as a result of the assurance framework.</p> <p>eg: has it reduced financial risk in the contract?</p> <hr/> <p>Do you think the programme has delivered value for money (ie has it been a cost effective way of providing the DH with the assurance it needs and/or providing your organisation with its own assurances)?</p> <hr/> <p>What has been the impact on how the Board/ Audit Committee views clinical coding and data quality. Please try to tease out whether the report has been presented to the Board/ Audit Committee and how they responded</p> <hr/> <p>How have the PCT and the NHS trust/FT used the information from the Assurance Framework in negotiating and performance monitoring their contracts?</p> <p>Please explore whether delivery of the recommendations from the report are monitored as part of the contract; whether any coding or contract monitoring procedures have changed; and whether there have been any financial reconciliations as a consequence of the assurance framework.</p>
<p>Specific improvements</p> <p>Are there any particular improvements linked to the programme?</p> <p>Please ask specifically about all these areas.</p>	<p>coding accuracy</p> <hr/> <p>depth of coding (ie coding to sub-theme level)</p> <hr/> <p>data quality</p> <hr/> <p>quality of medical notes</p> <hr/> <p>quality of discharge letters</p> <hr/> <p>Any other improvements?</p>

Theme/main question	Detailed questions
Theme/main question	Detailed questions
The report	<p>Is the report set out in a useful way for your organisation?</p> <hr/> <p>Are the calculations accurate?</p> <hr/> <p>Were the recommendations in the report helpful?</p> <hr/> <p>Any barrier to implementing the recommendations or other potential improvements highlighted by the audit.</p>
National Benchmarking Tool	<p>Have you used the National Benchmarking tool on the internet?</p> <p>If so, was it easy to use and navigate and what were the outcomes?</p> <p>If not, why not?</p> <p>Please try to tease out here whether they have either: only used the NB analysis we have provided; or undertaken some NB investigations themselves, as part of the Assurance Framework; or used the NB outside of/in addition to the Assurance Framework.</p>
Methods of communication	<p>What methods been used to update the interviewee and their organisation about the development of the methodology and the results of audits?</p> <p>Please ask specifically:</p> <p>face to face meetings</p> <p>Please note that the interviewee is likely to refer here to the set-up and closure meetings – an integral part of the assurance process.</p> <p>newsletters</p> <p>conferences</p> <p>AC website - PbR Portal</p> <p>national reports</p> <p>National reports have a lot of national benchmarking information contained within. Has this been useful in facilitating change?</p> <hr/> <p>How effective has each of these methods been?</p> <hr/> <p>Have any other methods been used?</p>

Theme/main question	Detailed questions
<p>Additional costs incurred</p> <p>If additional costs are cited, please ask for a rough estimate and assess whether these are actual extra costs.</p>	<p>What (if any) additional costs (eg: staff time /financial) have there been due to the Assurance Framework?</p>
<p>Overall impression</p>	<p>How would you rate the PbR assurance framework overall?</p>
<p>Improvements for the future</p>	<p>Any ways in which PbR Assurance Framework could be improved for future years?</p> <p>Please also explore whether the interviewee or their organisation has made suggestions regarding improving the Framework in the past and whether they have noticed changes/improvements as a result (i.e. has the AC listened to its customers?)</p>
<p>Other information</p>	<p>Given the Audit Commission's abolition and the probable ending of our work in PbR assurance after 2011/12, please try and explore who and how PbR assurance should be delivered in the future, if at all?</p> <p>Any other points the interviewee wants to make.</p>

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