“Three key tools essential for your QIPP journey – NHS Comparator, PbR bench marker & Programme Budgeting”

P.Badrinath, N Jayatilleke & S Keeble
ERPHO & NHS Suffolk
Plan of the presentation

Introduction                    Badri
NHS Comparator           Nisha
PbR Bench marker        Stuart
Programme Budgeting   Badri
& Conclusion

Q & A -                          All
We have had good times

£19 Billion NHS Cake

This cake represents the cash increase between 2003/4 and 2007/8 for the hospital and community health services in England (Source: The King’s Fund)
NHS may face over £6bn annual cuts

28 MAY 2009 | BY SALLY GAINSBURY

NHS chief executive David Nicholson has warned that the health service faces annual savings equivalent to cuts of more than £6bn from 2011 onwards.

Mr Nicholson has insisted the primary care trust allocations for 2010-11 are safe but he used his report last week on the year 2008-09 to warn: “We should also plan on the assumption that we will need to release unprecedented levels of efficiency savings between 2011 and 2014 – between £15bn and £20bn across the service over the three years.”

A Department of Health spokeswoman said the £15bn-£20bn figure was an estimate of the impact year-on-year efficiency savings of around 3 per cent would have on the NHS.

Government departments are in the habit of counting efficiency savings made in one year on a cumulative basis. That means that the £15bn-£20bn figure could be constructed by adding together three years’ worth of the £2.3bn cut from the health service’s original spending plans for 2010-11, plus another three years’ worth of similar sized...
Changing times cont....

NHS told to find ways of saving £20 billion

The NHS will have to find ways of saving up to £20 billion, Health Secretary Andy Burnham has told think tank, the King’s Fund.

By Ian Johnston
Published: 10:20AM BST 19 Sep 2009
The way forward is not pessimism
We need to continue to provide high quality care in a resource constrained scenario – Time is the essence
One way forward is QIPP

Mike Farrar on QIPP - quality, innovation, productivity and prevention

10 SEPTEMBER 2009 | BY MIKE FARRAR

QIPP needs to become woven into the NHS’s DNA, and efficiencies come from the avoidable use of NHS resources, effective partnerships and best practice.

Only 18 months ago, the NHS was reflecting on its first 60 years and setting out on a new optimistic phase in its history: the shift of emphasis from speed of access to quality of care, from centralised targets to devolved local priority setting, from ivory tower administration to clinically driven leadership and from spending on supply side expansion to genuine demand side management.

QIPP is not an add-on program - it is the new landscape in which we...
“Quality, innovation, productivity and prevention is not a top-down, national initiative. It is about the NHS working in different ways to ensure that we deliver the highest quality care.

Making this a reality requires action at all levels of the system – from front-line clinicians to local providers and commissioners, SHAs, to the Department of Health and others at a national level.”
This is our humble attempt towards the QIPP initiative
Over to Nisha
Use of NHS Comparator in working towards QIPP
What is NHS Comparator?

• Set of comparators presented at GP practice, PCT, Provider and SHA level

• Purpose of the comparators is to enable comparison in terms of activity and costs between different organisations and populations to inform commissioning
Background

• Developed by the Information Centre, Connecting for Health and a panel of users / experts from across the NHS

• Emphasis is to alert users to areas that might merit further investigation

• It is not necessarily good or bad to be high or low
Interpreting NHS Comparator

• Comparators may indicate areas where activity or clinical practice is out of line with peers with possible quality of care implications, or areas where there are potential cost savings to be made

• Local knowledge will be needed to help with interpretation
Key points to note

• Population used is based on the population registered on GP Practice lists

• Other indicator packages generally use ONS population estimates

• Comparators standardise by age and sex
Types of data

• Secondary care activity data

• GP list size data (population data)

• Quality and Outcome Framework data

• Prescribing data
Aim of this presentation

• Give a flavour of potential uses of NHS Comparator by using some examples

• Not an exhaustive list

• Examples drawn from Commissioning view and provider view

• Examples include PCT level and GP practice level data

• Point out Q I P P – Colour coded (Red – potential for improvement, Amber – midway in bench marking Green – Fares better in bench marking)
Example one- Quality, Prevention
Example two- Quality, Productivity, Prevention

Suffolk PCT - Emergency Bed Days For Long Term Conditions per 1000 Population
Period/Year: Rolling Year - 2008/2009; Activity

- Lower level of morbidity population
- Effective management care
- Good NHS community provision
- Post discharge support through NHS community
- Effective discharge planning
Example three - Quality, Prevention, Productivity

Suffolk PCT - Emergency Asthma Admissions per 1000 Population
Period/Year: Rolling Year - 2008/2009; Activity

<table>
<thead>
<tr>
<th>Year</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Annual</th>
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<tbody>
<tr>
<td>2005/2006</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2006/2007</td>
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<td>2007/2008</td>
<td></td>
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<td></td>
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<td></td>
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<tr>
<td>2008/2009</td>
<td></td>
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</tr>
</tbody>
</table>

Δ Alerts

Value

0.0
0.2
0.4
0.6
0.8
1.0
1.2
1.4

The chart shows the trend of emergency asthma admissions per 1000 population for different periods and quarters.
Example four - **Quality, Prevention, Productivity**
Example Five - Quality, Productivity

West Suffolk Hospitals NHS Trust - % Vaginal Deliveries Following Prior Caesarean

Period/Year: Rolling Year - 2008/2009; Activity

% Vaginal delivery following prior Caesarean delivery

Vaginal birth after caesarean section (VBAC) should be considered an option for all women who have received prenatal care with a history of caesarean birth. Where such services exist, a repeat caesarean section should only be advised, but in the majority of cases a successful vaginal birth can be achieved safely for both mother and baby.
General exclusions

• Secondary care activity not covered by mandatory PbR tariffs

• Private patients

• Mental health

• Well babies
Take home messages

• Variation observed between East of England PCTs

• Comparator can be used to benchmark against national data as well as neighbouring PCTs

• By benchmarking PCTs can set goals and towards improving Quality, Productivity and Prevention
Over to Stuart
National Bench marker by the Audit Commission
What is National Bench marker?

• An audit tool which allows acute trusts and commissioners to benchmark inpatient and outpatient activity at specialty and HRG level against national standards.

• Allows the identification of anomalous areas of activity at acute trusts (important to note that the term "anomalous" is used to mean "unexpected" and does not necessarily imply the behaviour is undesirable)
What source data does the National Bench marker use?

• PBR dataset (HRG 4)
• Hospital activity data sourced from:
  – Secondary Uses Service (SUS)
  – Hospital Episode Statistics (HES) on a quarterly basis
• Quarterly updates (Up to March 09)
Indicators and measures

• There are 46 indicators covering inpatient and outpatient activity grouped under the following headings:
  – Lead indicator - e.g. Average price of spell
  – Length of stay indicators - e.g. Mean length of stay
  – Management of Care indicators - e.g. Daycase spell ratio
  – Spell type indicators - e.g. Planned procedure not carried out
  – Coding indicators - e.g. Mean diagnosis per spell
  – Episode indicators - e.g. Multiple episode ratio
Indicators and measures

- For each indicator there are three values:
  - **Observed value** - the actual value for a particular trust.
  - **Expected value** - calculated by applying national age and gender specific rates (Based on all acute trust activity) to the acute trusts population. (Indirect standardisation)
  - **All trusts value** - the average value for all acute trusts in England
Tools

• Data explorer
  – Drill down into Specialities, subchapters and HRG by indicator

• Scorecard viewer
  – Combines indicators
  – Allows user to target specific areas of interest and investigation e.g.
    • Inpatient audit set 09/10
    • Inpatient Efficiency (Areas for Improvement)
    • Inpatient potential Over reporting/ under reporting
IP - Mean price of spell - Productivity & Quality

I121 Mean price of spell
• Hospital 1 - Specialty

![Graph showing mean price of spell for Hospital 1 - Specialty]

<table>
<thead>
<tr>
<th>Most recent 12 months</th>
<th>Q1 08/09 (07/08)</th>
<th>Q2 08/09 (07/08)</th>
<th>Q3 08/09 (07/08)</th>
<th>Q4 08/09 (07/08)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of spells</td>
<td>1,229 (1,674)</td>
<td>1,250 (1,351)</td>
<td>1,079 (1,308)</td>
<td>1,068 (1,286)</td>
</tr>
<tr>
<td>Expected price of spells</td>
<td>£1.9m (£2.6m)</td>
<td>£1.5m (£2.1m)</td>
<td>£1.5m (£2.2m)</td>
<td>£1.6m (£1.9m)</td>
</tr>
<tr>
<td>Observed price of spells</td>
<td>£2.1m (£2.6m)</td>
<td>£2.1m (£2.2m)</td>
<td>£1.9m (£2.3m)</td>
<td>£1.9m (£2.1m)</td>
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</tbody>
</table>

• Hospital 2 - Specialty

![Graph showing mean price of spell for Hospital 2 - Specialty]

<table>
<thead>
<tr>
<th>Most recent 12 months</th>
<th>Q1 08/09 (07/08)</th>
<th>Q2 08/09 (07/08)</th>
<th>Q3 08/09 (07/08)</th>
<th>Q4 08/09 (07/08)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of spells</td>
<td>1,017 (1,040)</td>
<td>1,074 (1,045)</td>
<td>1,152 (1,071)</td>
<td>1,231 (1,109)</td>
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<td>Expected price of spells</td>
<td>£1.5m (£1.6m)</td>
<td>£1.6m (£1.6m)</td>
<td>£1.7m (£1.7m)</td>
<td>£1.6m (£1.7m)</td>
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<tr>
<td>Observed price of spells</td>
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<td>£1.8m (£1.9m)</td>
<td>£2.0m (£1.9m)</td>
<td>£2.1m (£2.1m)</td>
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</table>
IP - I121 Mean price of spell - Productivity & Quality

I121 Mean price of spell
- Hospital 1 - HRG sub chapter

<table>
<thead>
<tr>
<th>Most recent 12 months (Previous 12 months)</th>
<th>Q1 08/09 (07/08)</th>
<th>Q2 08/09 (07/08)</th>
<th>Q3 08/09 (07/08)</th>
<th>Q4 08/09 (07/08)</th>
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</thead>
<tbody>
<tr>
<td>Number of spells</td>
<td>671 (951)</td>
<td>669 (725)</td>
<td>602 (699)</td>
<td>602 (719)</td>
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<tr>
<td>Expected price of spells</td>
<td>£962k (£1.1m)</td>
<td>£978.3k (£1.1m)</td>
<td>£887.1k (£1.1m)</td>
<td>£878.6k (£1.1m)</td>
</tr>
<tr>
<td>Observed price of spells</td>
<td>£1.2m (£1.5m)</td>
<td>£1.2m (£1.2m)</td>
<td>£1.2m (£1.3m)</td>
<td>£1.2m (£1.3m)</td>
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</table>

- Hospital 2 - HRG sub chapter

<table>
<thead>
<tr>
<th>Most recent 12 months (Previous 12 months)</th>
<th>Q1 08/09 (07/08)</th>
<th>Q2 08/09 (07/08)</th>
<th>Q3 08/09 (07/08)</th>
<th>Q4 08/09 (07/08)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of spells</td>
<td>575 (525)</td>
<td>592 (588)</td>
<td>677 (630)</td>
<td>732 (818)</td>
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<tr>
<td>Expected price of spells</td>
<td>£331.3k (£327.3k)</td>
<td>£850.7k (£384.4k)</td>
<td>£991.5k (£343.6k)</td>
<td>£1m (£387k)</td>
</tr>
<tr>
<td>Observed price of spells</td>
<td>£1.2m (£1.2m)</td>
<td>£1.1m (£1.1m)</td>
<td>£1.3m (£1.2m)</td>
<td>£1.4m (£1.3m)</td>
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</table>
I101 Mean length of spell

- Hospital 1 - Specialty

- Hospital 2 - Specialty
IP - Mean pre op period - Productivity & Quality

I119 Mean pre-op period of elective spell

- Hospital 1 - Speciality and HRG sub chapter

- HRG
IP - Mean pre op period - Productivity & Quality

I119 Mean pre-op period of elective spell

- Hospital 2 - Speciality and HRG sub chapter

- HRG
IP - Emergency spell ratio - Quality & Productivity

I104 Emergency spell ratio

• Hospital 1 - Speciality

• Hospital 2 - Speciality

• HRG sub chapter

• HRG sub chapter
**IP - Daycase spell ratio** - **Productivity & Quality**

I103 Daycase spell ratio

- Hospital 1 - Speciality

![Graph for Hospital 1 Speciality]

<table>
<thead>
<tr>
<th>Most recent 12 months (Previous 12 months)</th>
<th>Q1 08/09 (07/08)</th>
<th>Q2 08/09 (07/08)</th>
<th>Q3 08/09 (07/08)</th>
<th>Q4 08/09 (07/08)</th>
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<td>1,079 (1,308)</td>
<td>1,068 (1,286)</td>
</tr>
<tr>
<td>Number of elective spells</td>
<td>345 (806)</td>
<td>293 (440)</td>
<td>243 (336)</td>
<td>169 (362)</td>
</tr>
<tr>
<td>Expected number of daycases</td>
<td>224.47 (498.75)</td>
<td>191.51 (279.02)</td>
<td>163.56 (214.83)</td>
<td>115.66 (238.94)</td>
</tr>
<tr>
<td>Observed number of daycases</td>
<td>187 (504)</td>
<td>128 (259)</td>
<td>111 (184)</td>
<td>88 (219)</td>
</tr>
</tbody>
</table>

- Hospital 2 - Speciality

![Graph for Hospital 2 Speciality]

<table>
<thead>
<tr>
<th>Most recent 12 months (Previous 12 months)</th>
<th>Q1 08/09 (07/08)</th>
<th>Q2 08/09 (07/08)</th>
<th>Q3 08/09 (07/08)</th>
<th>Q4 08/09 (07/08)</th>
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<tbody>
<tr>
<td>Number of spells</td>
<td>1,017 (1,040)</td>
<td>1,074 (1,045)</td>
<td>1,152 (1,071)</td>
<td>1,231 (1,105)</td>
</tr>
<tr>
<td>Number of elective spells</td>
<td>408 (422)</td>
<td>430 (395)</td>
<td>448 (435)</td>
<td>520 (456)</td>
</tr>
<tr>
<td>Expected number of daycases</td>
<td>263.83 (264.15)</td>
<td>281.19 (250.34)</td>
<td>294.9 (276.26)</td>
<td>349.52 (284.54)</td>
</tr>
<tr>
<td>Observed number of daycases</td>
<td>174 (171)</td>
<td>192 (162)</td>
<td>204 (196)</td>
<td>284 (219)</td>
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</tbody>
</table>
I105 Zero length spell ratio

• Hospital 1 - Speciality

<table>
<thead>
<tr>
<th>Most recent 12 months</th>
<th>Q1 08/09 (07/08)</th>
<th>Q2 08/09 (07/08)</th>
<th>Q3 08/09 (07/08)</th>
<th>Q4 08/09 (07/08)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of spells</td>
<td>3,430 (3,127)</td>
<td>3,237 (3,159)</td>
<td>3,421 (3,043)</td>
<td>3,398 (3,337)</td>
</tr>
<tr>
<td>Number of spells (exc daycases)</td>
<td>3,314 (2,979)</td>
<td>3,109 (3,029)</td>
<td>3,304 (2,966)</td>
<td>3,301 (3,244)</td>
</tr>
<tr>
<td>Expected number of spells of zero length (exc daycases)</td>
<td>625.32 (569.83)</td>
<td>614.92 (564.39)</td>
<td>604.26 (532.67)</td>
<td>615.39 (593.67)</td>
</tr>
<tr>
<td>Observed number of spells of zero length (exc daycases)</td>
<td>525 (793)</td>
<td>51 (780)</td>
<td>884 (859)</td>
<td>574 (900)</td>
</tr>
</tbody>
</table>

• Hospital 2 - Speciality

<table>
<thead>
<tr>
<th>Most recent 12 months</th>
<th>Q1 08/09 (07/08)</th>
<th>Q2 08/09 (07/08)</th>
<th>Q3 08/09 (07/08)</th>
<th>Q4 08/09 (07/08)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of spells</td>
<td>1,886 (1,870)</td>
<td>1,858 (2,016)</td>
<td>1,981 (2,042)</td>
<td>2,162 (2,014)</td>
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<tr>
<td>Number of spells (exc daycases)</td>
<td>1,635 (1,743)</td>
<td>1,647 (1,854)</td>
<td>1,824 (1,794)</td>
<td>1,975 (1,763)</td>
</tr>
<tr>
<td>Expected number of spells of zero length (exc daycases)</td>
<td>385.15 (392.44)</td>
<td>395.07 (419.31)</td>
<td>412.16 (384.91)</td>
<td>465.05 (384.74)</td>
</tr>
<tr>
<td>Observed number of spells of zero length (exc daycases)</td>
<td>402 (435)</td>
<td>450 (485)</td>
<td>505 (380)</td>
<td>569 (395)</td>
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</tbody>
</table>
IP - Zero length spell ratio - Productivity, Quality & Prevention

I105 Zero length spell ratio

- Hospital 1 - Speciality

- Hospital 2 - Speciality
IP - Mean episodes per spell - Productivity & Quality

I113 - Mean episodes per spell

- Hospital 1 - Speciality
- Hospital 2 - Speciality

- HRG sub chapter
OP - Follow up ratio - Productivity & Quality

I230 Follow up ratio

- Hospital 1

<table>
<thead>
<tr>
<th>Most recent 12 months</th>
<th>Q4 07/08 (06/07)</th>
<th>Q1 08/09 (07/08)</th>
<th>Q2 08/09 (07/08)</th>
<th>Q3 08/09 (07/08)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of appointments</td>
<td>3.267 (0)</td>
<td>2.646 (2.772)</td>
<td>3.255 (2.973)</td>
<td>3.366 (3.278)</td>
</tr>
<tr>
<td>Number of attendances</td>
<td>2.932 (0)</td>
<td>2.625 (2.694)</td>
<td>2.984 (2.664)</td>
<td>2.992 (2.932)</td>
</tr>
<tr>
<td>Expected number of attendances classified as follow-ups</td>
<td>1.630.99 (0)</td>
<td>1.456.85 (1.369.94)</td>
<td>1.572.86 (1.438.5)</td>
<td>1.608.83 (1.604.32)</td>
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<tr>
<td>Observed number of attendances classified as follow-ups</td>
<td>1.651 (0)</td>
<td>1.521 (1.169)</td>
<td>1.745 (1.250)</td>
<td>1.853 (1.658)</td>
</tr>
</tbody>
</table>

- Hospital 2

<table>
<thead>
<tr>
<th>Most recent 12 months</th>
<th>Q4 07/08 (06/07)</th>
<th>Q1 08/09 (07/08)</th>
<th>Q2 08/09 (07/08)</th>
<th>Q3 08/09 (07/08)</th>
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</thead>
<tbody>
<tr>
<td>Number of appointments</td>
<td>1.555 (0)</td>
<td>1.444 (1.314)</td>
<td>1.407 (1.328)</td>
<td>1.252 (1.510)</td>
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<tr>
<td>Number of attendances</td>
<td>1.208 (0)</td>
<td>1.079 (936)</td>
<td>1.043 (932)</td>
<td>881 (1.028)</td>
</tr>
<tr>
<td>Expected number of attendances classified as follow-ups</td>
<td>683.14 (0)</td>
<td>607.47 (515.44)</td>
<td>574.36 (511.5)</td>
<td>477.83 (569.41)</td>
</tr>
<tr>
<td>Observed number of attendances classified as follow-ups</td>
<td>733 (0)</td>
<td>575 (473)</td>
<td>499 (465)</td>
<td>387 (489)</td>
</tr>
</tbody>
</table>
Summary (1)

• Provides national benchmarked data
• Allows identification of anomalous areas of activity at acute trusts for further investigation.
• Potential to identify good practice
Summary (2)

• For general surgery both providers mean price of spell was higher than expected.
• The mean number of pre-op spells in T&O was higher than expected for hospital 1 and slightly better than expected in hospital 2.
• The emergency spell ratio for general surgery was higher than expected for both hospitals.
• For general medicine the 0 LOS ratio for both hospital 1 and hospital 2 was higher than expected.
Over to Badri
Programme Budgeting & QIPP
Programme Budgeting

• Collected annually by DH – 23 programme areas
• Key management information
• Where the money is going and what we get for it
• Evaluate value for money & strategic planning
• To identify priority areas for investment
• To identify areas for disinvestment
2007-08 PCT Programme Budgeting Benchmarking Workbook

Contents Page

Sheet Label

1) Guidance on Data Use
2) Definitions
3) PCT Expenditure
4) PCT Benchmarking
5) Chart 1 - PCT Time Series
6) Chart 2 - PCT v Cluster Ave
7) Chart 3 - Cancer Sub Cats
8) Chart 4 - RANK Graph
9) Chart 5 - Radar Main Cats
10) Chart 6 - Radar Sub Cats

Sheet Contents

Summarised guidance on the use of data contained in the following Worksheets

Definitions of terms used throughout the Workbook

Table showing expenditure on PCT own Population across all Programme Budgeting Categories and subcategories for 2004-05 to 2007-2008

Table showing selected PCT expenditure/100,000 population across all Programme Budgeting Categories + Table showing Cluster data for comparison.

Chart showing selected PCT Expenditure per 100,000 population for 2004-05 to 2007-08 across main Programme Budgeting Categories

Chart showing Selected PCT Expenditure per 100,000 population against Cluster average for 2004-05 to 2007-08.

Chart comparing PCT expenditure per 100,000 population to Cluster average for all Cancer Sub-categories.

Chart showing selected PCT Expenditure/100,000 along with Rank against other PCTs within their Cluster for selected Programme Budgeting Category

Radar Chart showing selected PCT national index score in comparison to Cluster Average for main Programme Budgeting Categories (For Calculation of National Index Scores please see sheet 12)

Radar Chart showing selected PCT national index score in comparison to Cluster Average for sub-categories within Programme Budgeting Categories 2, 5, 10 and 23

http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_102860.zip
# PBC 20A Unintended consequences of medical treatment

<table>
<thead>
<tr>
<th>PBC Code</th>
<th>Programme Budgeting Category</th>
<th>Sub Categories</th>
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<tbody>
<tr>
<td>18</td>
<td>Maternity and Reproductive Health</td>
<td>X Maternity and Reproductive Health</td>
</tr>
<tr>
<td>19</td>
<td>Conditions of neonates</td>
<td>X Conditions of neonates</td>
</tr>
<tr>
<td>20</td>
<td>Adverse effects and poisoning</td>
<td>A <em>Unintended consequences of treatment</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td>B <em>Poisoning</em></td>
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<tr>
<td></td>
<td></td>
<td>C <em>Violence</em></td>
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<tr>
<td></td>
<td></td>
<td>X Poisoning and adverse effects</td>
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<tr>
<td>21</td>
<td>Healthy Individuals</td>
<td>A NSF Prevention programme</td>
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<tr>
<td></td>
<td></td>
<td>B NSF Mental health prevention</td>
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<td></td>
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<td>22</td>
<td>Social Care Needs</td>
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<td>23</td>
<td>Other</td>
<td>A General Medical Services/Personal Medical Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>B Strategic Health Authorities (inc WDCs)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>X Miscellaneous</td>
</tr>
</tbody>
</table>
What is 20A

• Total of 193 ICD codes which form the PBC20A
• Side effects of treatment, Never events, Post operative complications including infections
• Complications associated with prosthesis
• Full list available on request
• Some top ICDs are:
Some top International Classification of Disease codes – PBC 20A

T814 Infections following a procedure not elsewhere classified
T810 Haemorrhage and haematoma complicating a procedure not elsewhere classified
T840 Mechanical complication of internal joint prosthesis
T857 Infection and inflammatory reaction due to other internal prosthetic devices, implants and grafts.
T845 Infection and inflammatory reaction due to other internal joint prosthesis.
T828 Other complications of cardiac and vascular prosthetic devices, implants & grafts
T830 Mechanical complications of urinary (indwelling) catheter
T827 Infection and inflammatory reaction due to other cardiac and vascular devices, implants and grafts
T855 Mechanical complications of gastrointestinal prosthetic devices, implants and grafts
T841 Mechanical complication of internal fixation device of bones of limb
T813 Disruption of operation would, not elsewhere classified
How PBC20A relates to QIPP

• Many of them are avoidable although not all
• Reflects clinical quality and patient safety
• Avoidable proportion – Opportunity cost and hence productivity
• Also links to prevention as many of these and their consequences are potentially preventable
Preventable events
Examples of self-evident, or “unforgiveable,” preventable adverse medical events include the following:

Wrong surgery (wrong site, wrong patient, wrong procedure)

Retained foreign body left at surgery

Blood or transplant organ incompatibility

Transmission of an infectious agent to a patient

Administering incorrect medication or dosage

In-hospital trauma (falls, burns)

Deep venous thrombosis or pulmonary embolus without appropriate prophylaxis

Surgical site infection without indicated antibiotic prophylaxis

Pressure ulcers

Catheter-acquired infections
Forum

Medicare’s Decision to Withhold Payment for Hospital Errors: The Devil Is in the Details

Robert M. Wachter, M.D.
Nancy E. Foster
R. Adams Dudley, M.D., M.B.A.

A variety of strategies have been implemented to try to promote patient safety in American hospitals and clinics. These have included analyses of the extent of the problem; media engagement; development of measures for patient safety; pressure from regulators, accreditors, and other safety-related organizations to adopt safety practices; and public reporting of errors. Although there is debate on how effective these strategies have been, it is clear that they have not eradicated medical mistakes.

Why not? Part of the problem, of course, is that improving safety is really challenging. But many believe

Article-at-a-Glance

Background: Medicare recently announced its intention to withhold additional payments for “serious preventable events.”

The Intervention: Beginning in 2009, Medicare will withhold its usual additional payments associated with hospitalizations that included one of several potentially preventable adverse events, such as certain hospital-acquired infections, pressure ulcers, and retained surgical objects. Several more events are being considered for the future. A new coding category: “present on admission.”
Data analysis results
PBC 20A Spend per head of Unified weighted population - EOE PCTs
PBC20A total spend in East of England is £61,356,000
## CONTENTS

Spend on PCTs own population split for Primary and Secondary Care,

**Select the PCT (Shown by SHA)**
Q35 Suffolk PCT (SPT)

**Select financial year**
2007-2008

**Select Weighting Basis**
UNIFIED WEIGHTED POPULATION

<table>
<thead>
<tr>
<th>Programme Budgeting Category</th>
<th>Primary Care</th>
<th>Secondary Care</th>
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<tbody>
<tr>
<td></td>
<td>Spend</td>
<td>Rank</td>
</tr>
<tr>
<td>20 Adverse effects and poisoning</td>
<td>0</td>
<td>N/A</td>
</tr>
<tr>
<td>20a Unintended consequences of treatment</td>
<td>0</td>
<td>N/A</td>
</tr>
<tr>
<td>20b Poisoning</td>
<td>0</td>
<td>N/A</td>
</tr>
<tr>
<td>20c Violence</td>
<td>0</td>
<td>N/A</td>
</tr>
<tr>
<td>20x Poisoning and adverse effects</td>
<td>0</td>
<td>N/A</td>
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<tr>
<td>All</td>
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<td>36</td>
</tr>
<tr>
<td>Programme Budgeting Category</td>
<td>2004-05</td>
<td>2005-06</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
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<td>---------</td>
</tr>
<tr>
<td>20a Unintended consequences of treatment</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>20b Poisoning</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>20c Violence</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>20x Poisoning and adverse effects (other)</td>
<td>-</td>
<td>-</td>
</tr>
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<td>21 Healthy Individuals</td>
<td>6,315</td>
<td>7,698</td>
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<td>21a NSF Prevention programme</td>
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<td>-</td>
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<tr>
<td>21b NSF Mental health prevention</td>
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<td>-</td>
</tr>
<tr>
<td>21x Healthy Individuals (Other)</td>
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<td>-</td>
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<tr>
<td>22 Social Care Needs</td>
<td>12,790</td>
<td>33,702</td>
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<td>23 Other</td>
<td>88,913</td>
<td>77,964</td>
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<td>23a GMS/PMS</td>
<td>75,485</td>
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<td>23x Miscellaneous Other</td>
<td>13,428</td>
<td>1,516</td>
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<td>All Total</td>
<td>616,204</td>
<td>638,462</td>
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</table>
## Contents

**Select PCT (Shown by SHA)**

- 013 Suffolk PCT (SPT)

**Select expenditure type**

- EXPENDITURE ON OWN POPULATION

**Select weighting basis**

- UNIFIED WEIGHTED POPULATION

**Select cluster level**

- 3 SUB GROUP (20 groups)

**Select cluster data for comparison**

- CLUSTER AVERAGE

---

### Suffolk PCT

<table>
<thead>
<tr>
<th>Prospering Smaller Towns - D</th>
<th>PCT Selected</th>
<th>Cluster</th>
<th>2004/05</th>
<th>2005/06</th>
<th>2006/07</th>
<th>2007-08</th>
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<tr>
<td>Population (as per Allocations)</td>
<td>499,068</td>
<td>499,068</td>
<td>531,479</td>
<td>536,270</td>
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<tr>
<td>Dist from Target £'000 (Under/Over)</td>
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<td>161</td>
<td>(16,895)</td>
<td>(14,878)</td>
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<tr>
<td>Dist from Target % (Under/Over)</td>
<td>0.15%</td>
<td>0.03%</td>
<td>-2.50%</td>
<td>-2.01%</td>
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### EXPENDITURE ON OWN POPULATION

£ per 100,000 population

<table>
<thead>
<tr>
<th>Programme Budgeting Category</th>
<th>2004-05</th>
<th>Rank</th>
<th>2005-06</th>
<th>Rank</th>
<th>2006-07</th>
<th>Rank</th>
<th>2007-08</th>
<th>Rank</th>
<th>% Change</th>
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</thead>
<tbody>
<tr>
<td>20 Adverse effects and poisoning</td>
<td>1,595,774</td>
<td>12</td>
<td>1,207,450</td>
<td>107</td>
<td>1,213,782</td>
<td>114</td>
<td>1,405,637</td>
<td>103</td>
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<tr>
<td>20a Unintended consequences of treatment</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>838,603</td>
<td>116</td>
<td>1,153,897</td>
<td>85</td>
<td>38%</td>
</tr>
<tr>
<td>20b Poisoning</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>239,729</td>
<td>27</td>
<td>230,854</td>
<td>79</td>
<td>-23%</td>
</tr>
<tr>
<td>20c Violence</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>63,972</td>
<td>36</td>
<td>-</td>
<td>-14</td>
<td>-100%</td>
</tr>
<tr>
<td>20x Poisoning and adverse effects (other)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>11,477</td>
<td>150</td>
<td>20,383</td>
<td>126</td>
<td>82%</td>
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<tr>
<td>All Total</td>
<td>123,470,924</td>
<td></td>
<td>127,930,837</td>
<td></td>
<td>129,931,852</td>
<td></td>
<td>137,925,611</td>
<td></td>
<td>6%</td>
</tr>
</tbody>
</table>
PBC20A analysis using HES

- Data for 2007-08 from HES
- Data on ICD10 diagnosis (primary) forming PBC20A
- Counts and directly standardised rates (England)
- Funnel plot benchmarking analysis
Standardised rates of PBC20A by PCTs

All admissions
Standardised rates of PBC20A by PCTs

Elective admissions
Standardised rates of PBC20A by PCTs

Non elective admissions
Standardised rates for top ICDs by PCT

Top 10 ICDs for unintended consequences of medical treatment (PB20a)

- T857
- T848
- T845
- T840
- T830
- T827
- T818
- T814
- T813
- T810
ICD 810 haemorrhage complicating a procedure
ICD 814 infections following a procedure NES
ICD 840 Mechanical complications of IJ Prosthesis

ICD 840 - Mechanical complications of internal joint prosthesis

Rate per 100,000 PCT resident population per Year

PCT resident population

Data
Average
2SD limits
3SD limits
Summary (1)

• PB is a useful tool for targeting areas
• We have developed a picture on unintended consequences of treatment
• By identifying through PB data and benchmarking using HES data
• Variation across PCTs especially for three ICD codes
Summary (2)

• Does not tell us right or wrong
• Points out variations worthy of further investigation
• Need to bring in local intelligence and clinical engagement
• Be aware of data quality, coding practices and the way health services are organised
• Potential area for Commissioning for quality and innovation (CQUIN)
Beware of pitfalls of benchmarking
Trusts frustrated over ‘worse’ mortality rates

12 NOVEMBER 2009 | BY DAVE WEST

Hospital trusts are “surprised and frustrated” by latest mortality ratios that suggest their performance has worsened.

A number of trusts are due to record a rise in their hospital standardised mortality ratios for 2008-09 - due to be published by Dr Foster in its annual Hospital Guide in the coming weeks - in spite of efforts to bring it down.

We need to get the message out there and explain that actually the hospitals in this situation have still improved

Despite thinking they had either improved safety or coding or both, and having reduced mortality rates by other measures, they have been given a higher Dr Foster ratio than in 2007-08.

This has occurred because the national mortality average has dropped significantly since last year. Dr Foster has “rebased” the ratios for 2008-09 so the “expected” mortality ratio, 100, is based on the new average.

Dr Foster director of product strategy and design Roger Taylor said hospital mortality rates in England had fallen by about 7 per cent from the previous year.

He told HSJ: “Everyone is improving but we rebase the figure to take out the improvement that happens across the board.”

Several trusts have told HSJ they are concerned it will be incorrectly interpreted by the public as a sign their safety and service quality is getting worse.

Related Articles

- Who let standards fall so low at Mid Staffordshire? 26 March 2009
- Patient outcomes linked to nursing staff levels 31 March 2009
- CQC names high death-rate NHS trusts 20 August 2009
- Trusts with high death rates to be named 3 June 2009
- CQC to name trusts with highest death rates 4 June 2009

Related Internet Links

Health Service Journal is not responsible for the content of external internet sites.

- Dr Foster
Hope we have provided you with an introduction to interest you to explore the three tools to take forward QIPP in your day to day work and beyond
Thank you for your time & attention
Questions are guaranteed in life; Answers aren't.