

CAPITA

Payment by Results Data Assurance Framework

Key findings from the
2012/13 programme

Health and wellbeing

Contents

SUMMARY	3
Admitted patient care data	4
Accident and emergency data	4
Outpatient data	5
Arrangements for assurance in 2013/14	5
INTRODUCTION	6
2012/13 local audit programme approach	6
ADMITTED PATIENT CARE DATA	8
ACCIDENT AND EMERGENCY DATA	12
OUTPATIENT ATTENDANCE DATA	15
ARRANGEMENTS FOR ASSURANCE IN 2013/14	18

Summary

For the past six years the Payment by Results data assurance framework (PbR DAF) has provided assurance over the quality of the data that underpin payments as part of PbR, promoting improvement in data quality and supporting the accuracy of payment within the NHS. In 2012/13 the work focused on providing both local and national assurance through:

- a. a flexible audit resource to commissioners to deliver locally focused reviews driven by local issues and areas identified from previous reviews under the framework; and
- b. supporting tariff development and implementation by undertaking national data quality reviews of PbR in mental health and best practice tariffs. The Audit Commission have published reports on **Best practice tariffs and their impact**¹ and **Assuring mental health currencies**².

This report summarises the key findings from locally focused audits carried out at acute NHS foundations trusts and NHS trusts in 2012/13³ on behalf of the Audit Commission. All of the results from the 2012/13 audits have also been published on the Audit Commission's website⁴.

Audits of admitted patient care, accident & emergency (A&E) and outpatient data were selected by commissioners based on local and national risk assessments. Previously, national comparisons for each trust, based on their overall error rates compared to national averages, have been provided. However, this was not possible in 2012/13 because each PCT Cluster was given flexibility to choose which trusts and areas they wanted to audit. This was based on national and local risk assessments with considerable variation in sample sizes audited.

In 2012/13, the audits reviewed 33,800 patient episodes or hospital attendances with a value of approximately £31 million. The table below summarises the key results from the 2012/13 audits.

Area audited	Percentage of trusts reviewed	Average error rate affecting price	Average net financial error rate ⁵
Admitted patient care	78%	8.0%	0.3%
Accident and emergency	34%	16.4%	2.9%
Outpatient	28%	9.8%	-1.4%

¹ Audit Commission, Best Practice Tariffs and their Impact, 29 November 2012.

² Payment by Results Data assurance Framework, Report on Assuring Mental Health Currencies, July 2013

³ Five private hospitals delivering care under NHS contracts to PbR rules had APC data audited.

⁴ <http://www.audit-commission.gov.uk/information-and-analysis/data-assurance-framework>

⁵ A positive value indicates commissioners were under charged for the sample audited and a negative figure indicates they were over charged.

Admitted patient care data

In admitted patient care, clinical coding accuracy was affected by a combination of factors. There were a large number of errors in diagnosis coding, and particularly secondary diagnosis coding. Many of these errors were due to poor accuracy in recording co-morbidities and complexities that often impact on the patient spell Healthcare Resource Group (HRG), which is used for determining payment. Across the trusts that were audited there were common factors that resulted in poor data quality.

At some providers, coders only used discharge summaries to code from. When discharge summaries are comprehensive they can provide good information for coding. However, clinical coding errors were caused when other more accurate information was available, or the discharge summary was not accurate and differed from the information recorded in the patient health record⁶.

When paper case notes were in a poor condition, it made it difficult for coders to extract the right information from them. This is made worse as coders are required to code to tight deadlines to ensure information is available for management information, contracting and payment purposes. Case notes that are well structured, do not have loose sheets, and are clearly written, enable coders to extract information accurately and quickly. The NHS Classifications Service⁷ is the definitive source of clinical coding guidance and sets the national standards used by the NHS in coding clinical data. Some errors were caused by coders not following national standards or not using the correct approach for coding.

A&E data

For the first time the Pbr DAF provided a view on the quality of A&E data that underpins the HRGs used for Pbr. PCT clusters requested audits of A&E data quality at 34 per cent of trusts. The average error rate for investigations and treatments not recorded accurately in the data submitted to Secondary Uses Service (SUS) is high: this means the quality of the underpinning data used for payment purposes is poor. On average nearly 25 per cent of investigation codes and 33 per cent of treatment codes submitted to SUS in the sample audited were not an accurate reflection of the care delivered to patients.

In 2013/14, Pbr rules base the A&E tariff on the full 11 HRGs for A&E, rather than grouping tariffs into five price bands. This makes the tariff more specific to the treatments and investigations carried out, and improves consistency between the costs and the tariff. If error rates were to continue to remain the same in the trusts audited, the attendance payment error rates would increase in

Summary continued

2013/14 from an average of 16.4 per cent in 2013/14 to 23.0 per cent. There were consistent issues identified that caused poor quality of A&E data. These included:

- a. under recording activity data, such as drugs used, and investigations undertaken, for example electrocardiograms (ECGs);
- b. clinicians that were responsible for entering data were not always using systems effectively; and
- c. data entry staff did not always input information accurately when it was recorded by clinicians.

Outpatient data

In trusts where outpatient data was audited, the majority of errors were in procedure code recording. Trusts with high attendance error rates were not recording procedures accurately. Only nine trusts out of the 48 audited had no procedure recording errors. Often, trusts were still submitting data to SUS and charging commissioners for outpatient attendances at the first attendance or follow-up attendance rate, rather than for a mandated outpatient procedure HRG when a relevant procedure had been carried out. The two issues that typically impacted significantly on the accuracy of outpatient procedure recording were:

- a. proformas not being updated in line with NHS Classifications Service updates; and
- b. poor arrangements for entering codes into trust systems.

Arrangements for assurance in 2013/14

The PbR DAF for 2013/14 will be managed by the Department of Health (DH) on behalf of NHS England and Monitor. The management and delivery of the PbR DAF in 2013/14 will continue to be delivered by Capita CHKS on behalf of DH. The 2013/14 programme will comprise:

- a. an audit of reference costs at 50 NHS and Foundation acute trusts;
- b. a local audit programme comprising clinical coding audit at 50 NHS and Foundation acute trusts;
- c. a review of the tariff development areas at 25 NHS and Foundation mental health trusts;
- d. updating and development of the PbR National Benchmark;
- e. data quality risk profiles for all acute trusts; and
- f. follow up of recommendations made to acute providers in 2012/13.

Introduction and approach

1 For the past six years the Pbr DAF has provided assurance over the quality of the data that underpin payments as part of Pbr, promoting improvement in data quality and supporting the accuracy of payments within the NHS. During that period there has been consistent improvement in the overall quality of the clinical coding in admitted patient care and outpatient data.

2 In 2012/13 the work focused on providing both local and national assurance through:

- a. a flexible audit resource to commissioners to deliver locally focused reviews driven by local issues and areas identified from previous reviews under the framework; and
- b. supporting tariff development and implementation by undertaking national data quality reviews of Pbr in mental health and best practice tariffs. The Audit Commission have published reports on Best practice tariffs and their impact⁸ and Assuring mental health currencies⁹.

3 This report summarises the key findings from locally focused audits carried out at acute NHS foundations trusts and NHS trusts in 2012/13¹⁰. All of the results from the 2012/13 audits have also been published on the Audit Commission's website¹¹.

2012/13 local audit programme approach

4 Previously, national comparisons for each trust, based on their overall error rates compared to national averages, have been provided. This was not possible in 2012/13. This is because each PCT Cluster was given flexibility to choose which trusts, and which areas they wanted to audit, based on national and local risk assessments.

⁸ Audit Commission, *Best Practice Tariffs and their Impact*, 29 November 2012.

⁹ Payment by Results Data assurance Framework, *Report on Assuring Mental Health Currencies*, July 2013

¹⁰ Five private hospitals delivering care under NHS contracts to Pbr rules had APC data audited.

¹¹ <http://www.audit-commission.gov.uk/information-and-analysis/data-assurance-framework>

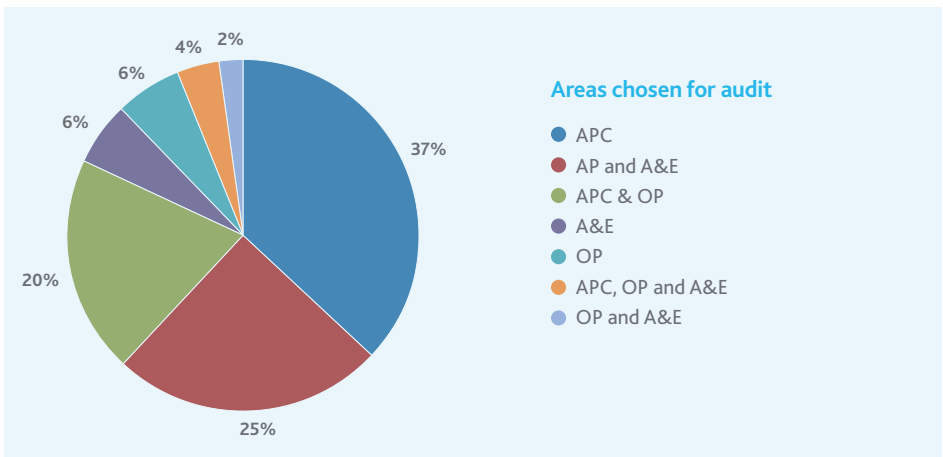
Introduction and approach continued

5 Every PCT cluster had the option, based on its risk assessment, to audit data at its NHS providers in its local area in one or more of the following areas.

- a. Accident and Emergency (A&E):
 - i. data items that drive payment.
- b. Admitted patient care (APC):
 - i. clinical coding audits; and
 - ii. other data items that drive payment.
- c. Outpatient (OP):
 - i. procedure coding for HRGs with an outpatient tariff; and
 - ii. other data items that drive payment for attendances without procedures.

6 An audit at over 90 per cent of acute trusts was undertaken in 2012/13. The majority of PCT clusters chose an audit in admitted patient care. Figure 1 shows the split of audits carried out at trusts covering different combinations of areas. In total 18,700 FCEs in ad were audited with a total value of £29.1 million. 7,600 outpatient attendances with a total value of £900,000 were audited along with 7,500 accident and emergency attendances with a total value of £800,000.

Figure 1: Variation in areas chosen for audit



Introduction and approach continued

7 There was also considerable variation in how PCT clusters chose to make up the audit sample. Examples of the variation in the areas chosen included:

- a. a PCT cluster audited A&E attendances at each of its four providers and one area of APC at each of the providers;
- b. a PCT cluster focused on APC data at all its providers where the admissions were associated with falls; and
- c. a PCT cluster focused on HRGs with and without co-morbidities and complications in general medicine and cardiology across five of its providers.

8 In some PCT clusters, a combination of comparative areas and areas focused on specific issues were chosen. This allowed comparisons between the data quality at providers in a PCT cluster area for the first time, looking at specific issues.

9 Enabling PCT clusters to focus on areas where they wanted to check the accuracy of data meant that in a large number of providers the audit samples were small. This meant it was not possible to provide a comparison to the findings from previous years of the PbR DAF.

10 Admitted patient care clinical coding data at 78 per cent of acute trusts in England was audited in 2012/13. The total number of Finished Consultant Episodes (FCEs) audited was 18,700, with a total financial value of £29.1 million. This covered a diverse range of areas and volumes of FCEs; the smallest number of FCEs audited at a trust was 38 and the largest number of FCEs was over 400 at an individual trust. For trusts with a small sample, the errors rates are distorted when reported as a percentage result. For example 10 FCEs wrong out of a sample of 40 means an error rate of 25 per cent, compared to 10 FCEs wrong out of a sample of 100, which is 10 per cent.

11 A large proportion of the sample reviewed was targeted by commissioners in risk areas. Some commissioners used the audits to follow up issues identified in previous audits.

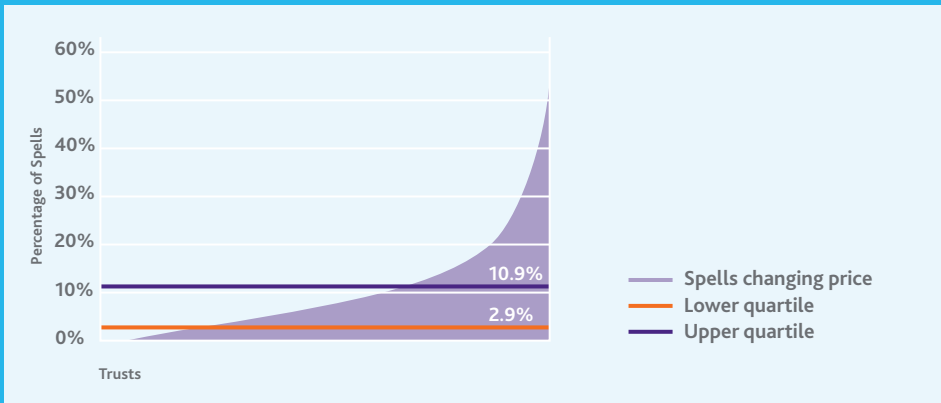
Admitted patient care data

12 There was a large range in the proportion of spells changing price at trusts audited. The best performing 25 per cent of trusts had error rates between zero and 2.9 per cent of spells changing price. The average error rate at trusts audited was 8.0 per cent of spells changing price. 25 per cent of trusts had between 10.9 per cent and 49.0 per cent of spells changing price. Table 1 below shows the percentage of spells changing payment in the sample audited. Figure 2 shows the spread of errors in spells changing payment across the trusts audited.

Table 1: Percentage of spells changing payment in the sample audited

Inter quartile range	Minimum	Lower quartile	Mean	Upper quartile	Maximum
Spells changing price	0.0%	2.9%	8.0%	10.9%	49.0%

Figure 2: Spells changing payment by trust and area audited



13 The spells audited had a total value of £29.1 million. There was a gross financial error of £1.1 million, or 3.9 per cent, for the spells audited. This is the total value of the errors, irrespective of who they favoured. The net financial error was 0.3 per cent, or £100,000. This shows that, for the spells audited, commissioners were under charged by £100,000 for the total sample.

Admitted patient care data continued

14 The accuracy of clinical coding across the trusts audited was variable. Some trusts continue to achieve high diagnosis and procedure coding accuracy rates. However, a high proportion of trusts audited are still performing poorly with clinical coding error rates over 14.0 per cent. Table 2 shows the variation in performance for clinical coding data for the sample audited.

Table 2: Variation in performance for clinical coding data

Inter quartile range	Minimum	Lower quartile	Mean	Upper quartile	Maximum
Primary diagnosis coding error	0.0%	4.8%	11.2%	14.0%	80.0%
Secondary diagnosis coding error	0.0%	7.4%	15.3%	18.5%	100.0%
Primary procedure coding error	0.0%	2.2%	11.8%	15.0%	100.0%
Secondary procedure coding error	0.0%	1.6%	16.0%	23.0%	100.0%

15 There were a large number of errors in diagnosis coding, and particularly secondary diagnosis coding. Many of these errors were due to poor accuracy in recording co-morbidities and complexities that often impact on spell HRG. A common error causing the HRG to change was coders failing to record all relevant co-morbidities in the secondary diagnosis position. In one instance the coder did not record that a patient had Parkinson's disease, which, in this case, was a relevant co-morbidity because it affected the mobility of the patient, which could cause complications in treating a leg problem. Correct inclusion of the co-morbidity changed the HRG from admission for unexplained symptoms with intermediate complications and comorbidities (CC) (WA18X) charged at £2,050, to admission for unexplained symptoms with major CC (WA18V) charged at £3,336¹².

16 Clinical coding accuracy was affected by a combination of factors at the trusts audited. In some trusts, coders only used discharge summaries to code from. When discharge summaries are comprehensive they can provide good information for coding. However, clinical coding errors were caused when other more accurate information was available, or the discharge summary was not accurate and differed from the information recorded in the patient health record¹³.

Admitted patient care data continued

- 17** In one trust the error rate was high because either the primary diagnosis was incorrect, or part of the treatment (the procedure) had been incorrectly coded. There were instances where the primary diagnosis in the case note did not match the primary diagnosis on the discharge summary.
- 18** A trust used discharge summaries as the source document for coding even though they frequently did not contain all the information required to code patients accurately, particularly around relevant and mandatory co-morbidities. Across the whole audit at this trust, 147 secondary diagnoses were recorded incorrectly, and 113 of these were incorrect because coding was based on poor information in the discharge summaries.
- 19** When paper case notes were in a poor condition, it made it difficult for coders to get the right information from them. This is made worse because coders are required to code to tight deadlines to ensure information is available for management information, contracting and payment purposes. Case notes that are well structured, do not have loose sheets, and are clearly written enable coders to record information accurately and quickly. For example, in some trusts, information was found to have been spread across various volumes of notes, and information was not filed in chronological order.
- 20** There were also cases where the electronic patient record did not contain all the information available in the paper case notes, which resulted in coding errors because the coders did not have access to this information.
- 21** The NHS Classifications Service is the definitive source of clinical coding guidance and sets the national standards used by the NHS in coding clinical data. Errors were caused by coders not following national standards, or not using the correct approach for coding.
- 22** In some trusts, the source documentation was good and most coding errors were due to errors by coders. The commonest coder error was not extracting information correctly, and incorrect identification and coding of co-morbidities. In some cases, trust staff were not following national guidelines.

¹⁴ Type 1 A&E departments are a major A&E consultant led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients. Type 2 A&E departments are single specialty consultant led mono-specialty A&E's (e.g. ophthalmology, dental) with designated accommodation for the reception of patients.

Accident and emergency data

23 For the first time the PbR DAF provided a view on the quality of A&E data that underpins the HRGs used for PbR. PCT clusters requested audits of A&E data quality at 34 per cent of trusts. Only Type 1 and Type 2 A&E departments¹⁴ were included in the scope of the audits.

24 The audits focused on A&E attendance data used to generate the HRG, and consequently payment. SUS data was checked against the main source of evidence for that record (usually the casualty (CAS) card or patient case notes) to determine the accuracy of the investigation and treatment codes. The investigation and treatment codes are used to determine the HRG, which determines payment

25 The submission of A&E attendance data to SUS was mandated in 2004, along with the use of national investigation and treatment codes. These were last updated in 2006. Some trusts used these effectively. However, a number of trusts highlighted difficulties with the data set because the codes did not reflect the depth of detail trusts wanted to record for their activity in A&E.

26 7,500 A&E attendances were audited. The attendances audited had a total value of £800,000. There was a gross financial error of £54,200, or 6.5 per cent, for the attendances audited. This is the total value of the errors irrespective of who they favoured. The net financial error was 2.9 per cent, or £23,800. This means that for the spells sampled, commissioners were under charged by £23,800 for the total sample audited.

27 The range of errors in A&E attendances changing payment was large within the sample audited. Some trusts were able to accurately record all investigations and treatments, providing SUS and commissioners with 100 per cent accuracy rates. But the majority of trusts had poor data quality. In the worst performing 25 per cent of trusts audited, between 23.0 and 43.1 per cent of attendances changed payment because one or more investigations or treatments were wrong. Table 3 shows the percentage of attendances changing payment in the sample audited.

Table 3: *Percentage of attendances changing payment in the sample audited.*

Inter quartile range	Minimum	Lower quartile	Mean	Upper quartile	Maximum
Attendances changing payment	0.0%	9.0%	16.4%	23.0%	43.1%

Accident and emergency data continued

28 The variation in payment for getting a single A&E attendance wrong is small: in most cases less than £100. But when these errors are multiplied by the large number of patients seen in an average district general hospital, the financial impact may be significant.

29 The average error rate for investigations and treatments not recorded accurately in the data submitted to SUS is high. This means the quality of the data used to underpin payment is poor. On average, 24.8 per cent of investigation codes and 33.0 per cent of treatment codes submitted to SUS in the sample audited were not an accurate reflection of the care delivered to patients. 25 per cent of trusts had an error rate higher than 35.9 per cent for investigations, and 43.6 per cent for treatments. This is shown in detail in table 4.

30 There were a number of consistent issues at trusts that performed poorly. These included:

- a. under recording activity data such as drugs used and investigations such as ECGs;
- b. clinicians that were responsible for entering data were not always using systems effectively; and
- c. data entry staff did not always input information accurately when it was recorded by clinicians.

31 In a small number of trusts the use of local codes did not result in an accurate national A&E code. These trusts had, or were implementing, data recording systems where they were attempting to collect their own local codes and then convert these to national codes for submission to SUS.

Table 4: *Variation in performance for A&E investigations and treatments*

Inter quartile range	Minimum	Lower quartile	Mean	Upper quartile	Maximum
Investigations incorrect	0.0%	10.8%	24.8%	35.9%	82.5%
Treatments incorrect	1.2%	15.6%	33.0%	43.6%	86.1%

32 A common issue identified was that trusts had designed satisfactory systems for accurately recording data, but these systems were not being implemented properly by staff. These trusts used a tick list of investigations and treatments in A&E that should be completed by clinicians when a patient was treated. There were omissions in the data where treatments were recorded in the CAS card by the clinicians, but not recorded on the tick list and therefore not coded. There were also instances where the data entry staff had not coded information that had been recorded on the tick list completed by clinicians.

Accident and emergency data continued

33 Commonly, at the trusts where clinicians enter data into the A&E coding system, the errors affecting price were a result of under recording activity: both investigation and/or treatment. Information was often clearly recorded in the CAS card but not coded. In one example of under recording of activity, a patient's six investigations were accurately coded along with three treatments. However, the CAS card also showed that the patient received an electrocardiogram (A&E code 21) and other parenteral drugs (A&E code 291). Including the two additional treatments changed the HRG to a more expensive one.

34 In 2012/13 there were five A&E tariffs for services delivered in A&E and minor injury units (MIUs), spread over 11 HRG classifications based on investigation and treatment. In 2013/14 PbR rules base the A&E tariff on the full 11 HRGs for A&E, rather than grouping tariffs into five price bands. This will make the tariff more specific to the treatments and investigations carried out, and improves consistency between the costs and the tariff.

35 Table 5 summarises the impact of the results from the 2012/13 audits by showing the percentage of attendances that would change payment using the 11 2013/14 HRGs compared to those in 2012/13. If error rates were to continue to remain the same in the trusts audited, the attendance payment error rates would increase in 2013/14.

Table 5: Attendance error rates from 2012/13 applied to 2013/14 HRGs.

Inter quartile range	Minimum	Lower quartile	Mean	Upper quartile	Maximum
Attendances changing payment in 2013/14	0.0%	12.2%	23.0%	34.0%	59.0%
Attendances changing payment in 2012/13	0.0%	9.0%	16.4%	23.0%	43.1%

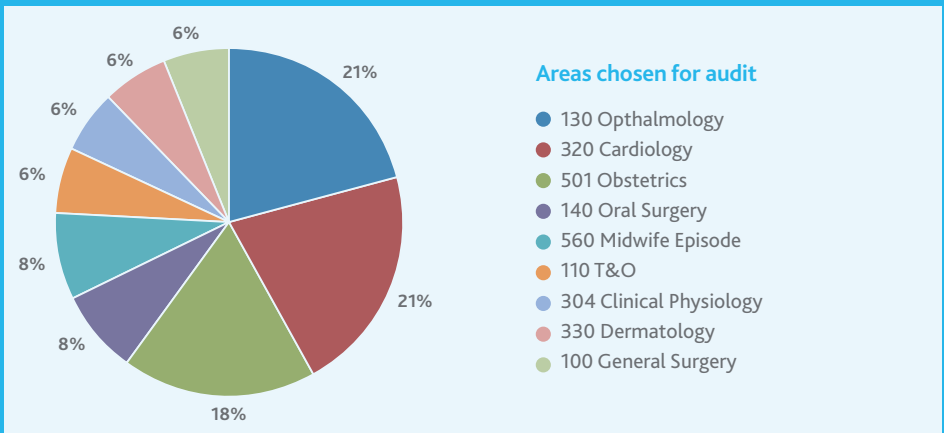
Outpatient attendance data

36 The PbR DAF has previously¹⁵ audited outpatient attendances at every trust in England. These audits focused on the accuracy of the attendances, based on the treatment function code. In 2012/13 the audit approach was expanded to include reviewing the accuracy of procedure recording to reflect developments in PbR system.

37 Since 2010/11, there has been a gradual increase in the number of procedure HRGs that can be delivered and paid for in an outpatient setting. In 2012/13 the number of outpatient procedure HRGs increased to 84 with a mandated outpatient tariff. This covers approximately 75 per cent of procedures coded in outpatients.

38 A large proportion of the sample reviewed was targeted by commissioners on risk areas. Some commissioners used the audits to follow up issues identified in previous audits. PCT clusters chose to audit outpatient attendances and procedures at 46, or 28.2 per cent, of trusts. Figure 3 shows the most popular areas to be audited. Ophthalmology and cardiology were the most common areas chosen for outpatient audit.

Figure 3: Most common areas chosen by PCT clusters for outpatient audits¹⁶



¹⁵ Outpatients audits were carried at all trusts between 2008 and 2010.

¹⁶ If an area was chosen by two or less trust it has been excluded from this chart.

Outpatient attendance data continued

39 Overall error rates for attendance data and procedure recording varied considerably between the trusts audited. The best performing trusts had very low attendance error rates: 25 per cent of trusts had less than 1 per cent of attendances changing payment due to an error. An error can be caused by one or more of the following being wrong:

- a. the attendance was recorded as a first when it should have been a follow-up, or vice versa;
- b. the patient did not attend but were recorded as doing so;
- c. the treatment function code was wrong; or the procedure code was wrong

40 A total of 7,600 outpatient attendances were audited. The attendances audited had a total value of £900,000. There was a gross financial error of £64,000, or 7.2 per cent, for the attendances audited. This is the total value of the errors irrespective of who they favoured. The net financial error was -1.4 per cent, with a value of £12,600. This means that commissioners were over charged by £12,600 for the total sample audited.

41 Table 6 summarises the findings from all areas and trusts audited. The high percentage of errors was mainly caused by errors in procedure code recording.

Table 6: *Outpatient attendances changing payment.*

Inter quartile range	Minimum	Lower quartile	Mean	Upper quartile	Maximum
Attendances changing payment	0.0%	0.9%	9.8%	13.4%	58.7%

42 Trusts with high attendance error rates were not recording procedures accurately. Often trusts were still submitting data to SUS and charging commissioners for outpatient attendances at the first attendance or follow-up attendance rate rather than for a mandated outpatient procedure HRG when a relevant procedure had been carried out. Only nine trusts out of the 48 audited had no procedure recording errors.

Outpatient attendance data continued

43 Table 7 shows the number of attendances with a procedure error compared to attendances with other errors. In the trusts where the areas audited included outpatient procedures, on average trusts recorded 54 per cent of the procedures incorrectly. The worst performing 25 per cent of trusts recorded 76.9 per cent or more procedures incorrectly.

Table 7: *Attendances with a procedure error compared to attendances with other errors*¹⁷

Error type	Number of attendances with error
Procedure error only	1650
Procedure error and other error (e.g. First/ follow-up)	150
Other error only (e.g. First/ follow-up)	450

44 There were consistent issues which were causing the poor accuracy in procedure recording. These were:

- a. proformas not being updated in line with National Classification Service updates; and
- b. poor arrangements for entering codes into trust systems.

45 The main type of error noted was data entry error. There were instances where procedures were coded but there was no evidence in the case notes to confirm that the procedure was undertaken. In some cases, attendance data did not include all main procedure codes, and some subsidiary codes were omitted.

46 Proformas for recording procedures carried out were poorly completed by clinicians. On occasion, the information on the proformas did not match the information recorded in the case notes.

47 There were instances where trusts were accurately recording multiple same day attendances where a patient was having a procedure in the morning and then seeing a consultant for a follow-up appointment in the afternoon. However, the commissioners had not agreed that this should be recorded and charged for in this manner. When this was investigated it was found that commissioners and trusts were not agreeing charging mechanisms in line with PBR flexibilities guidance. It is important that the guidance set out in the DH's PBR rules is followed so that there is transparency and agreement in charging for activity delivered in this way.

¹⁷ Only includes errors at trusts where more than one procedure was wrong.

Arrangements for assurance in 2013/14

48 The PbR DAF for 2013/14 will be managed by the Department of Health (DH) on behalf of NHS England and Monitor. Subject to the passage of the Local Audit and Accountability Bill, the Audit Commission is likely to close in 2015. Therefore, transitional arrangements consistent with those established for setting the 2013/14 PbR tariff have been agreed nationally whereby DH will oversee the delivery of the assurance framework while future arrangements are discussed and consulted on by NHS England and Monitor. The management and delivery of the PbR data assurance framework in 2013/14 will continue to be delivered by Capita CHKS on behalf of DH. The 2013/14 programme will comprise:

- a. an audit of reference costs at 50 NHS and Foundation acute trusts;
- b. a local audit programme comprising clinical coding audit at 50 NHS and Foundation acute trusts;
- c. a review of the tariff development areas at 25 NHS and Foundation mental health trusts;
- d. updating and development of the PbR National Benchmark;
- e. data quality risk profiles for all acute trusts; and
- f. follow up of recommendations made to acute providers in 2012/13.

49 Local reports for all work undertaken will be produced and shared with providers and commissioners. A summary of national findings from the reference costs, coding and mental health audits will be produced in 2014.

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