OUTCOME
of Welsh Information Standards Board (WISB) Appraisal

TITLE OF ANALYSIS METHOD:	Chronic Conditions (Basket of 9) Emergency Hospital Multiple Admissions
REF. NO.	IGRN 2007 / 026
SPONSOR OF STANDARD:	Cathy White, Head of Primary and Community Care Policy, Department of Health & Social Services, Welsh Government
APPROVAL HISTORY:	n/a
DATE CONSIDERED BY WISB:	15th August 2013

WISB COMMENTS:

1. Members noted that the rationale for the Indicator itself was that improved, integrated packages of services for chronic condition management in the community should reduce the level of 'multiple emergency admissions' into acute care.

2. Members queried whether this list of ICD-10 codes and descriptions had been used in previous years. They concluded that previous, recent chronic condition indicators had been limited to three conditions but that this list was currently being used in reports provided to the DHSS Internal Delivery Board. It was observed that the publication of these analysis methodologies would remove this uncertainty in the future.

3. Members were informed that there was a willingness on the part of the Sponsor and Performance Departmental colleagues to revisit the content of the list as it had been taken from previous Wales Audit Office work and had not been specifically designed for the business purpose identified at 1.

4. Members considered two aspects of list revision that would be helpful for the Sponsor.

5. The first was a review from a Clinical Classifications perspective to ensure that the codes included were complete, consistent and meaningful for the condition types proposed. There were many extant co-morbidity indices, designed to describe how ill a patient was. These ranged from American Cancer co-morbidity indices to Charlson and current English guidance on co-morbidity coding for Clinical Coders amongst others.

6. The second was a clinical review. Members recognised that the aim of this indicator must be to identify high rates of readmission within a set of categories which would point to failings in community management of the symptoms. Existing intelligence was cited about repeat admissions coming in through emergency streams which is related to age and multiple co-morbidity which means that if you are try to link individual readmission categories to the original one you will miss many relevant readmissions as they may be re-admitted with any of the categories and not be counted.

   In addition to this, there are several categories not included on the list which cause frequent readmissions such as low level sepsis, urinary tract infections, substance abuse and self-harm *inter alia.*

   Additionally some of the current categories appear to be incomplete. For example Alzheimers is

included but not other causes of dementia.

7. From a business requirement perspective, given that this indicator was focused on improving integrated community care, Members felt that consideration could productively be given to reviewing the problem from a secondary care perspective. This might include identifying those patients who constitute around 50% of major attendances who cause 'time spent' targets to be breached. Their source of admission, whether they are terminal or pre-terminal, whether they are moved from setting to setting, what the most effective setting for their care might be and so on; such intelligence would help inform the development of integrated community services.

8. Members considered the data that should be used for the analysis, namely primary or primary and secondary diagnosis codes, admitting episode or discharge episode and whether individual or multiple diagnosis codes and the methodology to link episodes over time: the 'Provider Spell' methodology. Members were informed that the Provider Spell methodology was scheduled for consideration by the AM group.

9. After lengthy discussion, Members agreed that
   - Primary and secondary diagnoses should be included in the analysis
   - It was difficult to distinguish between reason for admission being related to a chronic condition or simply the accompanying presence of a chronic condition; should the Sponsor re-consider their requirement in this respect?
   - Further analysis of existing data should be undertaken to identify which / how many episodes should be included in any methodology intended to link multiple admissions for chronic condition**s.** No evidence was presented as to why admitting or discharging episodes should be used for linkage.
   - The possibility of including Source of admission in the analysis methodology could be explored.

10. It would be useful to explore the existence of clinically-meaningful groupings of ICD-10 codes. This might include use of groupings within the classification itself.

ACTION(S) TO BE TAKEN BY SUBMITTER *AND/OR SPONSOR*:

1. Complete the clinical classifications review.
2. Undertake a review of suggested chronic conditions having confirmed the business requirement.
3. Carry out analyses of existing multiple admission data to identify which episodes should be used in the revised methodology.
4. Review available standardised diagnosis groupings.

WISB APPRAISAL ASSESSMENT:	**Refinement Required**
WISB APPRAISAL ASSESSMENT KEY:	**1. Accredited:** This Analysis Method has been appraised by WISB and is felt to be fit for purpose in that it: - meets the business requirement - has clarity of scope - is reproducible by local organisations where appropriate **2. Refinement Required:** WISB suggests that modifications are made to the Analysis Method as outlined in the appraisal Outcome.
STATUS OF DATA STANDARDS ASSURANCE:	**WISB Reviewed** (see Outcome)
STATUS OF DATA STANDARDS	**1. WISB Reviewed**: the data used in this Analysis

ASSURANCE KEY:	Method has been through the Information Standards Assurance Process **2. Not WISB Reviewed:** some or all of the data used in this Analysis Method has not been through the Information Standards Assurance Process. This may include data flows which predate the establishment of WISB.