

Patients Discharged with Non-specific Diagnoses Following an Emergency Hospital Admission

Qualitative report

31 October 2025

Document control

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1. Introduction and methods

1.1 Introduction

A 2021 analysis by the Strategy Unit demonstrated that - compared to more affluent and White patients living in the Birmingham area - patients from deprived communities and from Black and Asian ethnic groups were more likely to be discharged without a specific diagnosis following an emergency admission. The Strategy Unit have recently investigated this finding further, examining the extent to which it reflects the national picture.

This updated quantitative analysis used Hospital Episodes Statistics for Admitted Patient Care data from 2023/24, and examined inequalities in the dimensions of ethnicity, socio-economic status, and sex¹. Similar to the Birmingham analysis, the national analysis identified a difference in the rate of non-specific diagnosis (NSD) spells for some ethnicities. It also identified that nationally, females aged 11-64 years had approximately 1.5 times higher standardised rate of NSD spells, compared to males. This finding held regardless of socio-economic status and was intersectional with ethnicity.

To complement the quantitative analysis, qualitative interviews were conducted with NHS clinicians working in inpatient settings relevant to emergency admissions, with the objective of:

- exploring perspectives on NSD diagnosis following an emergency admission
- interpreting the findings of the national analysis
- gathering views on the emerging classification system for patients discharged with an NSD.

This short report summarises the qualitative approach and provides a synthesised account of the findings. Two appendices are also included: the interview topic guide and the figures used in the interview.

1.2 Methods

Interviewees were recruited² via LinkedIn³ and through direct contact of members of the Q network by the Health Foundation. A participant information sheet was shared with potential interviewees

¹ We refer to biological sex in this report to reflect the recording of binary male and female categories in NHS datasets. Interviewees used sex and gender identifiers ("female" and "women") interchangeably.

² The initial recruitment strategy which aimed to recruit a range of medical staff working in emergency inpatient settings at case study hospital trusts was amended due to challenges with recruiting trusts.

³ LinkedIn post can be viewed here: https://www.linkedin.com/posts/the-strategy-unit_nhs-emergencymedicine-diagnoses-activity-7362157136384016384-Zp1x?utm_source=li_share&utm_content=feedcontent&utm_medium=g_dt_web&utm_campaign=copy

to explain the purpose of the interview, and the processes for consent and handling the interviewee's data.

Five people participated in an interview: four females and one male. Four interviewees worked in the emergency medicine specialty, two of which specialised in paediatric medicine, and the fifth interviewee worked in the geriatric medicine specialty.

A topic guide (Appendix A) based on a priori causal mechanisms set out in the project plan was used to explore interviewee perspectives on:

- Why some groups of patients are more likely to be discharged with an NSD following an emergency hospital admission.
- Their interpretation of key quantitative findings (shared on screen at the time of the interview)
- Our proposed classification of patients who are discharged with NSDs.

Interviews were recorded and transcribed with the interviewees' consent. Analytical tasks were shared between two qualitative evaluators: transcripts were coded deductively using themes expected from the topic guide and inductively, surfacing novel themes from the data.

We have identified two limitations to this work:

- The small number of interviews limits the extent to which the findings are generalisable
- Interviewees drew on their experience of working with patients in several settings including emergency departments, acute medical units, and specialty wards.

2. Qualitative findings

2.1 Understanding of the cohort

At the start of the interview, all interviewees had the following statement read to them:

Each week more than 100,000 people in England are admitted to hospital in an emergency. In most cases, by the time the patient's stay in hospital comes to an end, the clinical team has reached a view about the underlying medical condition that led to their admission.

But our quantitative analysis finds that for 1 in every 6 patients (17%), this is not the case: they are discharged with a non-specific primary diagnosis.

We defined a non-specific discharge diagnosis as: if the primary diagnosis code recorded in the final episode of their hospital spell was found in ICD-10 Chapter 18 (XVIII), "Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified". The quantitative analysis focused on the experience of patients aged 11-64 years, but we are happy to take your reflections on all patients.

Interviewees were asked to reflect on whether this statistic reflects their experience.

- Two interviewees said that this was a bit higher than expected, but that they weren't surprised
- Two interviewees reported that the statistic was about right, although one stated that they wouldn't have been surprised if it was higher
- One participant said that this was lower than expected.

In the first part of the interview, interviewees were asked to think about their own use of NSD codes, the use of NSD codes that they had observed in practice, and the cohort of patients who received an NSD.

Most interviewees expected a higher proportion of patients discharged with an NSD following an emergency admission to have social and emotional dysregulation rather than physical or mental health issues or have a pain somatisation code⁴. One interviewee suggested that the cohort with social care needs would be more likely to be young - 11 to 18 years of age - as there was a legal, safeguarding requirement to admit children in the absence of social care support. Similarly, interviewees pointed out that for patients presenting with mental health symptoms, an emergency admission was necessary to manage clinical risk, and that this cohort of patients could then be discharged with an NSD.

⁴ Psychological distress would result in the presentation of physical symptoms.

Other reasons for discharging patients with an NSD following emergency admission (especially from an emergency or short-stay ambulatory setting) included:

- Chest pain - particularly where it is recurrent and serious conditions have been excluded
- Abdominal pain and vomiting – warranted emergency admission for symptom management, but requires extensive diagnostic testing after discharge to identify the underlying cause, resulting in the spell being coded with an NSD
- Gynaecological pain – no conclusive investigation or pathways available to refer patients to.

Most interviewees predicted that rates of NSD at discharge would be higher in females and minoritised ethnic people. Some interviewees suggested that patients from lower socioeconomic groups would also be more likely to be discharged with an NSD attributing it to deprived communities having poorer access to primary and community care and being higher users of secondary care.

The findings presented to interviewees related to age, gender and ethnicity. In the sex and ethnicity sections below, we present a synthesised qualitative account of the themes that emerged from interviewees' interpretations of this data. Qualitative findings related to age have been incorporated into these synthesised accounts.

2.1.1 Sex

Generally, interviewees were unsurprised by the sex disparities in the national findings. They explained that the current practices of delivering medical care did not account for sex differences in symptom presentation and that doctors defaulted to referencing a male medical model for diagnosis; a model that was taught at medical school and maintained by medical culture in hospitals and medical research commissioning. They described that this default model privileged investigation and diagnostic pathways for males, even when the health condition affected both sexes (such as for cardiovascular disease).

I suspect there's something around the symptomatology of women and the health research into women and understanding diagnosis and how people interpret pathology or symptoms in women compared to men.

Interviewee 4

Across interviewee accounts there was acknowledgement of medical misogyny in current medical practices which led to dismissal of female patients' pain and symptoms, particularly those symptoms that disproportionately affected females, when they sought diagnosis, care and treatment.

It might have changed since I was at medical school, but certainly in medical culture, we find it hard to change how we classify symptoms in that we're really used to what we're taught. Which is that, you know, chest pain going to the jaw and the arm is cardiac chest pain and other things are non-cardiac and that kind of thing. And [minoritised ethnic females] are just more likely to experience symptoms differently than what has been recorded in studies and textbooks which is geared towards the western, white man. And I don't know, I wonder if there is an element of medical misogyny in that we see these symptoms as less important.

Interviewee 1

Descriptions were provided for the disparity in diagnostic and clinical pathways, for example male testicular pain was stated as having clearer diagnostic pathways compared to female abdominal/gynaecological pain. These clearer pathways were suggested as benefitting younger males in being diagnosed with a specific condition, compared with their female peers.

I feel like [younger females], they're discharged quite a lot. Also the work up, I think it's put down to, 'oh, it's probably something gynae if it's an abdominal pain,' no one looks further into it. For men I just wonder whether there are clearer pathways for what it could be when they're younger [.....] He's got abdominal pain, you're like, 'well, it's either appendicitis or is it obstruction? Is it testicular pain? It's torsion,' whatever, so you get those appropriate paths but for women it's really difficult for the gynae surgical overlap, is it uro-gynae, is it urinary?

Interviewee 3

Given the understanding that higher rates of NSD at discharge for younger females was due to dismissal of symptoms when there was no other cause for concern, there was some surprise at the high rates of discharges with NSD for older females whose symptoms were less likely to be dismissed. Only one interviewee offered an explanation for the increase in NSD for females aged 45-60, attributing it to under-investigated and medically dismissed menopause-related health challenges.

Another interpretation of the gender data was in the different health seeking behaviours – with women perceived to exhibit more health seeking behaviours. More frequent attendance by women in any healthcare setting with unspecified pain especially, meant that they could be labelled early in the diagnosis pathway as having a psychosomatic presentation and subsequently dismissed for all related healthcare attendances or admissions.

So, I think women go to the doctors' more. I think another reason that explains the charts is obviously men's health-seeking behaviour is completely different, and they won't attend until obviously when they're old and then you can see the spike there, is they're retired and

with all their health problems, but women do attend the doctors'. But I'm not entirely sure that that's useful for them to do because I don't think they often get listened to or taken seriously.

Interviewee 2

2.1.2 Ethnicity

In comparison to the sex-based findings, interviewees found the ethnicity findings more difficult to interpret. Of those who offered a view, most reflected on their medical experience, rather than the findings presented, understanding the ethnicity findings to be proportional to the general societal and systemic disadvantages faced by ethnically minoritised and socio-economically deprived communities.

I suspect there may be something around depending on where these people are seen, whether there are any language or cultural difficulties in terms of them being able to convey or the clinician being able to understand what is being given as part of a consultation. Then you've got just to worry about inherent cultural and institutional biases towards those from a demographic from the black and ethnic minority groups.

Interviewee 4

Some of the reflections on ethnicity can be grouped by patient factors: communication of symptoms, reticence in voicing taboo or sensitive symptoms, and the ability to self-advocate for diagnosis, treatment or care. Communication of symptoms by the patient to a medical professional was described to be subject to literacy, language or linguistic differences in how symptoms were communicated.

For example, the description of symptoms and the localisation of symptom associated pain could vary by the patients' linguistic heritage, presenting a challenge for diagnosis if it did not correspond to conventional medical understanding.

I've worked in a couple of hospitals with communities with lots of people from the Bengali and Pakistani communities along with other Asian communities, and I think there are differences in how symptoms are reported and then what's recorded. So, for example, and I think this is well-described in the literature as well, people can report all over body pain that might be the primary symptom of actually then a very specific problem.

Interviewee 1

Another example was that minoritised ethnic patients may be more reticent in discussing their health issues with clinicians of the opposite sex, and that this communication challenge could be

compounded with the use of interpreters, both NHS language support services, or in the presence of family interpreters.

Sometimes I don't know how much of it might be cultural as well in terms of women being able to explain the pain that they have sometimes, you know, in terms of are they actually able to say, 'It's in my breast,' or, 'I have this pain in my genital area.' If that's something that culturally they do but also sometimes trying to take a history by a language line, even if you're trying to account for the fact that perhaps you're speaking different languages, it's very difficult to take history when you're across a language barrier as well.

Interviewee 3

Similar to the perspective that males could self-advocate better than females, there was a view that people from the White ethnic group advocated more for themselves, describing that some cultures still upheld a respectful status for doctors and avoid questioning medical opinion.

And then there's probably also that advocacy for the white ethnic group where they probably challenge you a lot more. Because we've gone from-, I'm not saying this is a bad thing, but where doctors were kind of respected and you never questioned them. That's still a thing in the older generations, but actually, culturally, there's still a lot of respect shown compared to culture in the UK, towards doctors, and you don't challenge them.

Interviewee 5

Other factors suggested as leading to disparities in NSD rates by ethnicity related more to medical processes of history taking and diagnostic decision-making which were impacted by the patient's culturally adapted communication of symptoms. This was explained as further enhancing the possibility of symptoms being dismissed in ethnically minoritised people, particularly female, because their symptoms did not fit conventional medical understanding.

Another view on medical processes was that patients from Asian and Chinese communities were more likely to be discharged from hospital, compared to White British as there was more likelihood of family support to manage follow-up in the community.

Having worked with Asian, Chinese families, they will have multiple generations often. They'll just have support which will mean that probably your threshold to discharge them, or not to admit them and be able to manage them in the community, is a lot higher.

Interviewee 2

2.2 Non-specific diagnosis coding

Although the primary focus of the interviews was on patients discharged from inpatient settings without a specific diagnosis, some of the interviewees also spoke about patients who were discharged from an ED without a specific diagnosis. They saw parallels between the experiences of these two patient groups but also suggested that when patients were admitted via ED with an NSD, that this had implications for their treatment on admission.

Challenges of clinical coding were raised by a few interviewees as a contributing factor to default NSD coding, especially in busy clinical settings. They highlighted challenges of working with limited options on patient information systems in emergency settings which lead to an NSD code being chosen, with the more accurate diagnosis being recorded as free text in the patient notes on discharge.

I think the coding that we do in ED in this country is absolutely ridiculous because you have a very limited list, and you tend to put 'no abnormality detected' for everything that you can't find anything that's vaguely near. So actually, some of those patients haven't left with no abnormality detected. It just meant you couldn't find it on the list. So you then put it in your actual diagnosis in the free text to the GP.

Interviewee 5

Interviewees explained that when colleagues resorted to selecting the nearest or quickest code from a drop-down list (such as an NSD code) because they need to work quickly especially in the early stages of emergency admission or diagnosis, they contributed to a 'chaos of information' on a patient's record. These inaccurate codes were described as: following patients through to other specialties and to other admissions; creating confusion for the next steps in diagnosis and treatment; and contributing to the patient's symptoms being dismissed (see also section 2.2).

Then when GPs are receiving these letters with diagnoses that are really non-specific, it's really challenging, because...it's unclear what they're following up on, what the seriousness of that is, and what needs to be done. And I think that works, kind of, both ways, because I often access GP records on shared care records, and I find it really hard when I see things like lung problems, throat problems, or something like that. I'm trying to understand more about the background of the patient, actually I don't really know at all, because it's just been coded on symptom and not on diagnosis.

Interviewee 1

2.3 Impact of a non-specific diagnosis

Most interviewees agreed that discharging a patient with an NSD following an emergency admission could have negative consequences. These consequences include increased patient or family dissatisfaction that a view on diagnosis had not been reached, linking an NSD to a failure on the part of the health service or professional and/or the quality of care they had received.

Clinicians on their part reflected that on occasion an NSD was clinically appropriate, with acute presenting symptoms resolving following an emergency admission, especially in children or young people. In these cases, clinicians had to balance the need for more diagnostic tests with the potential iatrogenic harm caused by over-medicalisation or over-investigation of symptoms.

Regardless of the patient or staff experience of receiving or providing an NSD, interviewees perceived that it was inevitable that in many cases an NSD would lead to revolving emergency door, repeat admissions and/or diagnostic testing for the same symptoms, and queried the healthcare costs associated with seeking a specific diagnosis.

I think there's a lot more searching for the answers. I wonder whether there's more healthcare consumption because if the parents haven't felt satisfied and I think a lot of it comes down to their understanding of it as well because it's quite difficult...to be like, 'Oh, you've presented really unwell and we don't really know what caused it, but you're better now.'

Interviewee 3

2.4 Medical hierarchy

Interviewees also interpreted the findings from the lens of medical hierarchy with respect to which seniority of doctors could make an NSD. They acknowledged that this could differ by hospitals and specialities but generally meant that it was often consultants who made an NSD for discharge purposes.

I think there has been a shift over the years of that [diagnosing] being transferred upwards to more senior levels. So, I think diagnoses are given by consultants and maybe registrars, and not so often by more junior grades of clinician. And maybe that is what fuels a little bit of the non-specific diagnostics being coded as well.

Participant 1

Their explanation for the more senior clinical decision making was the current medical practice was over-protocolised, focusing on the clinical risk management and that junior medical staff may not have the confidence and experience to discharge a patient without a specific diagnosis.

I think when you are junior and less experienced, because you're not confident and experienced enough the risk of iatrogenic harm, or reinforcing or over-medicalising obviously, is really high, because that's your model, you're working in a very medical model environment. So, even a junior reg, even with a plan, they would struggle, whereas I think senior clinicians and consultants are more confident to make decisions that are a bit more overarching and holistic.

Participant 2

2.5 Non-specific diagnosis classification

Interviewees were shown the following table and asked to reflect on the proposed classification of this cohort.

A. The patient was experiencing psychosocial distress or despair and were admitted primarily for reasons of safety rather than for medical diagnosis or intervention.
B. The patient's condition was deemed to be medically trivial or insignificant during the hospital stay and did not require further attention.
C. The patient's condition warranted admission, but diagnosis required specialist input after discharge.
D. The patient's condition warranted admission and could have been diagnosed during the hospital stay.

Improvements to the classification

Four of the five interviewees provided suggestions for improving the classifications:

- Two interviewees suggested expanding class A to include legal requirement to hold a patient (child/young person) in a place of safety.
- Three interviewees commented on class B.
 - Two interviewees suggested amending class B as symptoms that are 'medically trivial' are still important to the patient. One suggestion for amended wording was: 'The patient's conditions or symptoms was not clinically significant enough during the hospital stay'.
 - One interviewee suggested expanding class B to include patients who did require admission for observation but improved without further treatment.

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- Two interviewees commented on class C but did not offer any suggestions on how the description could be improved. They understood this group of patients to be those discharged from an inpatient stay to improve patient flow.
 - Two interviewees commented on class D.
 - One interviewee suggested changing 'could have...' to '...should have...'.
 - One interviewee suggested that the description included challenges with clinical coding (such as not having to ability to select the correct diagnosis code and therefore defaulting to a non-specific diagnosis).

Missing groups

Two of the five interviewees mentioned groups of patients that were not covered by the classes. However, these mirrored what other interviewees had said for improving the classes:

- The reflection that patients who are admitted to rule out serious physical conditions could be incorporated into class B.
- The reflection that patients that can more appropriately be treated in community settings could be incorporated into class C.

Small classes

There was no consensus on whether any of the classes would be trivially small:

- One interviewee viewed all groups to have large numbers
- Two interviewees viewed class A to be the smallest
- One interviewee ranked the classes in order of size expected (large to small): D, B, A, C
- One interviewee viewed classes C and D to be small.

Value of classification

All five interviewees were of the opinion that the classifications had value in understanding this group of patients:

- Three interviewees stated that the classification would provide insight to clinical decision-making especially in the context of the patient's understanding of their symptoms.
 - One interviewee suggested that the insight would vary by clinical speciality.
 - One interviewee suggested that the insight would reflect clinical hierarchy.

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- One interviewee stated that knowing the numbers associated with each class would be helpful for managing health resource.
 - One interviewee stated that it would provide insight into the roles for social and integrated care as well as neighbourhood hubs in managing these patients.
 - One interviewee stated that classification would only be helpful if used prospectively alongside a risk assessment tool.

3. Conclusion

We collected rich data across five interviews with clinicians predominantly working in the emergency medicine speciality. Most interviewees were unsurprised by the statistic that one in six patients are discharged following an emergency admission with an NSD code, and they expected a high proportion of these NSD codes to be associated with emotional disturbance and complex mental health and social issues.

Interviewees were unsurprised by the finding that females were one and a half times more likely to be discharged with an NSD code compared with males, relating it to an overriding medical misogynistic culture which contributes to the normalisation of female pain and other symptoms relating to gynaecological health.

Interviewees found it more difficult to interpret the disparities in NSD findings by ethnicity, relating it partly to language and linguistic communication mismatch. Other partial explanations included cultural attitudes to patient self-advocacy and family support, with the latter allowing for discharge to the community whilst awaiting specialist input in out-patient settings

The NSD cohort that were discharged following an emergency admission were also understood in the context of local processes such as the ease and accuracy of clinical coding in busy clinical settings and the hospital or speciality rules for who diagnoses an NSD. Furthermore, there was acknowledgement of a trade-off between those that got discharged with an NSD, because they were sufficiently well in that spell and the inevitability that symptoms would return, leading to revolving door of admission and discharges.

3.1 Next steps

The differences in sex-based NSD coding and interviewees' interpretation of the data indicate that further exploration of women's health across the life course is warranted. We suggest a mixed method and intersectional study with the primary aim of exploring:

The extent to which female abdominal pain from puberty to menopause is visible to health services.

The objectives of this study would be to:

- Quantify the number of females with undiagnosed abdominal pain that present to secondary care and:
 - Compare with expected prevalences of gynaecological diseases
 - Quantify the time taken from first presentation (in primary care) to specialist diagnosis

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- Disaggregate by age, ethnicity (would expect the burden of disease to be higher in Black females see [Palmer et al. 2025](#)), and socio-economic status
 - Estimate the costs to the NHS related to undiagnosed abdominal pain from the perspective of:
 - The patient revolving door of admission, diagnosis and readmission
 - An employer with a predominantly female workforce who are ethnically and socio-economically diverse
 - Explore the impact of a chronic undiagnosed abdominal pain on female lives with a focus on:
 - Collecting stories of patients seeking a diagnosis for abdominal pain highlighting the touchpoints with different health services
 - Describing medical misogyny from the perspective of clinicians with lived experience of chronic abdominal pain
 - Ensuring maximum variation sampling in the qualitative study to incorporate a diversity of voices.

Appendix A: Interview topic guide

Exploring the views of clinicians and operational managers on patients discharged with non-specific diagnoses following an emergency hospital admission

This preamble to introduce the work will take into account previous contact with the interviewee and only cover any further detail requested (and if participant information sheet has not been read).

Introduction to the Strategy Unit

The Strategy Unit is a specialist NHS team. We provide research, analysis and consultancy services to the NHS and public and third sector organisations.

About this project

We are working in partnership with the Health Foundation to deliver a project describing a cohort of patients who are discharged with non-specific diagnoses following an emergency hospital admission, so that we might better understand the care they receive and outcomes.

The project consists of:

- A literature review on the existing evidence base, both in the UK and other comparable healthcare systems
- Quantitative analysis of admission data, including national incidence of non-specific diagnoses following emergency admission, the characteristics of patients discharged with non-specific diagnoses, and the extent to which inequalities exist among this cohort at a national level
- Qualitative clinical and operational interpretation of the quantitative findings.

Your participation

We are interviewing six clinicians and operational managers working in emergency inpatient settings to support the interpretation of the quantitative findings. Specifically, our questions relate to your perspectives on:

- Our proposed classification of patients who are discharged with non-specific diagnoses
- Why some groups of patients are more likely to be discharged with a non-specific diagnosis following an emergency hospital admission

The interview will last up to an hour.

Confidentiality

- Check they have received and read the participation information sheet
- Ask for consent to record for the purpose of aiding recall. Recordings will only be accessed by the research team and will be stored securely. If consent to recording is not provided,

detailed notes will be taken by the interviewer. If consent for neither recording nor notes is given, advise that the interview cannot take place

- Confirm that any quotes used will not be linked to any individual. No individuals will be identified in the reporting
- Explain that the interviews will be transcribed, and transcriptions will be accessible only to the research team. All information shared with us will be kept confidential and held securely in accordance with Data Protection legislation.

Topic guide

Interview questions below should be understood as guiding 'a conversation with a purpose'. However, this topic guide includes sections of text that should be read out verbatim to the participant, including definitions used in the project. This text is highlighted in coloured text boxes. The interviewer will also share charts and a table on their screen at the time of the interview.

Section 1: Participant background (5 minutes)

1. Can you state your role in the emergency setting?
2. What other experience do you have in the emergency in-patient settings?

Section 2: Views on this cohort (15 minutes)

Each week more than 100,000 people in England are admitted to hospital in an emergency. In most cases, by the time the patient's stay in hospital comes to an end, the clinical team has reached a view about the underlying medical condition that led to their admission.

But our quantitative analysis finds that for 1 in every 6 patients (17%), this is not the case: they are discharged with a non-specific primary diagnosis.

We defined a non-specific discharge diagnosis as: if the *primary diagnosis* code recorded in the *final episode of their hospital spell* was found in [ICD-10 Chapter 18 \(XVIII\)](#), "Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified". The quantitative analysis focused on the experience of patients aged 11-64 years, but we are happy to take your reflections on all patients.

3. Does the statistic that 1 in 6 patients leave hospital with a non-specific diagnosis fit with your experience?
Probes:
 - a. Is this a higher or lower proportion than you expected?
4. Based on your experience what are the characteristics of this cohort who are discharged with a non-specific primary diagnosis?
Probes:
 - a. What are the main reasons for their admission (physical health, mental health, emotional disturbance caused by pain)?
 - b. How long do they tend to stay in hospital for?
 - c. Are they likely to be readmissions or likely to be readmitted for the same symptoms?

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- d. What are their key demographic characteristics (age, sex, ethnicity)? Are patients with certain socio-demographic characteristics over-represented in this cohort who are discharged with a non-specific primary diagnosis?
 5. Do you think that leaving hospital with a non-specific diagnosis has implications for patient outcomes?
 6. Do you think that leaving hospital with a non-specific diagnosis can tell us anything about the quality of care provided?

Section 3: Views on national trends (15 minutes)

I'll now share a series of charts showing trends from our quantitative analysis. Our analysis suggests that women and people from Pakistani and Bangladeshi ethnic groups are more likely to be discharged without a diagnosis. This difference is present after we control for the age profile of these groups.

Figure 1: Number of emergency admissions by age, sex, and diagnosis group.

Figures 7 and 8: Age-standardised rate of NSD spells by ethnic group (females and males)

7. Do you have any thoughts on why that is the case?

Probes:

- a. admission/discharge thresholds
- b. access to diagnostic tests
- c. quality of patient-clinician interaction
- d. differences in coding practices

Section 4: Views on provisional classification of patients in this cohort (10 minutes)

Based on our quantitative findings, we have developed a set of statements to classify these admissions. Whilst they are unlikely to be exclusive or exhaustive, the next questions will ask whether you think that each statement is reflective of your experience, and if there are any ways the classification statements or their descriptions be improved.

Share screen showing the classification

- A. The patient was experiencing psychosocial distress or despair, and were admitted primarily for reasons of safety rather than for medical diagnosis or intervention.

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- B. The patient's condition was deemed to be medically trivial or insignificant during the hospital stay, and did not require further attention.
- C. The patient's condition warranted admission but diagnosis required specialist input after discharge.
- D. The patient's condition warranted admission and could have been diagnosed during the hospital stay.
8. In your experience do these classes describe the patients who are discharged with a non-specific diagnosis?
- Could the descriptions of any of the classes be improved upon?
 - Are there any groups of patients who are discharged without a diagnosis, that are not covered by these classes?
 - Do you think any of these classes might be trivially small?
 - Do you think this classification has value in helping us understand this group of patients?
9. Do you have any further reflections on the experience of patients who are discharged with a non-specific diagnosis following an emergency admission?

Thank participant for their time. The information you have provided will help us to frame our analysis, and to modify our proposed classification.

Appendix 1: Hypothesised mechanisms for why there are disparities in diagnosis

1. Differences in admission thresholds

Are patients from ethnic minority and deprived communities admitted in an emergency at lower thresholds? If this is the case then more patients may be discharged shortly after admission, having been assessed by hospital staff as low risk and not in need of hospital care.

2. Differences in case mix

Do patients from ethnic minority and deprived communities exhibit case mix characteristics (e.g. age, sex, comorbidities) that are strongly and independently associated with being discharged following an emergency admission without a specific diagnosis? If this is the case, then the finding may be explained via the differential distribution of case mix variables.

3. Reduced access to diagnostic testing after admission

Do patients from ethnic minority and deprived communities experience poorer access to diagnostic testing services after admission? If this is the case, then these patients may be less likely to receive a specific diagnosis.

4. Differences in the level or quality of interactions with clinicians after admission

Do patients from ethnic minority and deprived communities experience poorer access to clinicians after admission, or is the quality of the interactions between these patients and clinicians inferior? If this is the case, then these patients may be less likely to receive a specific diagnosis.

5. Differences in clinical coding practices

Are clinicians and/or clinical coders less likely or more reluctant to attribute a specific diagnosis to a patient from an ethnic minority and deprived community, for a given level of diagnostic certainty?

6. Differences in discharge thresholds

Are patients from ethnic minority and deprived communities discharged at lower thresholds after an emergency admission? If this is the case, then these patients may be less likely to receive a specific diagnosis before discharge.

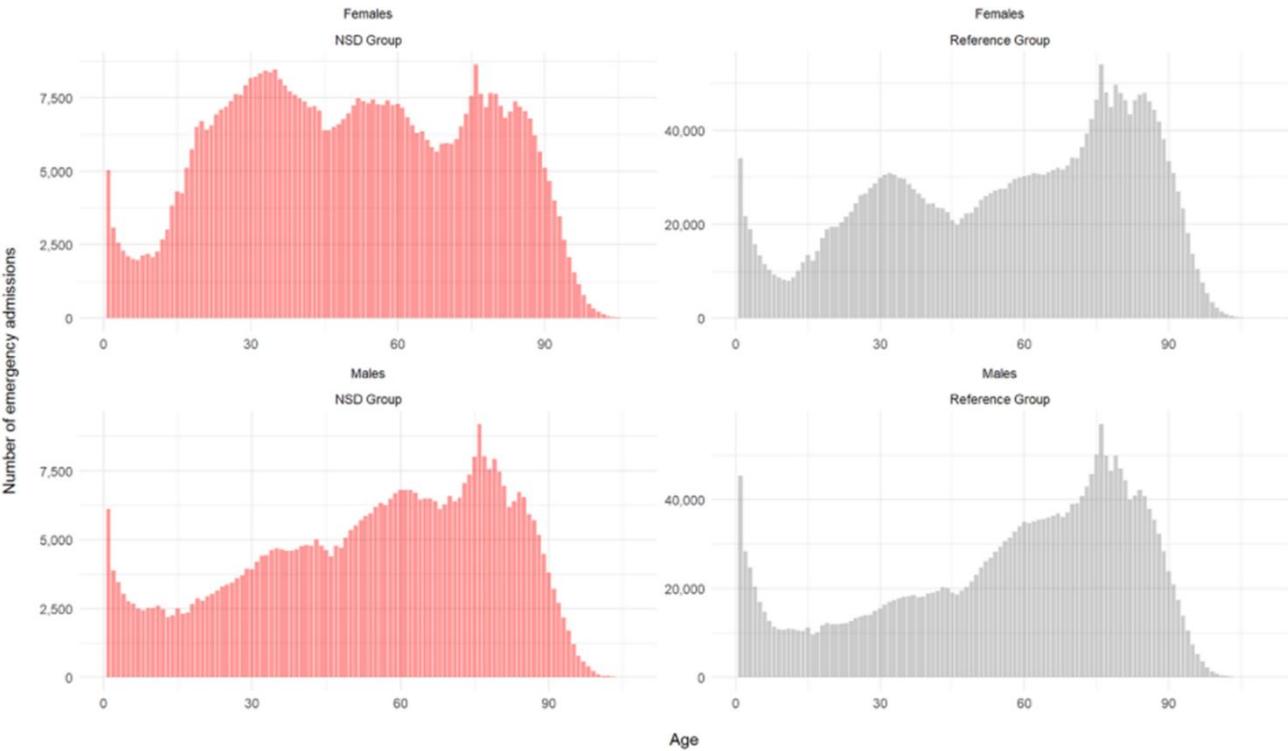
Appendix 2: Proposed classification of patients discharged with a non-specific diagnosis

Classification	Description
<p>A. The patient was experiencing psychosocial distress or despair, and were admitted primarily for reasons of safety rather than for medical diagnosis or intervention.</p>	<p>These hospital admissions are caused directly or indirectly by patients' social or economic context. In some cases, there may be evidence of drug or alcohol misuse, or self-harm. Subsequent admissions may occur with a primary diagnosis of F1* (Mental and behavioural disorders due to psychoactive substance use), X60-84 (Intentional self-harm), Y10-34 (Event of undetermined intent) or R* (signs and symptoms not elsewhere classified).</p>
<p>B. The patient's condition was deemed to be medically trivial or insignificant during the hospital stay, and did not require further attention.</p>	<p>These hospital admissions are likely to be short and contain minimal intervention from the hospital staff, and are rarely followed by another emergency admission in the next 3 months.</p>
<p>C. The patient's condition warranted admission but diagnosis required specialist input after discharge.</p>	<p>In these cases, a patient was appropriately admitted for a diagnosable condition, but no diagnosis was made during their stay. This might have been because the patient was discharged before diagnosis could be determined or because of some failure in the diagnostic process (poor dialogue between patient and clinician, poor access to diagnostic testing, failure to interpret the diagnostic test). These cases may be followed by subsequent emergency admissions.</p>
<p>D. The patient's condition warranted admission and could have been diagnosed during the hospital stay.</p>	<p>In some cases, reaching a decision on a patient's diagnosis may not be possible during the hospital spell. After the patient is stabilised and discharged, a referral for a specialist consultation and investigation may be necessary. The patients may have complex structural, psychiatric or functional conditions, that can only be diagnosed when symptoms advance or persist and other possible diagnoses have been ruled out. Subsequent emergency admissions may occur if the patient's condition is not diagnosed and managed.</p>

Appendix B: Quantitative figures

The following charts were shared with interviewees during the qualitative interviews. They are taken from the quantitative report, and the figure numbers align with those in the report.

Figure 1: Number of emergency admissions by age, sex and diagnosis group.



*To highlight the contrast between groups, we do not show admissions for children of age 0 as they greatly outnumber admissions for any other single year of age.

Figure 7: Age-standardised rate of NSD spells by ethnic group (females)

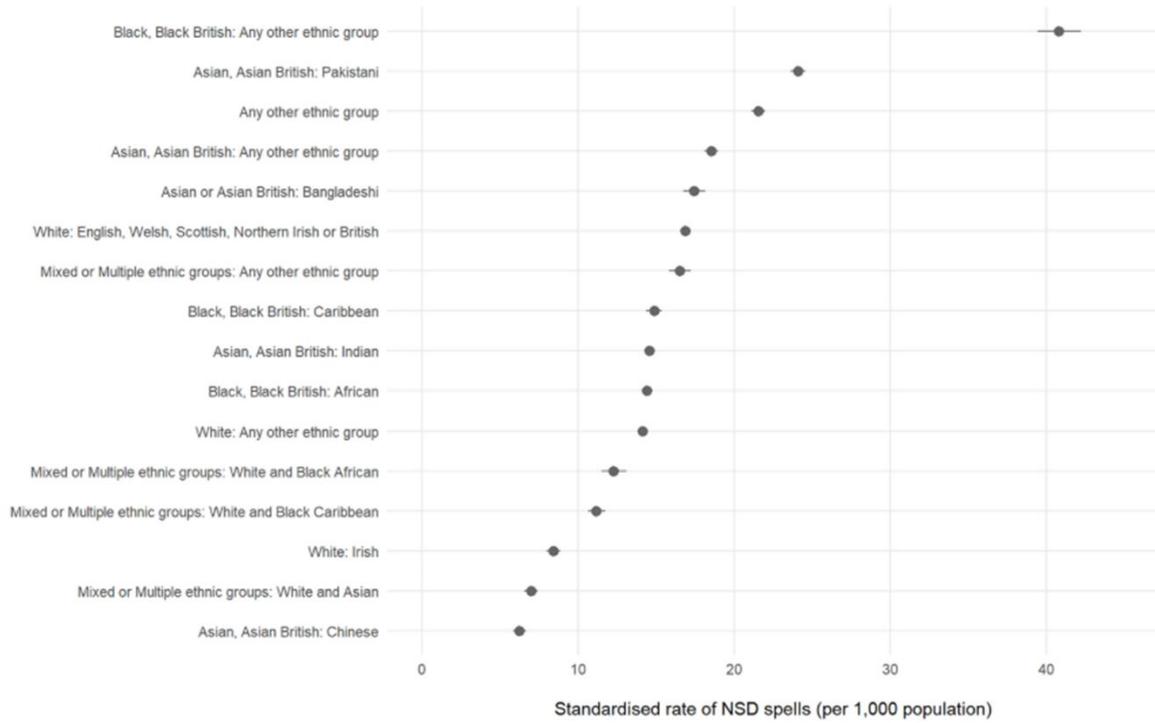
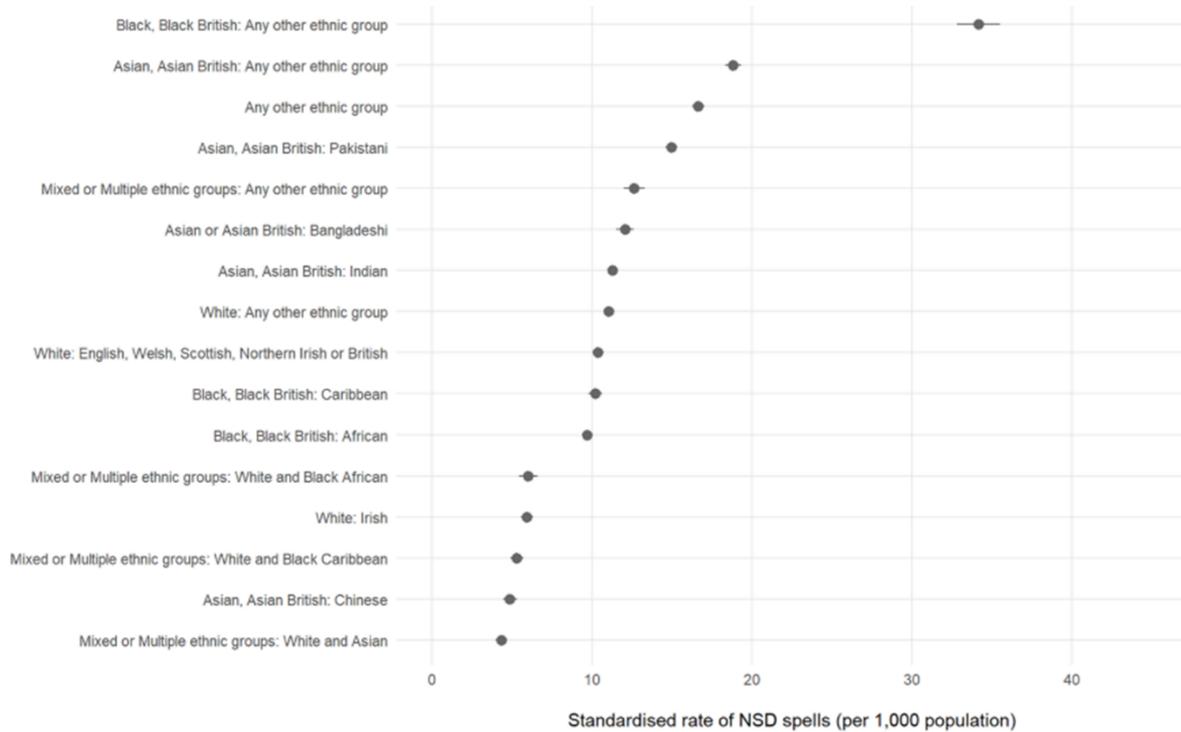


Figure 8: Age-standardised rate of NSD spells by ethnic group (females)



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