The Clatterbridge Cancer Centre **NHS**

NHS Foundation Trust

What Makes A Top Hospital? The Clatterbridge Cancer Centre Experience of Clinical Coding

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Quality Manager

Team:
Anne Bedford – Coding Manager
Clinical Effectiveness Team
EPR Team
Information Team

Objectives

- Inpatient coding
- Outpatient coding
- Testing and validating against EPR system
- Data validation against CDS
- External Audit

Background

- Chemotherapy and Radiotherapy for Adult Solid Tumours
- ~ 10,000 new patients annually
- ~ 300 inpatient episode monthly
- ~ 28000 outpatient appointments monthly
- Satellite clinics at major 8 DGH hospitals
- Chemotherapy delivered at 10 sites
- Radiotherapy delivered at 2 sites
- Electronic Patient Record system since 2002

MAP

- Merseyside
- Cheshire
- North Wales
- Isle of Man
- Parts of Lancashire

Inpatient Coding

- Inpatient Clinical Coding Team:-

- Clinical Coding Manager

- 2 x ACC Inpatient Clinical Coders

- 2 x 6 hour per week Novice Coders

Please Don't Bug Me I'm Busy Coding

Inpatient Coding Past and Present

PAST	PRESENT
Working in isolation	Working together with clinical engagement
Incomplete discharge summary	Electronic Discharge Summary
Case notes	EPR fully electronic record
Coding without validation	Encoder
No awareness sessions	Induction and Awareness sessions clinical and non clinical
Clinical Coder limited education	Ongoing training programme Cheshire & Merseyside Clinical Coding Academy
No query methods	Query proforma with Clinicians

Guide for Clinical Staff – Best Practice

Included in Staff Induction

1. Write clearly in all documentation and noting on EPR
2. Sign, Date and Time – print name and position (this is now automatic within EPR)
3. Record **ALL** diagnoses and procedures
4. If no clear diagnosis – Record main symptoms
5. Avoid using **new** or **ambiguous** abbreviations
6. Ensure all forms are completed fully
7. At the final ward round prior to discharge, ensure the **main condition treated is clearly, accurately and completely stated**
8. Impact of inaccurate coding, resulting in wrong HRGs

Validation against EPR system

System Setup and Testing

- Work with the owner of the clinic to identify the function of the clinic i.e. new, follow up, carry out what procedures etc

- Work with the coding manager to build the coding options specific for the clinic

- Work with the reporting teams to ensure data is reportable and in correct format

Out Patient Coding

Treatment Related Coding

- Centralised team codes diagnosis in all systems and chemotherapy OPCS codes

- Radiographers record radiotherapy OPCS codes

Non-treatment Related Coding

- Clinic clerks arrive, depart patients and record the Outcome of appointments

OPCS 4.8 Coding

Out-Patient Commissioning Dataset

Out Patient Coding

Activity today

Bay	
Chemo given	y
Was this C1D1?	**n**
Deferred	
Go Ahead	
PICC Flush	
Bottle disconnect	
PICC removal	
Medical review	
Other	

Next Steps

Ambulance req/nurse discretion	
Next chair appointment	25/10/17
Go Ahead Phone	
Go Ahead Face to Face	
Chair Time	rapid
Cool Cap required	
Medical review	
PICC Flush	
PICC Insert	
Bottle Disconnect	
Rapid Access Chair	rapid
Follow up (finished chemo)	

Additional Information

	Pri	From
☆		+ Oncology Event Task
		+ Oncology Event Message
☆		− Nurse to Sched Appt
☆	L	
☆	L	
	L	
☆	L	
☆	L	
☆	L	
☆	L	
☆	L	

H | M | L   Filter

Create

Regarding	Status	Date
	Complete	15/03/17
	Complete	30/08/17
	Complete	27/09/17
	Complete	27/09/17
	Complete	15/02/17
	Complete	02/08/17
	Complete	05/07/17
	Complete	12/04/17
	Complete	10/05/17
	Complete	07/06/17

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Out Patient Coding

Validation of Data

- Develop regular data quality report ~ daily, weekly, Monthly

- User fixes their own errors

- Identify error patterns and discuss with individual team

- Inpatient CDS

- Outpatient CDS

- Chemotherapy

- Radiotherapy

- Procedure Validation

- Diagnostic Imaging

Data Quality Group

External & Internal Audit

External Audit

- IG In-Patient Clinical Coding Audit

- Out-Patient Clinical Coding Audit – includes chemotherapy, radiotherapy, diagnostic imaging, procedures

Internal Audit

- Monthly sample of In-Patient Coding

- Monthly sample of Out-Patient Coding

External IG Inpatient Audit

Executive Summary

It is apparent from our work that the overall accuracy of clinical coding is very good with performance meeting level 3 standards defined in Information Governance Toolkit Requirement 505. A summary is shown below:

CODING FIELD	PERCENTAGE CORRECT	IG REQ 505 LEVEL 2	IG REQ 505 LEVEL 3
Primary diagnosis	98.00%	90%	95%
Secondary diagnosis	95.86%	80%	90%
Primary procedure	97.14%	90%	95%
Secondary procedure	93.89%	80%	90%

Good practice was noted in relation to the communication that the Clinical Coding Department has with the consultants at the Trust. This communication supports the accuracy of the clinical coding and builds relationships that nurtures the continued improvement.
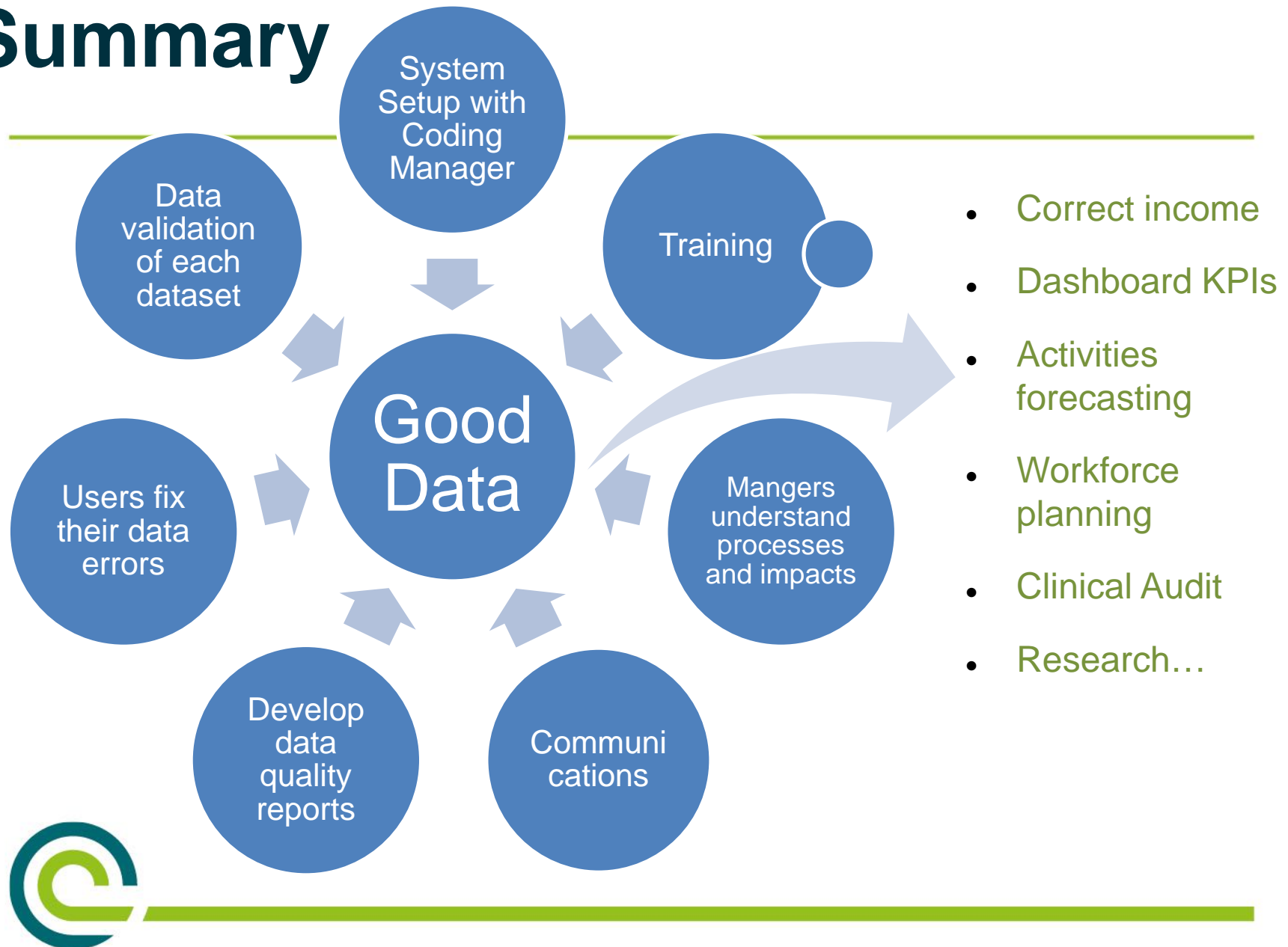
External Out-Patient Audit

CODING FIELD	RADIOTHERAPY PERCENTAGE CORRECT	CHEMOTHERAPY PERCENTAGE CORRECT
Primary diagnosis	96.00%	86.00%
Secondary diagnosis	100%	100%
Primary procedure	100%	96.00%
Secondary procedure	68.83%	87.30%

Good practice was noted in the relationship between the parties responsible for the recording of clinical coding data against outpatient attendances. There are good channels of communication and support from senior management teams.

Summary

System Setup with Coding Manager

Data validation of each dataset

Training

Users fix their data errors

Good Data

Mangers understand processes and impacts

Develop data quality reports

Communi cations

- Correct income

- Dashboard KPIs

- Activities forecasting

- Workforce planning

- Clinical Audit

- Research…

New development

- Haemato-oncology
- Building a new hospital site next to the Liverpool Royal Hospital site ~ opening in 2019

Thank you for listening

Any Questions?

"Skip all that medical mumbo jumbo
and just give it to me straight, Doc.
What's the ICD-10 code for this?"