Participants

- Paul Briddock, HFMA (chair)
- Richard Allen, head of income and contracts, Moorfields Eye Hospital NHS FT
- Mike Barnes, director, EPS Research
- Helen Cookson, associate FD, Imperial College Healthcare NHST
- Carolyn Cooper, clinical coding head, Guy's and St Thomas' NHS FT
- David Jellicoe, contract income planning head, Barking, Havering and Redbridge University Hospital NHST
- Paula Monteith, head of the National Casemix Office, NHS Digital
- David Moon, chief finance and strategy officer, University Hospital Coventry and Warwickshire NHST
- Pippa Ross-Smith, chief finance officer, Brighton and Hove CCG
- Ben Roberts, head of finance transformation, Bolton NHS FT
- Dawn Scrafield, FD, Colchester Hospital University NHS FT
- NHS Improvement: Amit Patel (pricing), Milton Salas Martinez (economist) and Dr Jarvis Punsalan (clinical lead)

An HFMA roundtable in March called for a greater focus on clinical coding and an increased awareness among clinicians of the value of this core data. Steve Brown reports

Coded message

HFMA ROUND TABLE

There is broad agreement the NHS needs to take an evidence-based approach to the management and transformation of services. But if this is going to become a reality, then the service will need to focus more on ensuring its core data is robust enough to enable the right decisions to be taken with confidence. This was the conclusion of an HFMA roundtable in March.

The roundtable – supported by healthcare software and analysis specialist EPS Research – brought together finance and coding managers alongside representatives from NHS Digital and NHS Improvement to talk about 'data quality – coding and the move to HRG4+'.

Delegates were quick to dismiss tariff as being the main driver for improving data quality. The original move to payment by results resulted in an increased focus on both coding (to ensure accurate payment) and cost data (to inform tariff setting and for service line reporting). But they were clear that the need for robust data was about much more than payment.

Many delegates reported that activity-based contracts were now accompanied by caps and collars, income guarantees or other risk-sharing mechanisms – even block contracts in some places – so the link between coding and payment was in some ways less direct. But this did not reduce the importance of getting data right.

'Good-quality data is fundamental to how you run health services,' said HFMA policy director Paul Briddock, chairing the session. 'If we are going to transform services in the way we have to, it is key that we understand what we are currently doing for patients and how we can implement changes to meet patient needs in a better, more cost-effective way.'

Coding of patient episodes is at the heart of robust data, but Mike Barnes, director of EPS Research said better coding began with clinicians. 'We need to get clinicians involved from the start. If they are clear in the notes, information will flow through the system properly,' he said. This would deliver sound information to inform provider and commissioner decision making and underpin whatever payment system is in place.

He also warned that coding departments were already 'overstretched' and that any attempts to improve data should place a minimal extra burden on clinical coders.

Clinicians were too often providing insufficient detail in patient notes. 'They need to understand the importance of writing down the primary diagnosis, for example, not simply what the patient presented with,' he said. On occasion, patient notes might just record that the patient had a headache or chest pain, but not include the eventual diagnosis made. Analysis of multiple presentations by the same patient shows differences from spell to spell – for example, a diabetes comorbidity being recorded on one occasion but not the next, then back again.

Patient care

'The key driver for this is patient care, if the right co-morbidities are not captured, it could be harmful for patients or lead to sub-optimal care,' said Helen Cookson, associate director of finance at Imperial College Healthcare NHS Trust.

The delegates were unanimous in dismissing upcoding – over-coding or coding cases at a higher complexity level – as a myth. Coding departments didn't have the time and clinicians

and coders did not have the inclination.

Accurate coding should mean accurate payment, but clinicians and coders do not need to think about the income side of things when they were completing notes of adding codes. Richard Allen, head of income and contracts at Moorfields Eye Hospital NHS FT, said clinicians did ask about how they ensure they get the right payment. 'But the message is to just get the coding right, the funding is not an issue.'

Carolyn Cooper, head of clinical coding at Guy's and St Thomas' NHS Foundation Trust, agreed. 'Healthcare resource groups and coding can't be about money – it is about the importance of patient care.'

It could have a direct impact on a specific care episode, as well as undermining more general analysis of trends and activity.

Properly coded data could provide a wealth of information to inform service change, Mr Barnes said. He showed delegates an analysis of patient activity for a single trust, with patients organised by primary reason for inpatient care (such as respiratory conditions) or as complex, where multiple diagnoses or interventions mean they don't fall easily into any one category.

Just 1,200 patients accounted for a staggering 80,000 bed days across a two-year period – losing the trust about £10m in the process. These patients were typically medical patients. Often diagnoses were unspecific – with codes for both chest pain or abdominal pain, for example. More than half of these patients were also being admitted on several occasions for the same things – multiple infections or falls, perhaps.

'You can also see clear evidence of patients getting sicker while they are in hospital,' said Mr Barnes. Patients might come in with heart failure, get a urinary tract infection while they are in hospital and then develop sepsis. They may well need physiotherapy to help get them more mobile again so they are fit for discharge.'

Earlier intervention

He said that the data was typical for most acute hospitals. Although there is room for improvement, there were opportunities to use this analysis to consider how services were currently provided for this cohort of patients, many of which will be frail elderly. 'If we can get to these patients earlier, there are significant benefits for patients and significant savings [from avoided admissions] downstream,' he said.

Even if admissions aren't avoided, Mr Barnes said, systems should be able to flag these patients on arrival into the hospital so that the appropriate response can be initiated quickly to avoid deterioration in condition and attempt to stop the repetitive cycle. The data could also be analysed to provide early warning signs of patients likely to become the next cohort of complex patients before they start having multiple admissions.

> **"Identifying the high-intensity users and the complex patients and understanding when they are medically fit for discharge is potentially really powerful"**
> **Pippa Ross-Smith**

But he added that the analysis, understanding and response could be even greater if documentation for coding improved. 'In an episode where a patient has been given antibiotics to tackle a presumed chest/urinary infection, it may not be clear from the notes what the actual infection was and therefore we can't fully understand the problems or develop a better response for the patient,' he said.

Inconsistent coding was evident, with the same patients having ischaemic heart disease for one spell, but not the next. And there were potentially useful codes often underused – living alone and delayed transfer codes for example. Mr Barnes stressed that the real potential lay with examining the detailed codes, not the healthcare resource groups in this instance.

'These complex patients often have few procedures undertaken – other than diagnostic imaging – and the HRG often doesn't provide the full picture about the patients' conditions or treatments,' he said. 'The relevant HRGs also typically have long trim points – up to 70 days in some cases – and so there is little financial incentive for commissioners to drive changes in the pathway.'

Delegates agreed there was huge potential to inform change based on robust coded activity.


Amit Patel

Pippa Ross-Smith, chief finance officer at Brighton and Hove Clinical Commissioning Group, said well-coded activity had huge potential in the current transformation climate in which there is pressure to move services out of acute settings. 'Identifying the high-intensity users and the complex patients and understanding when they are medically fit for discharge is potentially really powerful,' she said.

The NHS had to develop better ways of meeting the care needs of the elderly and this would involve trend analysis and joint planning, on the back of robust data, between commissioners and providers.

David Jellicoe, head of contract income planning at Barking, Havering and Redbridge University Hospital NHS Trust, agreed. Getting patients through the hospital and meeting referral to treatment targets was a challenge. So developing better responses for patients who were staying in longer than was good for them, and longer than necessary, made sense.

Ben Roberts, head of finance transformation at Bolton NHS FT, warned that, from a financial perspective, the trick would be to extract cost while changing pathways. 'You are talking about a small cohort of patients and the issue for providers is what cost you can take out,' he said. Patients staying longer than necessary in hospital was not good for patients, but lowering costs would need to involve reducing bed numbers and associated staff.

Dawn Scrafield, finance director at Colchester Hospital University NHS FT, said improving recording was a challenge. 'Coding is typically retrospective and the data quality is not quite good enough to pinpoint exactly how an intervention could have been different,' she said.

The group identified two focus areas for improving coding – the coding team and clinicians. Delegates stressed again that coding teams were under pressure – and continuing


Ben Roberts

calls to reduce corporate and administrative costs in the face of extreme financial restrictions made it difficult to invest further in the coding function. However, failure to do so could be short-sighted given the potential to help identify and inform transformation.

Lack of investment

There was concern that this lack of investment even stretched to a reluctance to support coders' development – some organisations have refused to allow coding team members to attend a first national coding conference.

Paula Monteith, acting head of the National Casemix Office within NHS Digital, said it was important to be seen and heard to value the coding function. 'You often hear things like "SNOMED CT [clinical terminology used in electronic patient records] could replace clinical coding". No it won't. But what you do in the process is upset the coding team and they leave. We need to find ways of showing they are valued as a profession.'

She said the story around coding – why it is important – needed to change. 'It is not just about income. Instead coders need to understand that they are responsible for telling a patient's story – and investments, service transformation and key decisions will all be based on this information. It is really important to make sure that coders are hearing this. Too often they are treated as an overhead when really they are about compiling clinical information to help people make the right decisions to help people get better.'

Delegates suggested there was more scope for improving coding by concentrating on clinicians. 'There is a lack of education for clinicians about how important data quality is,' said Mrs Cookson. 'For junior doctors, when they come to a trust you have about one week of induction programme and then they have so much clinical work and learning to do that it is almost too late. We need to educate them earlier, while they are still at university.'

Mrs Cooper underlined the point. 'What training they do get is around information governance – not writing something down that could get them into trouble at a later date,' she says. 'I don't think they always understand where the data goes and what it is used for.' She added that coders were often faced with multiple different diagnoses in notes and that it was often the coder making a judgement at the time of coding on the correct primary diagnosis.

Mrs Ross-Smith said getting junior doctors to examine previously coded notes would be a good start. 'If they could identify what was missing – what they would like to know about that patient to understand what happened – perhaps that would help them to include the key information when recording notes going forward,' she said.

> **"We also now have a nurse as a permanent clinical relationships facilitator. She is there to be the bridge between clinical services and the coding department"**
> **Carolyn Cooper**

Amit Patel, pricing regulation manager at NHS Improvement, said that 'engagement with clinicians' was the 'holy grail' in terms of securing better data. Clinicians were vital to better costing data, underpinning NHS Improvement's Costing Transformation Programme. And they were clearly key to better clinical coding, which provided the foundation for tariff setting and decision-making.

Mr Patel said he had previously worked on the reference cost audit programme. For 2014/15 data, this programme found that 34% of providers needed to improve diagnosis and procedure coding. 'From observation, it appeared that data quality was taken more seriously in organisations where coding sat under the medical director,' he said. 'In organisations where coding sits within finance and informatics, it was found to be difficult for the coding team to get the traction required to achieve positive clinical engagement to improve data quality.' He suggested that medical leadership of this function might encourage more clinicians to engage.

Mrs Cooper also said trusts needed to broaden their focus beyond the medical workforce to include all clinicians including nurses and allied health professions. 'We have included coding and data quality as part of our nurse training programme,' she said. Introductory courses – to coding in general, tariff payment and the SNOMED clinical terminology – were open to all interested staff, although Guy's and St Thomas' were yet to run a dedicated course for medical school undergraduates.

Coding work

Mr Allen said that at Moorfields clinicians had worked directly with coders to improve coding quality. However, he acknowledged that this was more achievable in a single specialty trust. David Moon, chief finance and strategy officer at University Hospitals Coventry and Warwickshire NHS Trust, said he had 'blitzed every specialty' with the head of coding at a previous trust to talk about the value of good coding. But this had not


Dawn Scrafield


Helen Cookson


David Moon

yet been replicated at UHCW. It was an effective approach, but time consuming.

Guy's and St Thomas' has transformed its coding performance in recent years, largely due to a programme of clinical engagement. Each specialty now has a coding triangle – made up of named coding, clinical and management leads. These meet regularly to discuss issues that arise, validate data and to encourage engagement between the different teams delivering and using coding data.

Mrs Cooper said it was a good system, although the coding workload was such that it was difficult for coders to juggle this additional responsibility and meet coding activity deadlines.

She also stressed that coders were trained for the coding process and to extract information. 'But they are not trained for clinical engagement or for improving education in that way,' she said. Others agreed that it could be intimidating for coders to seek out, confront or talk to clinicians, especially where they were challenging the accuracy or completeness of patient notes.

'As part of these triangles, coding leads now attend local inductions and have a section on the nurses and junior doctors' induction,' said Mrs Cooper. 'We also now have a nurse as a permanent clinical relationships facilitator. She is there to be the bridge between clinical services and the coding department. She has been brilliant, quadrupling the amount of clinical information recorded by clinicians that can be used for coding.'

Coding reviews

Specialty-specific audits and reviews of coding were used by many trusts to identify opportunities for improvement. Other trusts said that coding reviews were built into deep dives into service line performance.

Recording of comorbidities was a specific angle that some trusts have looked at. Ms Scrafield said a comorbidity self-service report was one tool the trust had developed to enable clinicians to see variation in current coding and to challenge it and feedback where appropriate.

Mrs Cooper also suggested that trusts should be comparing the level of comorbidities being reported with local prevalence data for the relevant conditions to gauge whether they are capturing comorbidities to a sufficient depth. 'By looking at prevalence data, you can roughly determine the level of comorbidities you should be seeing in your activity data,' she said.

Ms Monteith added that series analysis of HRG data provided a good way of looking at trends in complication and comorbidity rates and keeping a check on coding depth.

Bolton's Mr Roberts said that as well as clinical engagement, finance needed to work closely with informatics professionals to enhance data quality. And he flagged up the HFMA North West Branch annual conference – run as a joint finance and informatics conference – as a good step in the right direction .


Mike Barnes


Carolyn Cooper


Richard Allen

Technology was also seen as having a major potential to support coding with electronic patient records (EPRs) at the heart of revised approaches. Mrs Cooper said the NHS was in a 'strange place' compared with other services such as banking, where transactions are fully electronic. 'We'll record something electronically and then go and write it down on a piece of paper,' she said.

HFMA ROUND TABLE

'If a clinician makes a decision to start antibiotics as treatment for sepsis on the back of identifying the relevant symptoms, why shouldn't we take that information from an EPR as the diagnosis and push it through to the coding system. If we can suck information out and push it through to the coders – who can still be the validation point and operate to national standards – that will free up coders' time to get out there and do more clinical engagement and promote use of the data.'

Mrs Cookson said that Imperial was doing work with its EPR to make it easier for clinicians to make notes and add diagnoses in a consistent way. 'Rather than presenting a clinician with every possible diagnosis and procedure, a programme is being developed to break down information into relevant folders to make it easier for clinicians to record the right information,' she said.

Mr Roberts suggested that EPRs should provide the opportunity to flag complex patients as they reappeared in the system, helping providers to trigger multi-disciplinary responses to these patients.

'EPRs should also provide a way for coders to see previous coding of patients in earlier episodes,' he said. This could help tackle issues such as inconsistent recording of comorbidities between different episodes.

Delegates also felt that coding needed to expand to cover more activity, in a more detailed way, in the community. 'Our community services aren't data rich but the activity outside of hospital is huge and we don't know much about what is going on in detail,' said Mr Roberts, whose trust is starting to look at data quality for non-inpatient spells.

Ms Monteith pointed out that there was some detail in community services reference costs returns. Mr Barnes agreed enhanced community data would be a bonus, but that there was already a rich resource in acute data to start informing different pathways.

Overall, the delegates agreed that there needed to be better recognition of the importance of coding, breaking the misconception that it was a payment-related activity. Improvements should focus on education and awareness, with the clinical workforce – and junior doctors in particular – being the main focus. With investment difficult, organisations needed to share good practice on approaches to achieving these goals.