Validating Subsets through Audit and Payment

IHTSDO Showcase 2014

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Motivation for session

‘Share and Tell’

So please interject with own experiences
Profile:

• denise.downs@hscic.gov.uk
• Work in UK Terminology Centre, HSCIC
  – We author SNOMED CT, Read v2 and CTV3
• Informatics and Education Specialist
• Role is to support implementation of SNOMED CT in systems and education
• Been in current role since July 2009
Background:

NHS organisations
In the NHS in England there are currently:
• 211 clinical commissioning groups
• 160 acute trusts (including 101 foundation trusts)
• 56 mental health trusts (including 41 foundation trusts)
• 34 community providers (18 NHS trusts and 16 social enterprises)
• 10 ambulance trusts (including 5 foundation trusts)
• c.8,000 GP practices
• c.2300 hospitals in the UK
The National Programme for IT (NPfIT) resulted in a number of systems that utilised SNOMED CT as their clinical vocabulary.

Some trusts have procured their own solutions with a requirement for SNOMED CT.

Trusts have used different approaches to ‘require’ SNOMED CT in the clinical record.

The provision of subsets is seen as a key requirement for adoption.
National Subsets

• NPfIT produced a set of specialty subsets (350 in total) to enable services to indicate their provision against a defined list – these contain diagnosis, findings and procedures.
• Substantial effort has been expended in producing subsets in a variety of ways by various organisations
• ‘Not invented here’ issue
What to Nationally Provide?

• Interest mainly for data entry:
  – Starter subsets (most frequent)
  – Exhaustive subsets (contain all terms)
  – General subsets (defined by the terms all junior doctors would be expected to know)
  – Defined by the scope of current classifications

• We have spent time exploring different approaches
• We lack robust validation and feedback
Approaches used so far:

- Take terms from junior doctor curriculum
- Train staff to search effectively and collate subsets from records based on usage
- Brainstorm with experts
- Review paper records
- Work with expert reference group and use keywords to search using a subset tool
- Use the ICD-10 / OPCS codes and find candidates
The Patient Journey

- Patient visits GP
- Consultation and evaluation
- Referral to appropriate service
- Appointment made using Choose & Book
- Attends clinic
- Clinician makes diagnosis
- Discharge summary returned to GP
- Patient attends clinic
- Clinician makes a diagnosis and plans the intervention
- Intervention completed and the patient discharged
- Discharge summary is sent to GP
‘Testing the subsets’

Principles:

• We code data we wish to re-use ‘electronically’ – either in reporting, to trigger an alert, to extract to create say a discharge summary ….

• Now we have produced the subsets, we should test these meet current and planned requirements
Clinical Process and Business Process

• Clinical Care
  – NICE Guidelines / Quality Indicators
  – Best Practice
  – Professional Body guidance
• Clinical Audit
• Professional Audit
• Transfer of Care (ED, Clinician, GP)

• Clinical Coding and Payment
• Service Improvement
• Responding to change in trends
Quality Indicators

• Stroke:

• ‘Patients with acute stroke receive brain imaging within 1 hour of arrival at the hospital if they meet any of the indications for immediate imaging’
**Report**

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>No. patients</th>
<th>No. Acute</th>
<th>Total had imaging</th>
<th>Total acute had imaging</th>
<th>% imaging</th>
<th>% acute had imaging</th>
</tr>
</thead>
</table>

**Stroke Patients seen between <date> and <date>**

Decide what percentages trigger traffic light indicators
<table>
<thead>
<tr>
<th>Timeframe</th>
<th>No acute patients</th>
<th>30 mins</th>
<th>60 mins</th>
<th>90 mins</th>
<th>120 mins</th>
<th>&gt;120 mins</th>
</tr>
</thead>
<tbody>
<tr>
<td>**Stroke Patients seen between <strong>&lt;date&gt;</strong> and <strong>&lt;date&gt;</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Time to imaging</strong></td>
<td></td>
<td></td>
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</tbody>
</table>
Lessons Learnt

• We didn’t get completeness from just clinical input and review
• Validating with payment resulted in a number of more detailed codes being offered to the clinician – and they preferred these
• One of the audits had additional groups that needed to be recorded with own codes – these are well grouped in SNOMED CT
• There is increased interest from clinical staff now they are seeing the reporting possibilities
• There is an increased interest in standardisation by the professional bodies and linking with best practice guidance
• We are increasingly signposting the SNOMED CT terms on national guidance and information
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