AGENDA ITEM NO:

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
BOARD OF DIRECTORS
THURSDAY 25 APRIL 2013

Title:	**CHANGE IN PRACTICE OF CLINICAL CODING OF PALLIATIVE CARE**
Responsible Director:	Dave Rosser, Executive Medical Director
Contact:	Daniel Ray, Director of Informatics, Ext. 12416 Sophie Wheeley, Head of Informatics Cheryl Cottrell, Clinical Coding Manager

Purpose:	To update the Board of Directors on an improvement to Clinical Coding specifically to palliative service interventions and the subsequent impact on the Trust's performance in relation to the HSMR Mortality Indicator.
Confidentiality Level & Reason:	
Annual Plan Ref:	Core Purpose 1 - Strategic Aim - To deliver and be recognised for the highest levels of quality of care through the use of technology, information, and benchmarking
Key Issues Summary:	• Clinical Coding of Palliative Care has been ambiguous with National Guidelines open to interpretation. • Much Work has been done locally and nationally with key stakeholders to better understand and more accurately record Palliative Care. • UHB has identified and implemented a change in Coding practice to improve Palliative Care information for its patients, improving the quality of its clinical coding submitted to HES via SUS. • This change in Coding practice will impact the HSMR.
Recommendations:	The Board of Directors is requested to: **Approve** the proposed change in Clinical Coding practice in relation to Palliative Care and the consequential impact on the HSMR Mortality Indicator.

Signed:	**Date:** 10 April 2013

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS
FRIDAY 26 APRIL 2013

CHANGE IN PRACTICE OF CLINICAL CODING OF PALLIATIVE CARE

PRESENTED BY THE EXECUTIVE MEDICAL DIRECTOR

1. **Purpose**

To provide an overview of a change in practice to the allocation of palliative care clinical coding to individual patient level data. The Palliative Care Team within the Trust has a significant amount of input into complex decisions surrounding the care of patients. Improved data capture methodologies have been put in place to better record and code this information. This change will impact the Trust's published performance against the Hospital Standardised Mortality Ratio (HSMR) a metric with a high media profile, and as such this paper informs the board of this change.

2. **Strategic Context**

2.1 Background

A key element of the Hospital Standardised Mortality Indicator (HSMR) methodology is related to the coding of palliative care on Hospital Episode Statistics (HES) data, based on the premise that if a patient is undergoing palliative care then they are more likely to die. Whilst this methodology is seen by many to be flawed, it still means that the prevalence of coding of palliative care in an organisation's inpatient records can substantially drive the difference between an organisation appearing to be an outlier, or not, for the HSMR. Examples of the effect that palliative care coding can have on HSRM is shown in **Appendix A.** This, and the lack of a clear national definition of palliative care, means that the importance of the accuracy of the coding of palliative care has received more attention than perhaps some other clinical specialties.

2.2 NCS West Midlands Clinical Coding Academy

UHB is the strategic lead for the collaborative National Classifications Service Clinical Coding Academy (NCS CCA) for the West Midlands, a group of 15 Trusts working together to deliver high quality clinical coding training and improve consistency of coding across the West Midlands and nationally. As an NCS Academy a UHB representative sits on the National Academy Steering Group and Management Group.

In July 2012 a clinical coding conference was held by the West Midlands Academy, sponsored by the SHA, with 60 attendees from almost all Acute and Specialist Trusts across the West Midlands, with clinician speakers on palliative care and respiratory medicine, UHB informatics representation, Health and Social Care Information Centre (HSCIC) representation and National Classification Service (NCS) representation. The discussions from these meetings, workshops and engagements will inform new national guidance associated with the definitions surrounding the coding of palliative care coding. The changes proposed in this paper are in line with current guidance and the definitions proposed from the workshops to inform future guidance.

The discussions that resulted from the National Academy Meetings, the conference, associated networking, preparatory work, surveys and follow-up work has enabled the UHB Clinical Coding Team to investigate and implement new ways of collecting accurate palliative care information for our patients for submission of more accurate data in the SUS and HES datasets. Namely more accurately identify within the data the extent of which the Trust's Palliative Care Team have been involved in the decisions about the care of palliative patients.

3. Change in Practice

3.1 The Somerset Cancer Register is a database used by over 60 hospitals across the country including UHB. Analysis of the register and comparison with UHB's Patient Administration System has enabled identification of an additional cohort of UHB patients who have had treatment by our Specialist Palliative Care Team whilst in our hospital, but the palliative care treatment has not been recorded or identified from their Medical Records. The move to collect this additional information directly from the electronic system is in line with UHB's current clinical coding strategy, which is to collect clinical information from electronic records rather than paper where possible as we move towards a full Electronic Patient Record.

3.2 A new rule in relation to collection and use of this information from the Somerset Cancer Register has been written by UHB's Clinical Coding Manager who is an experienced Accredited Clinical Coder proficient in all national clinical coding guidlelines. This rule has also been reviewed and verified by another qualified clinical coding auditor, who has confirmed that they consider that the process and rule is in line with national guidance. The rule has been approved by the Executive Medical Director and Lead Palliative Care Consultant and an excerpt from the rule is detailed in **Appendix B.**

4. Implications and Impact

4.1 Impact on the 2012/13 HSMR

The informatics team has run a model to assess the impact of this change in clinical coding practice on the Trust yearly HSMR figure that will be published in November 2013 by Dr Foster, assuming the HSMR methodology does not change prior to publication. The model uses current April to February data with an estimate for March, the change in coding practice occurring for Quarter 4. The findings from the model indicate that the HSMR figure for the financial year with just the Quarter 4 changes will mean the HSMR reduces from 109.1 to 107.2 once implemented, improving UHB's mortality ratio and making outlier status much less likely, for 2012/13 and considerably less likely for 2013/14 when the changes will have been recorded for a full year. The HSMR calculation changes on an annual basis, therefore it is not possible to accurately predict the HSMR values.

4.2 Benchmarking and National Comparisons

Prior to the internal review of recording practice analysis comparisons with peers showed that UHB was potentially under coding palliative care, and that a number of Trusts have undergone sharp increases at a point in time in palliative coding similar to our current recommendation. The table below shows that given the types of services the Trust provides it is understating its level of palliative care interventions in its clinically coded data.

Discharge Month	2011	2012
Heart of England NHS Foundation Trust	897	717
Leeds Teaching Hospitals NHS Trust	766	905
Mid Staffordshire NHS Foundation Trust	324	296
Nottingham University Hospitals NHS Trust	842	893
Sheffield Teaching Hospitals NHS Foundation Trust	1008	996
University College London Hospitals NHS Foundation Trust	545	533
University Hospitals Birmingham NHS Foundation Trust	380	453

On a month by month basis the Trust will be increasing its palliative care coding by an average of 50 codes (30 included in the HSMR) increasing it from around 30 codes per month to 80. For context Heart of England NHS Foundation Trust currently have an average of 75 palliative care codes per month in total.

5. Conclusions

The Trust in comparison to peers has historically under coded the level of interventions the Palliative Care Team have made in light of ambiguity of national guidance. The change in practice has been thoroughly reviewed by

qualified clinical coding staff and clinicians to ensure that the practice meets national standards. As a result of this change this will also impact upon the Trusts Hospital Standardised Mortality Ratio.

6. Recommendations

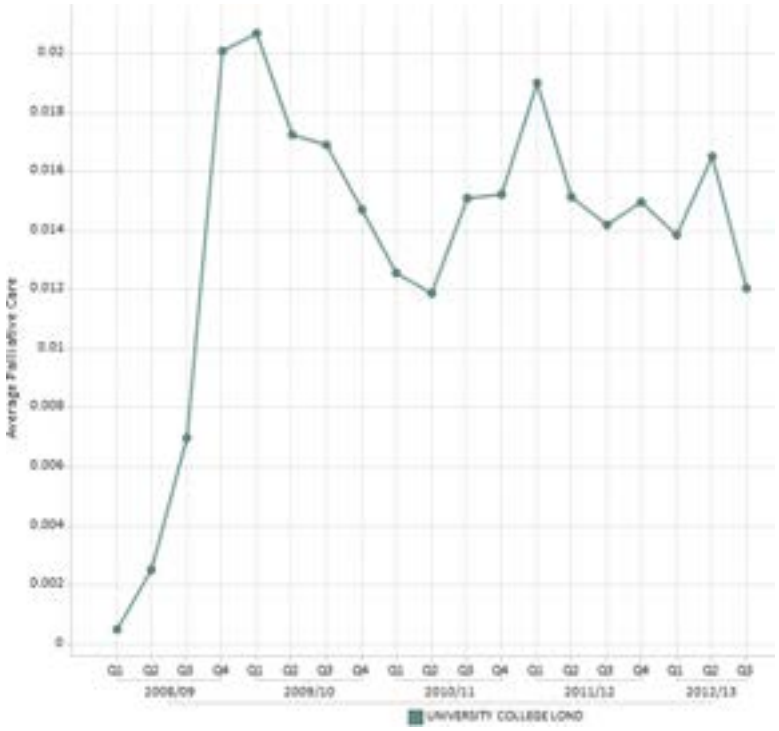
The Board of Directors is requested to:

Accept the report on the change in Clinical Coding practice in relation to Palliative Care and the consequential impact on the HSMR Mortality Indicator.

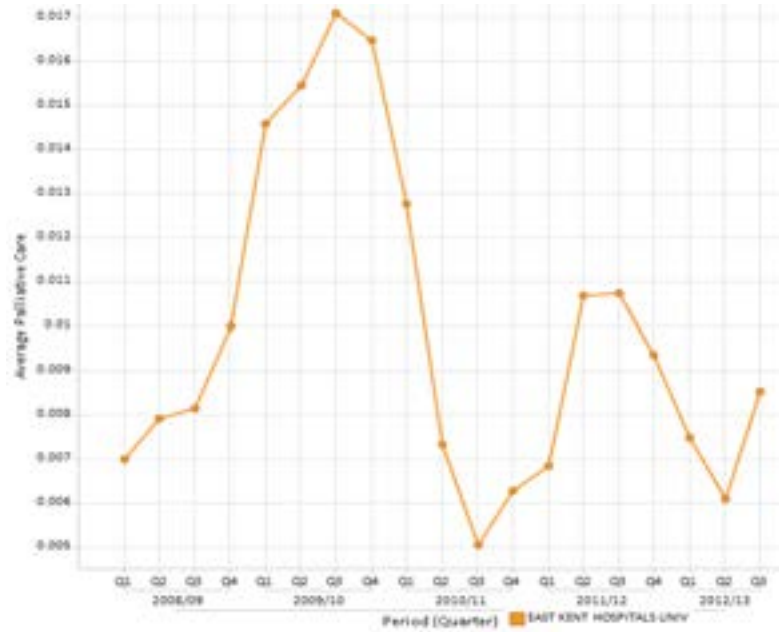
Dave Rosser
Executive Medical Director

Appendix A

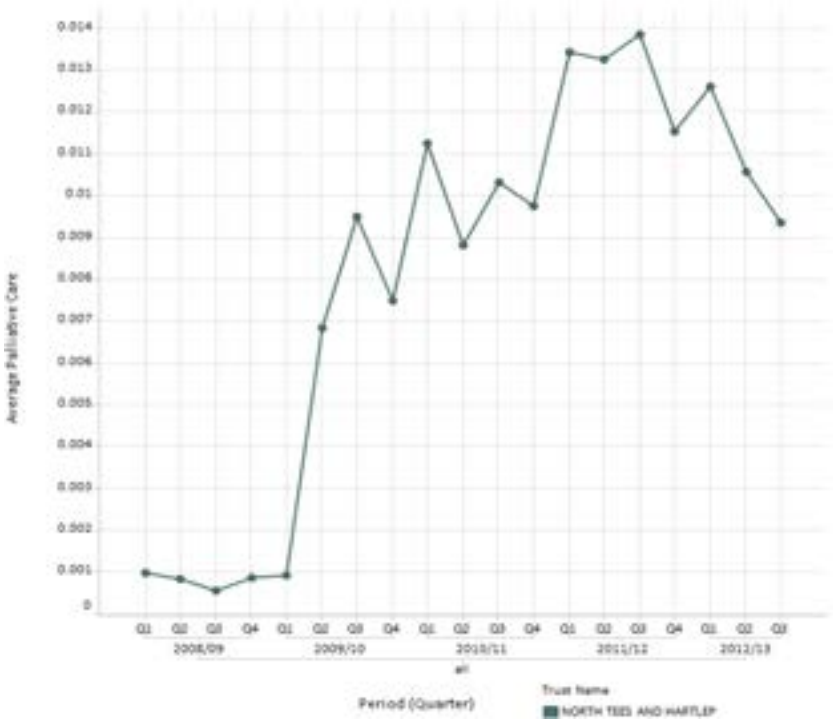
University College London Hospitals NHS Foundation Trust – **Foundation Trust of the Year and Overall Winner in the Dr Foster Guide 2009.**



East Kent Hospitals University NHS Foundation Trust – **Foundation Trust of the Year and Overall Winner in the Dr Foster Guide 2010**



North Tees and Hartlepool NHS Foundation Trust – **Identified specifically for reducing mortality ratios by improving clinical practice and coding in Dr Foster Guide 2011.**



This appendix details 3 examples of palliative care increases there are other examples of similar increases by Trusts.

Appendix B

Palliative Care
01/02/2013

University Hospitals Birmingham NHS Foundation Trust

Details of Local Rule:

The code Z51.5 is to be assigned to an episode when patients have been identified as being seen by the Palliative Care Team in the patient notes or have met all of the following criteria on Somerset Data;

- **Seen by member of Palliative Care Team**
- **Face to face meeting**
- **One of the following Activity levels of Care**
  - **Pain Control**
  - **Other symptom management**
  - **Palliative treatment**
  - **Terminal Care**
  - **Complex intervention**

Agreed by:

John Speakman: Palliative Care Consultant .....

David Rosser : Medical Director .....