Hospital Activity Data
A Guide for Clinicians

Produced by
the RCP Information Laboratory (iLab)

BACKGROUND
ABOUT THE DATA
THE CLINICIAN'S ROLE
OTHER SOURCES OF DATA
DATA QUALITY
HOW TO IMPROVE THE DATA
CASE STUDIES
BACKGROUND TO THE GUIDE

This guide has been produced to support consultants in England who have been presented with analyses of hospital activity data describing their practice. We have found that a number of common questions arise when looking at such information; this guide will provide you with answers. You will find additional detail in the Glossary¹, and there are some worked examples in the Case Studies section, with more examples online at http://hiu.rcplondon.ac.uk/iLab.asp. At the end is a summary of clinical coding tips which we would encourage you to copy and distribute to junior medical staff.

How will this guide help me?

Looking at hospital activity data can be educational, informative, confusing and frustrating in equal measures. This guide aims to help you better understand:

- What it is, where it has come from and what it is used for
- Some of the common quality issues encountered with consultant-level data
- Your role in this - what it can do for you and simple measures you can take to improve it.

From where does this guide originate?

It has been produced by the Health Informatics Unit at the Royal College of Physicians². In 2004-05 the unit's Information Laboratory (iLab) conducted a study across England, Wales and Scotland to examine the potential use of hospital activity data to support consultant appraisal. We supported individual clinicians in the provision and interpretation of their data. Many of the lessons we learned are in this guide.

Our methods of data analysis are freely available³ to hospital trust information departments, to supplement any existing methods they use so that consultants from any specialty - medical or surgical - can be provided with useful analyses.

The publication and distribution of this guide has been supported by the Information Centre for Health and Social Care⁴. Further details can be found at the end of this document.

ABOUT THE DATA

What am I looking at?

You are looking at tables and graphs of data routinely collected by your trust. The data represent individual 'finished consultant episodes' of care (FCEs), grouped together by a number of parameters. Each FCE is attributed to a single, responsible consultant (or consultant team) - you are looking at those held against your name, as well as comparisons with the activity of your specialty colleagues.

Each trust processes their data slightly differently, so this guide may not exactly match what you're seeing. Moreover, hospital activity data may also be analysed and presented to you by an external benchmarking company (see Other sources of data, p5). The amount of data available for analysis differs between clinical specialties too. For a full explanation of your personal data, consult your information department.

Where has this information come from?

The majority of this information comes from your hospital's patient administration system (PAS). There may be additional data available for certain specialties, from pathology or radiology systems, for instance.

How are PAS data collected?

All the clinical components of the data in front of you originate from the patient record. Information recorded by clinical staff (either written entries to the notes, letters or discharge summaries) are subsequently extracted to the PAS by clinical coding staff. In order to build a full picture of the patient's hospital stay and enable statistical analysis and

¹ Terms in the text which may be unfamiliar are highlighted in blue and linked to the Glossary
² http://hiu.rcplondon.ac.uk
³ Analysis methodology, sample analyses, this guide and reports of previous work are available online at: http://hiu.rcplondon.ac.uk/iLab.asp
⁴ http://www.ic.nhs.uk
comparison, details of diagnoses are coded using ICD-10 and procedures using OPCS-4. What is written in the notes, and how it is written, have an effect on the data available to the trust and to you. Other elements of the data (such as admission type, start and end dates, consultant allocation) are input to the PAS by a range of administrative staff in the hospital, e.g. ward clerks, clinic clerks, reception staff.

**What are PAS data used for? Are they important?**

*Figure 1* shows a schematic of the flow of information from its origin (patient notes) to its final destination (HES).

**Figure 1: Information flows for routinely collected data**

**Original design of dataset:**

- These data have been collected in roughly the same format since the late 1980s, when the decision to routinely collect an admitted patient care commissioning dataset (APC CDS) was made.
- There are also outpatient and A&E datasets, however, these currently contain less clinical data than the APC dataset.
- The design focuses on hospital administration, corporate resource management and the monitoring of health trends and hospital care at an aggregate level.
- The ability to assign activity to an individual consultant team was only added in 1998. This is done using the responsible consultant’s GMC code.

**PAS data** are used to produce reports for the internal running of the hospital (e.g. bed occupancy, patient throughput, waiting times).

Extracts from PAS are submitted to the Secondary Uses Service (SUS) - a secure, central data warehouse which receives and processes healthcare data for the whole NHS. Reports and analyses are available for a wide range of uses.

At pre-arranged times during the year, SUS sends extracts to HES, where it is further processed and archived for current and future use.

It is important these data are as accurate as possible to support the operating and improvement of services.
THE CLINICIAN’S ROLE

What has this got to do with me? Why have I been given these data?

Traditionally, doctors have had little to do with PAS data, which they see as a largely administrative dataset. However, the fact that much of its content is derived from the patient notes has implications for quality. Various national reports have highlighted a lack of clinical interest as a key reason for errors: if its validity is never checked, then improvements cannot be made (see Figure 2). And while it rarely occurs, it is worth bearing in mind that activity data pertaining to individual clinicians can be released into the public domain through a Freedom of Information request.

Initiatives in England such as Payment by Results depend heavily on accurate data originating from patient notes and PAS systems.

The Bristol Inquiry recommended building clinical confidence in PAS data by establishing closer working arrangements between doctors and clinical coding staff.

Consultants visiting the iLab during the study period found the data to be more useful than they had anticipated, and the majority stated they would use it to support their next consultant appraisal.

What relevance do these data have to my practice? How might I use the analyses?

Each consultant's analyses are unique. The iLab study found that for some clinicians, the data they were presented with gave a fair representation of their activity, whereas for others it did not. This variation is due not only to specialty differences, but also to local processes - both clinical and administrative. To understand why the data appear as they do, it often requires discussion with a member of the information or coding department. In this way improvements can be made.

Take another look at Figure 2. If clinicians can begin to look at their data, highlighting any problems they find, quality begins to improve and confidence builds. Consultants in the iLab study said they would also use the data for:

- Supporting local service development
- Job planning
- Clinical audit
- Research.

It must be remembered that many uses are outside the original scope of the dataset design - it is not advisable to try to make judgements from them. But when used sensibly and in conjunction with other data sources, they can add significant value.

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7 Details of a legal test case involving the publication of Scottish consultants’ mortality data can be found at http://www.itspublicknowledge.info/applicationsanddecisions/Decisions/2005200501123.asp


9 http://www.bristol-inquiry.org.uk/index.htm

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What influence do I have over the data collected?

The written record is completed by clinical staff, after which details of diagnoses and procedures are encoded by clinical coding staff, using national rules and conventions. Getting feedback on episodes which may be difficult to code is a good way of increasing quality. See the later section on Data Quality.

Remember, the information you are looking at has not been collected for your purposes. A corporate view of the data will differ from a clinical one: a greater understanding of these differences from both sides is key to improvement.

Are there factors which are out of my control?

Yes. There will be many instances of the data seeming at odds with what you know to be your activity. This goes back to the original, corporate design of the dataset and the underlying classification systems used.

Some of the most common reasons or discrepancies are listed in Figure 3 opposite.

Those involved with corporate information (both centrally and in Trusts) are aware of these limitations, and are addressing them wherever possible.

Your involvement is crucial if solutions are to be found.

Figure 3: Known limitations of consultant data

- The design of ICD-10 and OPCS-4 as statistical classifications mean that PAS data will contain much less clinical detail than the notes you have written.
- Activity is assigned to the responsible consultant only, despite other team members' contribution.
- Activity can only be assigned to one consultant team - shared care cannot be represented.
- Clinical outpatient data are not routinely collected.
- Specialty codes are difficult to assign consistently.
- Clinical coding rules and conventions are complex, sometimes opposing the clinical model of health information.
- Administrative data definitions can be vague and interpreted in different ways - making comparisons difficult.

OTHER SOURCES OF DATA

How does this information differ from that of external benchmarking companies (e.g. CHKS, Dr Foster)?

Any hospital activity data presented to you that has been benchmarked against colleagues will also have originated largely from your hospital PAS. However, the statistical assumptions made when grouping and comparing the data are outside the control of your trust information department.

Whenever a clinician interprets their activity data (from any source), they should always ask for an explanation of the assumptions made, as it can significantly affect the way the data look. Below are brief examples:10

- Reported by episodes vs inpatient spells
- Primary diagnosis vs all diagnoses (or procedure)
- Denominators for comparisons (local colleagues vs external peer group - defined how?)
- Definitions used for lengths of stay
- Time periods used (especially readmission data)
- Details of casemix and age adjustment
- Use of social deprivation index in calculations.

Information provided to you by your information department may have few adjustments - such 'raw' data might appear to contain more inconsistencies than adjusted data. Our experience shows that looking at unadjusted data can highlight problem areas, offering the greatest opportunity for positive change.

Figure 1 shows that any improvements to hospital PAS data will lead to increased validity of analyses both within the trust and when submitted centrally for wider secondary uses.

10 A comprehensive set of questions can be found in Annexes E and F at [http://hiu.rcplondon.ac.uk/HESguide.pdf](http://hiu.rcplondon.ac.uk/HESguide.pdf).
My specialty has a national audit database. Would it be more appropriate to use this clinically rich data for my appraisal?

Clinically designed and owned audit datasets are an excellent tool for examining services within one specialty. Your trust may encourage their use as a supporting source of evidence for appraisal. However, the following should be borne in mind:

- Audit datasets sit outside the processes shown in Figure 1, and do not feed the SUS or HES datasets. PAS data, however, collects all episodes of inpatient and daycase care.
- Scope is limited to certain specialties, and then to certain conditions or procedures performed within that specialty.
- Definitions of data items will invariably differ from those used for routinely collected data.
- Coverage is not guaranteed: comparisons with PAS-based analyses often demonstrate missing episodes.

It can be a useful exercise to help information staff cross-validate PAS data and audit data against each other.

I keep accurate records of my own activity on a personal or departmental database. Could this be used for my appraisal instead?

It depends what you want to use the information for. It is useful to compare your activity against that of your colleagues, and that's often not possible with personally held data.

Departmental databases can give useful measures of your colleagues’ and your own activity, because they are designed with clinicians in mind.

Sharing the outputs with information staff can increase their understanding of clinical information needs.

All the reasons listed in the question above apply.

The more unique the data source, the less likely that valid comparisons can be made against others.

DATA QUALITY

Isn’t the quality of PAS data poor?

There are several aspects to data quality, as depicted in Figure 4. When assessing quality, the following points should be noted:

- Judgements of data quality must be set in the context of its use (e.g. depth may be perfectly adequate for one use, but insufficient for another).
- PAS data quality is mixed. When collected, coded and used at an aggregate level (within the remit of its original design), PAS data quality is generally good.
- Data quality issues become more apparent when examining individual consultant team data.
- There are tensions between certain elements of data quality: to improve timeliness may result in reduced completeness or depth.

Figure 4: Elements of data quality

<table>
<thead>
<tr>
<th>ACCURACY</th>
<th>Are the data free from error?</th>
</tr>
</thead>
<tbody>
<tr>
<td>COMPLETENESS</td>
<td>Are all the required data items present?</td>
</tr>
<tr>
<td>TIMELINESS</td>
<td>Are data available at the right time?</td>
</tr>
<tr>
<td>DEPTH</td>
<td>Is information collected and coded at the right level of detail?</td>
</tr>
<tr>
<td>VALIDITY</td>
<td>Is the information &quot;within range&quot; of that expected?</td>
</tr>
</tbody>
</table>
Shouldn’t accuracy be improved before data are shared? Who checks the data?

Data quality is important for all staff working with health information throughout the entire process represented in Figure 1.

There are a number of processes in place to validate PAS data technically, when submitted. Your information department will be able to provide you with details of the internal quality checks that occur routinely (e.g. data quality meetings, clinical coding audits).

However, huge volumes of hospital activity are generated constantly, and checking every episode for each consultant is not possible. Sharing the information with you and getting your feedback is an invaluable part of the process of improving accuracy.

Will PAS data ever be able to reflect my activity accurately? What about future changes?

The quality of PAS data can certainly be improved, especially with the involvement of clinicians. But remember, when they were designed, it was not with the purpose of examining clinical activity in mind.

- PAS data are collected primarily to support corporate & administrative processes - reflected in their content
- The classification systems used (ICD-10 and OPCS-4) group detail into broader conditions so that comparisons can be made. These code descriptions are predefined, and because detail is lost, they may not describe your practice in a way which is clinically meaningful to you
- PAS systems are not electronic patient records; the information they produce should not be regarded as such
- In the future, development of more sophisticated health records underpinned by clinical terminologies (such as SNOMED CT) will enable more detailed clinical information to be collected and retrieved.

Large amounts of my activity are missing. Have they been allocated to the incorrect consultant?

There are several reasons why your data may not appear quite how you expect, some of which have already been described. As regards missing or incorrectly allocated data, refer back to Figure 1 and bear in mind the following:

- Information on diagnoses and procedures originates from the patient notes before it is coded. The details therefore need to be complete and clearly visible to coding staff (see Top 10 Coding Tips at end of guide)
- Your specialty may hold its activity data separately from the PAS (e.g. GU medicine, palliative care, radiology), or your practice may be largely outpatient-based (where little clinical activity is currently captured)
- PAS systems cannot keep pace with changes in clinical practice. Increasing sub-specialisation, multiple consultant transfers, assessment and admission units, ward referral activity and shared care all present big challenges. Some activity is hard to capture
- Transfers of care are notoriously difficult to record, especially for inpatient procedures (see Case Study 2 for a worked example). Daily ward returns are the principal means for recording transfers - communication with staff who complete them is essential
- Many genuine problems with accuracy can be uncovered and easily rectified by looking at analyses of your activity. Discussing your data with trust information and coding staff is an essential part of that process.

From Figure 1:

- Patient notes are the source document for clinical coding. If it’s not documented, it didn’t happen!

From Figure 3:

- There are a number of known limitations to using PAS data at consultant level
- These should always be considered when making judgements about data quality.

The next section gives ideas for improving data, using examples from the iLab study.
HOW TO IMPROVE THE DATA

Isn’t data quality simply an “information” or "coding" problem?
No. High quality health information supports patient care, both directly and indirectly. It is the responsibility of all NHS staff to ensure the information used in decision making is as accurate as possible.

One of the best ways to identify the sources of data quality problems is for clinicians and information staff to work through activity data together. This way, both can gain an appreciation of the information needs of the other.

Are there specific examples of changes that can be made?
Yes. In the next section there are worked examples of the following specific issues which were identified when working with consultant physicians in the iLab study:
- Rectifying mis-allocated data between two consultants
- Identifying inaccurate lengths of stay
- Understanding the coding of inpatient procedures.

What about general measures? What good practices can I encourage my team to follow?
There are many ways in which clinicians of any seniority can help data quality. These range from mindfulness of these issues during day-to-day practice, to getting more involved with initiatives managed by information staff:

- Open channels of communication between clinicians & information/coding staff:
  - Invite coding staff on a ward round
  - Offer to see the casenotes of any episodes they may be having difficulty coding
  - Find out the top three problem diagnoses or procedures that clinical coding staff encounter in your clinical specialty
  - Ask to see a proportion of your coded FCEs each month and feed back any problems
  - Discuss the design of any proformas you might use with coding staff: small changes can result in large coding improvements
  - Find out what data quality meetings exist in your trust, and ensure clinical representation. If there aren't any, then start one!

- Ensure that the details of all diagnoses and procedures are clear and easy to find in every set of casenotes
- Copy and circulate the Top Ten Coding Tips to junior staff. These are basic note-keeping tips which make a huge difference to coders
- Encourage juniors to undertake audits using hospital activity data
- Communicate all transfers of care to those responsible for the ward returns (usually ward clerks). Write them in the notes too
- Use structured admission and discharge proformas whenever practical
- Summarise diagnoses and procedures in the last entry in the casenotes before discharge.

CASE STUDIES

Case Study 1: Allocation of activity data
One of the most commonly identified data quality problems is that of incorrect allocation of activity to individual consultants. Figure 5 (over the page) represents a team of eight consultants working in one department. There may be a rational explanation for the obvious discrepancy between the two highlighted consultants, for example consultant 7 may represent a locum or an academic with few clinical commitments, while consultant 4's casemix might consist of multiple short-stay admissions. However, if you are aware that activity levels in the department should be distributed roughly equally, then this appearance may signify mis-allocation and warrant further investigation.
Allocation can sometimes be skewed for historical reasons, or when new consultants start, or it might be that administrative coding has resulted in procedures being mis-allocated. Consultants 4 and 7, for example, might be paired on an acute rota.

Without validation by a clinician who has knowledge of expected patterns of activity, simple errors can easily go undetected.

What can I do? Compare your knowledge of local practices with the reported activity levels. Discuss how any obvious discrepancies might be rectified with your information department.

The same principles apply when examining length of stay data. Before looking at their activity data, most clinicians will have a reasonable idea of lengths of stay within their department. When looking at distribution graphs or comparisons against colleagues, there are likely to be several rational explanations for differences or perceived anomalies. However, experience has shown that inaccurate lengths of stay can, and do, occur. Clinical validation of data is the best way to identify, and subsequently rectify, such errors.

Case Study 2: Coding of inpatient procedures

Another type of allocation problem which is more difficult to solve occurs when a patient under the care of one consultant undergoes an inpatient procedure under another. Because activity can be allocated only to one clinician at a time, there are two ways of capturing this data using finished consultant episodes (FCEs). Take the example of a medicine for the elderly patient being taken for an inpatient bronchoscopy by a respiratory consultant, before returning to their bed. Figure 6 shows how one such inpatient spell can comprise either one or three FCEs:

In Scenario A, overall responsibility is deemed to have passed to the respiratory consultant for the duration of the procedure. Two transfers of care (ToC) have been recorded, resulting in two FCEs for the geriatrician, and one (denoting the bronchoscopy) for the respiratory consultant.

In Scenario B, overall responsibility for the patient's care is deemed to have remained with the geriatrician throughout. They are allocated the only FCE (which includes the procedure performed by the respiratory consultant). Your activity data could reflect either of these consultants, in either scenario.

To most clinicians it may seem intuitive to always employ Scenario A, but what constitutes a "significant procedure" and how you define "responsibility" mean it's a grey area when recording data. Scenario B actually has more in common with the original design and purpose of the dataset - it's another example of how widening the uses of PAS data beyond their original scope can reveal limitations.

Because of this historical ambiguity, we know that different trusts follow different scenarios. The need for common measures in this and other situations is understood, and is being acted upon by those responsible for setting information standards in both England and Wales.

What can I do? Establish the policies for allocation used by your trust information department, and work with information and administrative staff to improve the accuracy of recording transfers.

11 Refer to the Other Sources of Data section (p5) for questions you should ask when examining such data
### Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td><strong>Aggregate level</strong></td>
<td>FCEs from PAS can be examined at various levels of grouping. At the most detailed level, this is the activity of an individual consultant team. Above this are department, directorate, hospital and trust (and International comparisons). Generally speaking, the higher the level of aggregation, the better the validity of the data.</td>
</tr>
<tr>
<td><strong>APC CDS</strong></td>
<td>Admitted patient care commissioning dataset. A mandated, centrally held subset of episode-based data items extracted from hospital patient administration systems (PAS) and submitted via SUS to HES. Collected in its current form since the late 1980s and used for key decision making in the NHS.</td>
</tr>
<tr>
<td><strong>Clinical coding</strong></td>
<td>The translation of a diagnostic or procedural term, as written by a clinician in the patient record, into an alphanumeric code (with associated code description), using the statistical classifications ICD-10 and OPCS-4. Use of such codes allow comparisons of activity to be made at an aggregate level.</td>
</tr>
<tr>
<td><strong>Consultant team</strong></td>
<td>The responsible consultant, or the &quot;name at the end of the bed&quot;. The contribution of other team members or junior staff is not recorded separately. Each FCE can only be attributed to one consultant team (i.e. shared care cannot be represented). See also transfer of care.</td>
</tr>
<tr>
<td><strong>FCE</strong></td>
<td>Finished consultant episode. The period of time a patient spends under the care and responsibility of one consultant team. See also transfer of care and inpatient spell.</td>
</tr>
<tr>
<td><strong>HES</strong></td>
<td>Hospital Episode Statistics. The national repository for record level hospital data concerning all episodes of inpatient and day case care (submitted via SUS as the APC dataset), from 1989 onwards.</td>
</tr>
<tr>
<td><strong>ICD-10</strong></td>
<td>International Statistical Classification of Diseases and Related Health Problems (Tenth Revision). The National and International standard for the classification of diagnoses, developed by the World Health Organisation. Because classification systems group similar diagnoses together for the purpose of comparison, clinical detail is lost in the clinical coding process.</td>
</tr>
<tr>
<td><strong>Inpatient spell</strong></td>
<td>The patient's entire stay in hospital. Usually this consists of one FCE, but a transfer of care can result in multiple FCEs under more than one consultant team. See Case Study 2 for implications.</td>
</tr>
<tr>
<td><strong>OPCS-4</strong></td>
<td>Office of Population, Censuses and Surveys Classification of Interventions and Procedures (4th revision). A UK classification of interventions and procedures, which is now reviewed annually and updated to keep pace with clinical practices. In 2006 the update from version 4.2 to version 4.3 was implemented across the NHS in England and included major changes (see box to right). In 2007, version 4.4 was implemented.</td>
</tr>
<tr>
<td><strong>PAS</strong></td>
<td>Patient administration system. The central computer database in a hospital, containing details of every patient admission to hospital (incl. diagnoses &amp; procedures), along with information about referrals, waiting lists and scheduling. Also contains administrative details of outpatient and A&amp;E attendances. There are different makes of PAS, so capabilities for analysis will differ from hospital to hospital. Regular central submissions of the APC dataset are sent from PAS, ultimately becoming Hospital Episode Statistics (HES; See Figure 1).</td>
</tr>
<tr>
<td><strong>SNOMED CT</strong></td>
<td>The Systematised Nomenclature of Medicine - Clinical Terms. A clinical terminology (computerised language) which underpins the development of electronic patient records. In England, all new computer systems will be SNOMED CT compliant. SNOMED CT incorporates all the clinical terms contained within The Read Codes.</td>
</tr>
<tr>
<td><strong>SUS</strong></td>
<td>Secondary Uses Service. The central warehouse for health data in the NHS, providing anonymous patient-based data for purposes other than direct clinical care (e.g. planning, commissioning, public health, clinical audit, benchmarking, research and policy development). Currently derived from commissioning datasets, but future developments aim to capture data from operational systems provided by Connecting for Health (CfH).</td>
</tr>
<tr>
<td><strong>Transfer of care</strong></td>
<td>A consultant transfer occurs when the responsibility for a patient transfers from one consultant to another within an inpatient spell. Ambiguity over the meaning of the word &quot;responsibility&quot; can result in hospitals currently recording transfers of care differently (see Case Study 2).</td>
</tr>
<tr>
<td><strong>Ward return</strong></td>
<td>A daily update of the hospital PAS, to include information about patients currently resident on a hospital ward, including which consultant team is providing their care. Also known as &quot;daily bed occupancy&quot; or &quot;daily bed management report&quot;. Usually completed by ward clerks, although sometimes by nursing staff, bed managers or even junior doctors. See also Transfer of care</td>
</tr>
</tbody>
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**OPCS-4.3**

To reflect changing practices, v4.3 of the UK procedures classification was 25% larger than its predecessor. New codes were introduced to cover most specialties, but the following were greatly enhanced:

- Diagnostic & interventional radiology
- Radio and chemotherapy
- Rehabilitation
- Diagnostic testing (e.g. patch tests).

Consultants are advised to contact their trust information department to ensure such information is accessible for coding.
Clinical coding is the process whereby information written in the patient notes is translated into coded data and entered onto hospital information systems. Coding usually occurs after the patient has been discharged from hospital, and must be completed to strict deadlines in order for hospitals can receive payment for their activity.

Clinical coding staff are entirely dependent on clear, accurate information about all diagnoses and procedures in order to produce a true picture of hospital activity. The coded data are vitally important, and are used for:

- Monitoring the provision of health services across the UK
- Research and the monitoring of health trends and variations
- NHS financial planning and Payment by Results
- Local and national clinical audit and case-mix analysis
- Clinical governance.

There are many ways in which clinicians can assist the process of clinical coding; 10 of the most important are summarised below. Each is based on the basic principles:

1. Write clearly and legibly in the notes and on discharge documentation, using black ink only. Make sure the patient is identified on every sheet of paper used in the notes.
2. Sign, date and time every entry in the notes. Print your name and position at the end of every entry.
3. Never remove notes from the hospital. If you need to take notes away from the ward or clinic for an audit or a meeting, always let administrative staff know, and return them immediately afterwards.
4. Always communicate any transfers of care to ward administrative staff. This includes when patients go for an investigation or a procedure performed by another clinical team.
5. Clearly record details of all the diagnoses (including co-morbidities) and procedures (including those done on the ward) in the notes. Write the main diagnosis first. Best practice is to summarise all of these as the last (discharge) entry in the notes – this will make your discharge summaries easier too. For injuries, note the cause; for overdoses, note the drug; and for infections, note the organism.
6. Ask a senior member of the medical staff to confirm or validate these diagnoses and procedures. This can be done when writing in the notes on the discharge ward round.
7. Include the details of all diagnoses and procedures on discharge summaries and TTOs (preliminary discharge summaries). Don’t let your discharge summaries pile up on a shelf for weeks on end, awaiting dictation – coding staff have strict deadlines to meet and delays cause huge problems.
8. If a clear diagnosis has not been reached, make sure you detail the main symptoms in the notes or discharge summary. Any ‘query’ diagnoses, or diagnoses preceded by a ‘?’ cannot be coded by clinical coding staff. If histology is awaited for a definitive diagnosis, note this down.
9. Avoid the use of new or ambiguous abbreviations (eg ‘M.S.’ could mean multiple sclerosis or mitral stenosis). Remember: clinical coding staff are not allowed to make any clinical inferences.
10. If your hospital has a standard proforma for admissions or discharge, use it! Fill in all the details it asks for.

If it isn’t documented, it didn’t happen.

Help clinical coding staff do their job – make the information they need easy to find, accurate and complete.

Remember that clinical coders – like you – have a job to do, and you can help make that job a lot easier.
The Health Informatics Unit (HIU) is part of the Royal College of Physicians of London. The unit was established in 2001 to improve the care of patients and the delivery of health services by improving the management of health information. To achieve this overall aim, the HIU is working in four key areas:

1. Developing standards for recording and communicating patient data.
2. Applying these standards to aid the development of a patient-focused, longitudinal, generic electronic record that can be customised to the wide variety of contexts in which patients are seen.
3. Improving the validity and utility of aggregate patient data derived from operational records.
4. Developing resources to support the implementation of changes in clinical information management.

For more information, or to get involved, please contact us or visit:
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The Information Centre is England's central authoritative source of health and social care information. We are here to support the NHS and social care to deliver better services.

Our fundamental purpose is to understand what health and social care information people need and why, and to ensure the right data is collected, analysed and made available to help them make decisions.

The IC has eight priority projects for 2007-08, one of which is to promote clinicians’ use of information. This project will raise awareness about the range of information that is relevant to their clinical practice, and investigate producing clinically meaningful analyses from existing data flows specific to clinical specialities and pathways. This will support both improvements in data quality and improvements in care and services for patients.

For more information, or to get involved, please contact us or visit:
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