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# How much clinical terminology is good for you?

Dispatches from an  
imperfect world

Ann Wrightson

# Policy development (1)

- “There is no ideal coding and terminology system... In all of the available systems, terms can be ambiguous and interpretation can differ between individuals and between groups. The categoric assumption that coding is ‘the solution to the problem’ fails to define either problem or solution.”
- “Whilst taking caution from the difficulties of using coding and terminology systems, codes *can* help people who are recording clinical information to be consistent, both with other people who are recording clinical information and across their own activities.”

*Extracts from NADB paper by Robin Mann, 2007*

## Policy development (2)

- “Reducing the variety of code sets and increasing the take-up of common sets will bring about a more manageable position, enabling organisational change, creating better clinical communication and providing a stepping-off point for a national move towards a single common code set, *but only when and if this becomes necessary.*”
- “We must be careful that coding does not become a solution in search of a problem. Coding is useful, but before effort is expended on introducing and using it in any area of care, we must be clear what the benefits are and how sustainable that use of codes will be.”

# So where are codes being useful now?



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- Transactions supporting shared services across organizations?
  - Yes – the obvious way to do it!
    - Welsh Pathology Handbook
- Sharing clinical information?
  - Not a priority
    - General medical records
  - An essential enabler
    - The Individual Health record (IHR)

- Embeds agreements on shared laboratory services into clinical practice
  - Local ‘views’ support local service agreements
  - ...also supporting the transition from local to national LIMS
- Who uses the codes?
  - Designers of the WPH handle the ‘raw’ codes
  - Clinicians ordering lab services just see a catalogue of services
    - Their requests are coded ‘under the hood’



- Lots of beneficial ways to use codes once they're in the record...
  - (e.g. reducing the work needed for statistical returns; clinical audit; clinical research)
- a lot less clear how to get them in there...
- ...and the 'bottom line' is that it's more important to do other things first and fast.



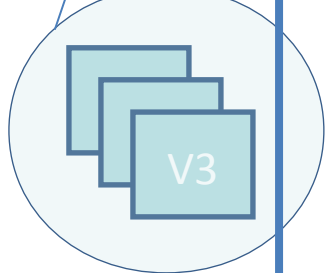
- **First and fast?**
  - Stop storing so much paper
  - Make a record available in more than one place at a time
  - Make the cultural change from records belonging to a location where they are created, to records being a resource for caring for the patient in any location



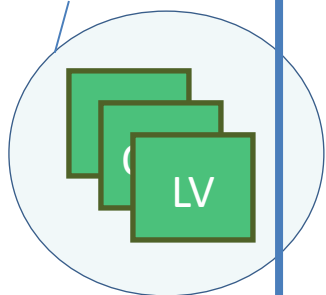
- IHR aim: enable access to key information from GPs' patient records in Out-of-Hours and other unscheduled care
  - <http://www.wales.nhs.uk/sites3/page.cfm?orgid=858&pid=49034>
- Key characteristics of GP systems:
  - Range of systems from several suppliers
  - Conform to extensive functional requirements but do not have a standard record format
  - **Codes are used extensively in patient records**

# IHR View in OOH system

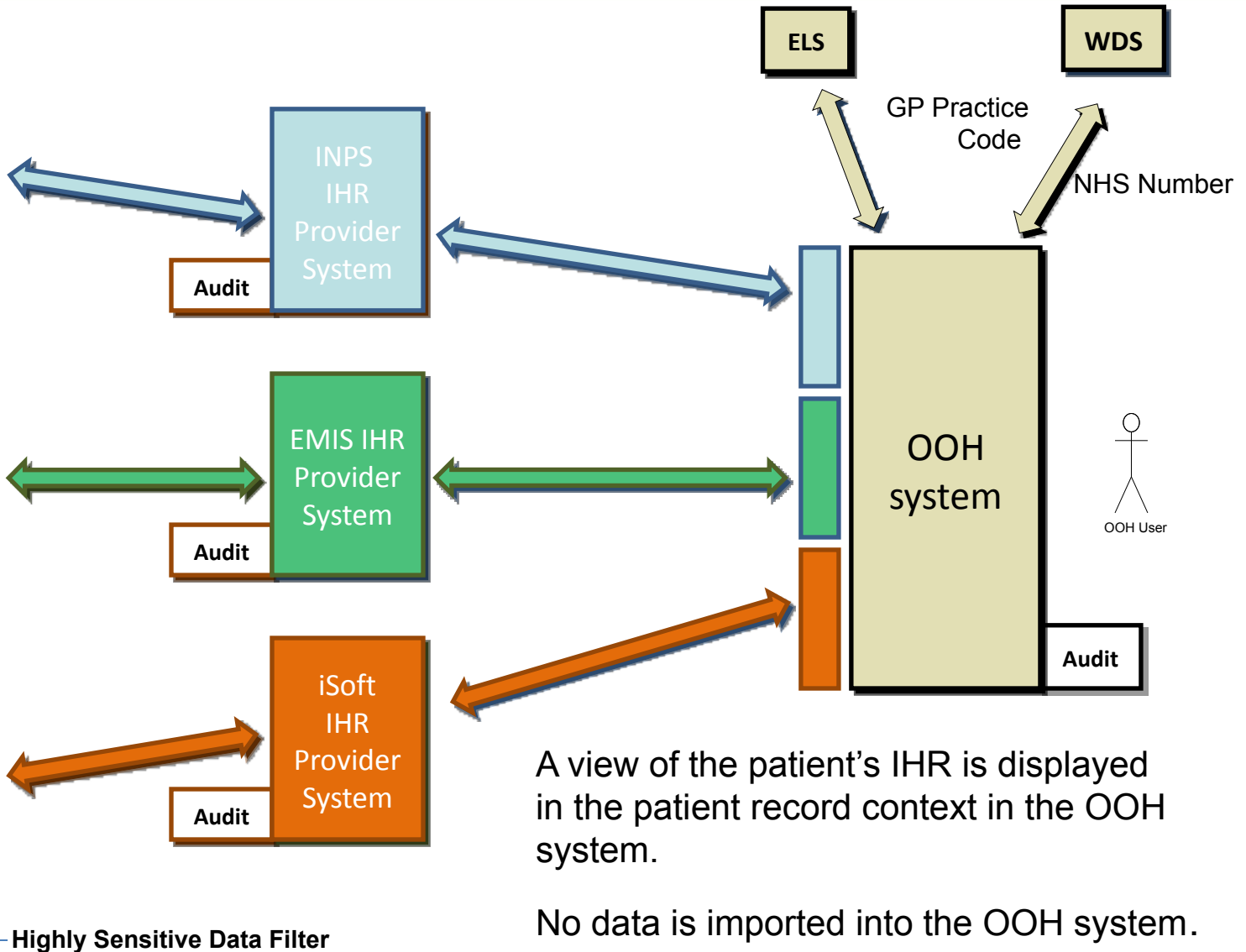
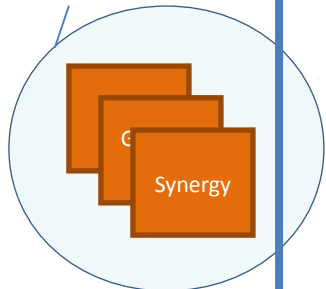
INPS GP Practices



EMIS GP Practices



iSoft GP Practices



A view of the patient's IHR is displayed in the patient record context in the OOH system.

No data is imported into the OOH system.

# Coding and the IHR

- Comprehensive coding in GP practice systems was a key enabler for the IHR programme.
  - No surprise, perhaps? – but where do you think the main benefit came through?
- Coding proved a basic enabler for any information sharing at all!
  - much nervousness about confidentiality, & legal concerns about sensitive information

- So how do the codes do it?
  - by providing convenient keys for filtering out sensitive information so it ‘does not leave the GP practice’
  - by providing clinically useful information without risk of leaking sensitive information via uncontrolled ‘free’ text
    - exceptions made for safety reasons, for allergies and test results



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Thank you for your attention

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