Welcome to the:

RCSLT Therapy Outcome Measures Event (TOMs)

17th July 2018
#RCSLTTOMsWales
Aims and objectives

After this event, delegates will:

• Understand value based healthcare
• Understand how TOMs fit with value based healthcare
• Be part of a network of implementers across Wales
• Learn from the pilot sites across Wales
• Agree an all-Wales solution
RCSLT Therapy Outcome Measures Event (TOMs)

17th July 2018
#RCSLTTOMsWales
Aneurin Bevan University Health Board

Royal College of Speech & Language Therapists – TOMS event

Value Based Health Care

Keynote address – Outcomes are essential for Value Based Health Care

Daniel Davies, Programme Manager. Daniel.davies@wales.nhs.uk
Aneurin Bevan University Health Board

Mr Daniel Davies  
Programme Manager – Value Based Healthcare, Digital Patient Participation Programme.

• 13 Years experience working in the Public Sector (local authority, Primary and Secondary Care).
• MSP, PRINCE2 and ITIL practitioner.
• Vast experience of “traditional” change management.
• Keen interests in:
  – Improving NHS services, patient experience and healthcare outcomes.
  – Technology and NHS systems
  – Reporting, Data and Information.
Value Based Health Care

What does this mean to you and what is the Value Based Health Care programme in ABuHB?
“VALUE” DEFINITION
The theoretical view(s)

Michael Porter’s definition for “value:”
“The health outcomes achieved that matter to patients relative to the cost of achieving these outcomes.” Must be measured over the care cycle

VALUE = OUTCOMES / COSTS

Prof Sir Muir Gray’s “transforming healthcare by delivering triple value”:
PERSONALISED VALUE – base decisions on the best current evidence, careful assessment of an individual’s clinical condition and an individual’s value.
TECHNICAL VALUE – improve the quality and safety of healthcare to increase the value derived from resources allocated to particular services.
ALLOCATIVE VALUE – allocate resources to different groups equitably and in a way that maximises value for the whole population.

International Consortium for Health Outcomes Measurement (ICHOM):
“Value is defined as the outcomes that patients experience relative to the cost of delivering those outcomes. Value based Healthcare, is healthcare that delivers the best possible outcomes to patients for the lowest possible cost.”
“VALUE” DEFINITION in ABuHB

“achieving the outcomes that matter to people and being good stewards of the finite financial resource available, working together to do the right thing across the whole system, improving Value for people suffering with a range of medical conditions.”

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Value Based Health Care - The case at ABuHB

Limited resources and budget/growing demand

Resource challenges

Improve use of available resources

Reduce wants/needs

Rising costs
Ageing population
Variation in care
Increased demand?

Clinical Futures strategy
Right Care
Right Place
Right Time
Right Resource

Voltaire (1694-1778)

‘Doctors pour drugs of which they know little, to cure diseases of which they know less, into patients of whom they know nothing’

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Value Based Health Care - The case at ABuHB

Clinical Futures strategy
Right Care
Right Place
Right Time
Right Resource

Prudent Healthcare
Public and professionals are equal partners through co-production

Care for those with the greatest need first

Do only what is needed and do no harm

Wellbeing of Future Generations Act
A Prosperous, a Resilient, Cohesive Communities and a More Equal Wales. Through partnership arrangements we are placing a greatest emphasis on the economy and vibrancy of a future NHS in Wales.

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Aneurin Bevan uHB definition for “outcomes:”
Aneurin Bevan defines outcomes as ‘measure that effect the treatment and interventions from the individual’s perspective, especially functional outcomes, wellbeing and adverse effects of treatment.

Why Collect Outcomes??

What you measure affects what you do. If you don’t measure the right thing, you don’t do the right thing.

— Joseph Stiglitz —

“If you can’t measure it, you can’t manage it”

Peter Drucker

“Customers don’t measure you on how hard you tried. They measure you on what you deliver.”

- Steve Jobs

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Value Based Health Care – Outcomes

How do we measure the effectiveness of our interventions? Are clinical outcomes enough? What about the Patient??

- Clinical Outcomes ✔
- PROM – Patient Related Outcomes ✗
- PREMs – Patient Experience Measures ✗

Historically

Holistic View considering all aspects for patients.

These should not be considered in isolation but should compare to costs...

Helps inform direct care and Shared Decision Making..

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Value Based Health Care – Outcomes

Example 1 - Patient
Rugby Injury –
- Clinical focus on mobility, movement and Pain.
- Patient focus on return to play.
- Evidence to support future ops and possible knee replacements.
- Identification of PHQ9 (anxiety/Depression).
- Treatment options.

Example 2 – Service Redesign
Variation of service provision across boroughs.
- Desire for equity of service.
- Outcomes supported/evidenced that adopting the “best practice” not only reduced cost, but would provide better outcomes.

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Value Based Health Care – Outcomes

EQ5D – PROM
NOCA – COM
ZARIT – Carer Burden

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So What: Outcome data

At individual Level

Clinical Outcomes – Stable
PROM – Complex patients struggle with Getting around, Problems Dressing – Yet early appointments....
So What (some examples):

Outcome data informing:

• Opportunity to re-model > 40% patients do not require physical outpatient appoints.
• Introduce virtual clinics - reduce follow up appointments by c 40%, to allow capacity freed up for new
• Opportunity to introduce rapid access clinics
• Variation in practice - titration practice - opportunity to improve outcomes

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In Summary and Thank You
RCSLT Therapy Outcome Measures Event (TOMs)

17th July 2018

#RCSLTTOMsWales
Embedding TOMs within an integrated AHP service: A case study of implementation.

Lyndsey Charles


Improvement Manager.
Yorkshire & Humber Academic Health Science Network.
Aims of presentation:

• Support and encourage participants to implement TOMs within their service.
• Provide a framework of key implementation principles.
• Identify and share lessons learnt.
• Share practical solutions and tools developed.
• Summarise the impact and outcomes of implementation to the service.
The Context: A little bit of information about us....

- LD Service: 450 staff, Community, Inpatient A & T, Health Respite, Health Facilitation, Specialist Supported living, Service User Involvement Team.
- Integrated teams: 7 professions, plus associate practitioners & support staff
- 4 AHP professions: Occupational Therapy, Physiotherapy, Speech & Language Therapy, Dietetics.
What would stop TOM’s being successfully implemented with in our service?
What would stop us from successfully embedding TOMs in everyday practice?...

- Lack of staff engagement & ownership.
- Lack of staff understanding as to why outcomes need measuring.
- Training in TOM (How to use tool)
- Unable to record & retrieve data – takes too long
- “When do you do a TOM?”
- Trust top trumps.
- Aiming for perfect.
- Getting TOM back to Service User.
What we did...

• Presented proposal at local and Trust Governance: Ratification for use.
• Engaged with Professor Enderby.
• CQUIN Indicated....
• Secured support of Informatics Team: Designed Electronic TOM recording form.
• Designed process map for “when to complete a TOM”
• All staff trained at the same time.
• One week later...all staff trained on electronic recording form & process
• “How to” resource guide written for all staff.
What happened?....

- Went live January 2011
- Prompts / communication formal and informal.
- April 2011 first data....😊
- Approximately 200 – 250 referrals

How many TOMs were done?
Expectations

Reality

31 😞
versus
67!!!!😊
Reflection: Change Equation.

Change is likely to occur when:

\[ D \times V \times F > R \]

Where:
- \( D = \text{Dissatisfaction} \) with the present situation
- \( V = \text{A Vision} \) of what is possible in future
- \( F = \text{Achievable First Steps} \) towards the vision
- \( R = \text{Resistance} \) to change

What this taught us...

- Leadership and culture.
- Space to discuss & problem solve...together!
- Getting data back to staff.
- Reward and celebration.
TOM & Service Users.

• Service User TOM report: Design, review & feedback.

• Service User Leaflet: What TOM is and how it will be used in their care. Staff resource tool.
**Leeds Partnerships NHS**

**what is toms?**
- **therapy**
- **outcome**
- **measures**

We measure your health needs at the start of your care.
We work with you on your health needs.
We measure your health needs at the end of your care and show you how things have changed.

We measure your health needs at the end of your care and show you how things have changed.

**why is toms helpful?**
- They help me to see how my health needs have changed.
- They help us to show how the things we do improve peoples health and lives.
- They help us to see if the services we deliver are improving peoples health and lives.

**plan**
- We will make a plan with you,
- This plan will say:
  - What we will do.
  - How we will do it.
  - We will follow the plan.
  - We will measure how well it is working.

**explain**
- We will write a special report,
- we give you a copy of the report and tell you what it says.

This is a toms report.

**We will use toms to measure:**
- Your health needs and how they effect you.
- We do this by finding out:
  - What your health needs are.
  - How your health needs effect how you look after yourself.
  - How your health needs effect how you take part in things.
  - How this makes you feel.
  - How this makes your carer feel.

**Why does toms work for people with learning disabilities?**
- It looks at the whole person.
- It measures the effect of illness on the service user.
- It measures the effect of the service users illness on the carer.
- It’s person centred.
- It’s easy to do.
- It’s been shown to work.
- It measures good service.
- It works well with people with complex needs.
- It can be used in lots of ways: planning care, running services, making services better.
C needed a long time to take her drinks and needed drinks to be given to her on very regular basis as she was losing most of the fluid from her mouth.

Now that C has a new cup and thicker fluids she is now able to drink much more appropriately. This means having drinks is a more pleasant and easy experience for her and takes up less of her time.
Relying on your data: “Rules” & Expectations.

- Ensuring that service users that are eligible for TOM are receiving one...in a timely manner.
- When do you not “do” a TOM.
- Time frame for recording initial TOM
- Service user outcome report.
- Inter-rater-reliability checks.
<table>
<thead>
<tr>
<th>TOM Dimension</th>
<th>% Number of TOM Scores that increased</th>
<th>% Number of TOM scores that maintained</th>
<th>% Number of TOM scores that reduced.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impairment</td>
<td>33%</td>
<td>63%</td>
<td>4%</td>
</tr>
<tr>
<td>Activity</td>
<td>47%</td>
<td>50%</td>
<td>3%</td>
</tr>
<tr>
<td>Participation</td>
<td>30%</td>
<td>63%</td>
<td>7%</td>
</tr>
<tr>
<td>Service User Wellbeing</td>
<td>69%</td>
<td>24%</td>
<td>7%</td>
</tr>
<tr>
<td>Carer Wellbeing</td>
<td>86%</td>
<td>7%</td>
<td>7%</td>
</tr>
</tbody>
</table>
Summary of key learning points.

- What will stop your team from embedding TOMs?
- Staff engagement.
- Support services engagement.
- Service User and Carer engagement – getting TOM back.
- Regular review and problem solving – smarter not harder: meeting agenda item.
- Get data back to staff
- Interrogating and understanding data.
- Training: TOM / How to record /exceptions,
- Set standards /exceptions & inter-rater-reliability check: Trusting your data.
- Communication and celebration.
Any questions?
Welcome to the:

RCSLT Therapy Outcome Measures Event (TOMs)

17th July 2018
#RCSLTTOMsWales
Welsh Community Care Information System and TOMS

Peter Cumpstone MCSP BSc(HONS)

17th July 2018
Aims of today:

• Introduction to WCCIS

• Standardisation of documents and form building

• Where does TOMS fit?
WCCIS

• Background
  – Joint Health and Social Care Computer System
  – 7 Health Boards
  – 22 Local Authorities
  – Who is in scope of using the system
  – Multiple AHP’s in scope of using the system
  – Supplier is Careworks
  – Multiple local authorities live and Powys Health Board
  – ABuHB signed their deployment order
WCCIS

• Integration
  – How will it talk to other systems?
  – What will and won’t WCCIS replace?
  – Can it push/pull data?
Current Issues

• Integration remains a problem
• Referrals – 2 types for health and social care,
• Waiting list management- system functionality continues to be developed in order to meet health requirements
• Mobile – Early stages of testing has begun with wider user engagement plan. Feedback is positive so far.
• Form developer resource- sourced from local health boards working nationally to build the all wales forms
• Information Standards – Over 30,000 questions, 80% are similar – core clinical and core non-clinical standardisation piece of work ongoing.
Sign in with your organizational account

<p>| |</p>
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</table>

Password

Sign in

NHS Wales Authentication Services,
managed by NHS Wales Informatics Services

By logging onto this computer system you are confirming that you are an authorised user and that access to the personal information of individuals recorded herein is for the legitimate purpose(s) of your role and your employer. Access to information that you are not entitled to see, or misuse of data within this system, is a breach of policy, the Computer Misuse Act (1990) and the Data Protection Act (1998)/the General Data Protection Regulation.

You are responsible for the actions taken on your account. Do not allow others to use your login details and always logout of the system after use. Access to and use of electronic resources is subject to audit.
## Personal Details

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCIS ID</td>
<td>591440</td>
</tr>
<tr>
<td>Last Name</td>
<td>William</td>
</tr>
<tr>
<td>First Name</td>
<td>Peter</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>23/02/1975</td>
</tr>
<tr>
<td>Referral Number</td>
<td>CAS-27727-ZT2KSY7</td>
</tr>
<tr>
<td>Referral Date</td>
<td>01/05/2018</td>
</tr>
<tr>
<td>NHS No</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>Male</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>Welsh</td>
</tr>
<tr>
<td>Religion</td>
<td></td>
</tr>
<tr>
<td>Preferred Language</td>
<td>Preferred Method of Communication</td>
</tr>
</tbody>
</table>
Speech and Language so far

• Excellent level of engagement from Paediatrics currently
• Adults have completed their paper forms and we are waiting allocation of a form developer to develop them into the system.
• Lots of agreement— not easy and a challenge to individuals and to health boards
• Keen to ensure education is included in all aspects as this plays a large part of your referrals
• Self-referrals need to be part of the pathway not just primary care.
Therapy Outcome Measures

• Has always been part of the plan to add TOMs into the form.
• Two options – questions built into the form itself, so that reports can be configured to pull the answers off routinely or a hyperlink to your ROOT system, where you could complete it separately.
• Potential for answers to be pulled through into the TOMs questions, although this depends on standardisation of information – no small task!
• The question can be hidden routinely and only shown if required, as not all areas are currently using it.
Summary

• Lots of background work in terms of the operating system and the user interface

• Secondary users – waiting list management, audit and finance

• Ongoing work around form development, information standards and core clinical/non-clinical data

• TOMs is on the list of essential inclusions for our forms, for SLT initially but potentially across the therapies
Thanks for listening
RCSLT Therapy Outcome Measures Event (TOMs)

17th July 2018
#RCSLLTTOMsWales
OUR EXPERIENCE WITH TOMS AND THE ROOT PILOT

Liz Rees
Speech and Language Therapist – Aneurin Bevan University Health Board

Jade Farrell
Speech and Language Therapist – Abertawe Bro Morgannwg University Health Board
WHY TOMS?

- Value based healthcare

Value = outcomes

- TOMs:
  - Enables us to demonstrate that what we are delivering is effective (RP RP RT)
  - Enables us to record outcome measures which will guide care and give information about the needs of the population and the benefits of our service.
## TRAINING

<table>
<thead>
<tr>
<th></th>
<th><strong>ANEURIN BEVAN UHB</strong></th>
<th><strong>ABM UHB</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TOMS Workshop</strong></td>
<td>• 8 staff attended</td>
<td>• 4 attended</td>
</tr>
<tr>
<td>(May 2015) Pam Enderby</td>
<td>• Implementation group formed</td>
<td>• Implementation group formed</td>
</tr>
<tr>
<td></td>
<td>• Cascaded training to whole team</td>
<td>• Cascaded training to whole team</td>
</tr>
<tr>
<td><strong>Train the trainer</strong></td>
<td><strong>session (October 2015)</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4 staff attended</td>
<td>2 staff attended</td>
</tr>
<tr>
<td><strong>TOMS implementation group</strong></td>
<td>• In place by end of 2015</td>
<td>• In place by end of 2015</td>
</tr>
<tr>
<td></td>
<td>• 8 members</td>
<td>• 4 members</td>
</tr>
<tr>
<td><strong>Team training</strong></td>
<td>• Training to paediatric and adult team in October 2015 and December 2015.</td>
<td>• Initial training to Band 7s for cascade within teams – November 2015 (limited success)</td>
</tr>
<tr>
<td></td>
<td>• Update sessions to whole service in July 2016, December 2016.</td>
<td>• Training to whole paediatric and adult teams early 2016 from trained trainers.</td>
</tr>
<tr>
<td></td>
<td>• Trainers provide further update sessions and training for new staff as required</td>
<td>• New starter induction includes TOMS training from trained trainers.</td>
</tr>
</tbody>
</table>
## DATA COLLECTION

<table>
<thead>
<tr>
<th>ANEURIN BEVAN UHB</th>
<th>ABM UHB</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Recorded in case notes</td>
<td>• Paper data collection forms in case notes (agreed set of aetiology, impairment and discharge codes included)</td>
</tr>
<tr>
<td>• Excel spreadsheet - by individual therapists – scope for omissions/errors</td>
<td>• Excel spreadsheet access for data entry by trained data enterers and implementation group only (10 people)</td>
</tr>
<tr>
<td>• E-form in development (no omissions possible)</td>
<td>• Data uploaded at end of episode of care and discharge</td>
</tr>
<tr>
<td></td>
<td>• Spreadsheet with restricted drop-down options and carry-over cells for maximum data accuracy</td>
</tr>
<tr>
<td></td>
<td>• Spreadsheet has evolved considerably to meet department needs since started</td>
</tr>
</tbody>
</table>
### MAINTENANCE

<table>
<thead>
<tr>
<th>ANEURIN BEVAN UHB</th>
<th>ABM UHB</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Implementation group quarterly meeting</td>
<td>• Implementation group meets every 2-3 months</td>
</tr>
<tr>
<td>• Regular item on team meeting agendas</td>
<td>• Monthly inter-rater reliability sessions within local teams and recorded on spreadsheet</td>
</tr>
<tr>
<td>• Inter-rater reliability sessions completed annually within borough</td>
<td>• Standard agenda item for quarterly Total Team Development days includes:</td>
</tr>
<tr>
<td>• Reinforcement and discussion via PADRs and supervision sessions</td>
<td>- Updates re: implementation group developments</td>
</tr>
<tr>
<td>• Prompts for completion on EoC document</td>
<td>- Feedback on data completed and analysed</td>
</tr>
<tr>
<td></td>
<td>- Assessment of activation levels</td>
</tr>
<tr>
<td></td>
<td>- Question/answer session</td>
</tr>
<tr>
<td></td>
<td>- Workshops targeting any identified issues</td>
</tr>
</tbody>
</table>

• Discussion and reinforcement during PADRs
## USE OF ROOT

<table>
<thead>
<tr>
<th>Aneurin Bevan UHB</th>
<th>ABM UHB</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Joined pilot 2016</td>
<td>• Joined pilot 2016</td>
</tr>
<tr>
<td>• Spreadsheet uploads by Professional Leads periodically</td>
<td>• Spreadsheet uploads</td>
</tr>
<tr>
<td></td>
<td>• Working towards quarterly upload of data through TOMs administrators with implementation group support</td>
</tr>
<tr>
<td></td>
<td>“the highest success rate that we have had so far, thanks to your brilliant data”</td>
</tr>
</tbody>
</table>

### Experiences

- Support from Kathryn Moyse and ROOT website staff
- Challenges - familiarity with the upload process if not frequently used
- Challenges – requiring support for direct upload due to issues with mapping section
- ROOT unable to analyse by all dimensions at present e.g. filter through teams, time spent, who delivered the intervention
- Responsive to feedback – maintains good communication with pilots for feedback, updates etc
### Analysis and Reporting

<table>
<thead>
<tr>
<th><strong>Aneurin Bevan UHB</strong></th>
<th><strong>ABM UHB</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>E-form in the process of being developed where data can be pulled from directly and analysed.</td>
<td>Spreadsheet contains information that can be analysed not available yet from ROOT. Basic analysis functions embedded into the spreadsheet. Intention of quarterly analysis through ROOT.</td>
</tr>
</tbody>
</table>

**Challenges:**
- What do we want to know?
- Numbers still relatively small for some areas
- Do standard analysis questions or does it need to be case specific?
- Requires deeper analysis to truly interrogate the results.

**Benefits:**
- More than we have had before
- Exciting for staff - engagement
TOMS: Therapy Outcome Measures for Rehabilitation Professionals

Number and Percentage of Patient Changes Between Admission and Discharge

Report Date Range: Between Thursday, January 1, 2015 and Thursday, April 19, 2018

<table>
<thead>
<tr>
<th>Key</th>
<th>Impairment (E = 283)</th>
<th>Activity (E = 283)</th>
<th>Participation (E = 283)</th>
<th>Wellbeing (E = 283)</th>
<th>Carer Wellbeing (E = 9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Down</td>
<td>42%</td>
<td>56.5%</td>
<td>56.9%</td>
<td>56.5%</td>
<td>88.9%</td>
</tr>
<tr>
<td>Same</td>
<td>1.1%</td>
<td>0.7%</td>
<td>40.6%</td>
<td>1.4%</td>
<td>11.1%</td>
</tr>
<tr>
<td>Up</td>
<td>42.8%</td>
<td>1.4%</td>
<td>58%</td>
<td>41.7%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Abertawe Bro Morgannwg University Health Board Episodes: (283)
Patients: (283)
<table>
<thead>
<tr>
<th>Measure</th>
<th>Average Type</th>
<th>Start</th>
<th>End</th>
<th>Change</th>
<th>Start</th>
<th>End</th>
<th>Change</th>
<th>Start</th>
<th>End</th>
<th>Change</th>
<th>Start</th>
<th>End</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Toms Scales</td>
<td>Mean</td>
<td>2.63</td>
<td>3.57</td>
<td>0.94</td>
<td>2.69</td>
<td>3.55</td>
<td>0.95</td>
<td>2.8</td>
<td>3.18</td>
<td>0.38</td>
<td>3.18</td>
<td>3.72</td>
<td>0.54</td>
</tr>
<tr>
<td></td>
<td>Median</td>
<td>2.5</td>
<td>2.5</td>
<td>1</td>
<td>2.5</td>
<td>2.5</td>
<td>1</td>
<td>2.5</td>
<td>2.5</td>
<td>0.5</td>
<td>2.5</td>
<td>3</td>
<td>0.5</td>
</tr>
<tr>
<td>Aphasia/Dysphasia</td>
<td>Mean</td>
<td>2.21</td>
<td>2.96</td>
<td>0.77</td>
<td>2.39</td>
<td>3.16</td>
<td>0.73</td>
<td>2.31</td>
<td>3.07</td>
<td>0.76</td>
<td>2.77</td>
<td>3.52</td>
<td>0.75</td>
</tr>
<tr>
<td></td>
<td>Median</td>
<td>2.5</td>
<td>2.5</td>
<td>1.25</td>
<td>2.5</td>
<td>2.5</td>
<td>1.25</td>
<td>2.5</td>
<td>2.5</td>
<td>0.75</td>
<td>2.5</td>
<td>2.5</td>
<td>0.75</td>
</tr>
<tr>
<td>Cognition</td>
<td>Mean</td>
<td>2.64</td>
<td>2.57</td>
<td>-0.07</td>
<td>2.43</td>
<td>2.21</td>
<td>-0.25</td>
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<td>-0.25</td>
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<tr>
<td></td>
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<td>2.5</td>
<td>0.25</td>
<td>2.25</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>0</td>
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<tr>
<td>Dysarthria</td>
<td>Mean</td>
<td>3.44</td>
<td>3.8</td>
<td>0.36</td>
<td>3.77</td>
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<tr>
<td></td>
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<td>2.5</td>
<td>2.5</td>
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<td>2.75</td>
<td>3</td>
<td>0.5</td>
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<td>2.75</td>
<td>2.75</td>
<td>1.25</td>
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<tr>
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<td>Mean</td>
<td>2.61</td>
<td>3.64</td>
<td>1.03</td>
<td>2.63</td>
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<td>3.64</td>
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<tr>
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<td>2.5</td>
<td>0.75</td>
<td>2.75</td>
<td>2.5</td>
<td>0.5</td>
<td>2.25</td>
<td>2.25</td>
<td>0.25</td>
<td>2.25</td>
<td>2.25</td>
<td>0.25</td>
</tr>
<tr>
<td>Dysphonia</td>
<td>Mean</td>
<td>2.64</td>
<td>3.41</td>
<td>0.77</td>
<td>2.73</td>
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<td>3.05</td>
<td>4.37</td>
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<td>3.59</td>
<td>4.27</td>
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<tr>
<td></td>
<td>Median</td>
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<td>2.75</td>
<td>1.25</td>
<td>2.5</td>
<td>2.5</td>
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<td>3.25</td>
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<td>2.75</td>
<td>3.25</td>
<td>0.75</td>
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<td>Tracheostomy</td>
<td>Mean</td>
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<td>3.28</td>
<td>1.83</td>
<td>0.84</td>
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<td>1.5</td>
<td>2.5</td>
<td>3</td>
<td>1.5</td>
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</table>
# Aneurin Bevan University Health Board

Episodes = (23) Patients: (23)

<table>
<thead>
<tr>
<th>Impairment</th>
<th>Activity</th>
<th>Participation</th>
<th>Wellbeing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Legend:**
- **Down**
- **Same**
- **Up**

<table>
<thead>
<tr>
<th>Impairment</th>
<th>Activity</th>
<th>Participation</th>
<th>Wellbeing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **69.6%**
- **30.4%**
- **0%**
- **26.1%**
- **34.8%**
- **6.3%**
- **4.3%**
- **4.3%**
- **69.6%**
- **26.1%**
DYSPHONIA: ABUHB/PILOT COMPARISON

Aneurin Bevan University Health Board
Episodes = (3) Patients: (3)

Legend:

<table>
<thead>
<tr>
<th>Impairment</th>
<th>Activity</th>
<th>Participation</th>
<th>Wellbeing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Down</td>
<td>Same</td>
<td>Up</td>
<td></td>
</tr>
</tbody>
</table>

Pilot
Episodes = (837) Patients: (828)
# Dysphagia: ABUHB/Pilot Comparison

<table>
<thead>
<tr>
<th>Legend</th>
<th>Down</th>
<th>Same</th>
<th>Up</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Impairment</th>
<th>Activity</th>
<th>Participation</th>
<th>Wellbeing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aneurin Bevan University Health Board</strong> Episodes = (5) Patients: (5)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><img src="chart1.png" alt="Impairment Chart" /></td>
<td><img src="chart2.png" alt="Activity Chart" /></td>
<td><img src="chart3.png" alt="Participation Chart" /></td>
<td><img src="chart4.png" alt="Wellbeing Chart" /></td>
</tr>
<tr>
<td><strong>Pilot</strong> Episodes = (6758) Patients: (6078)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><img src="chart5.png" alt="Impairment Chart" /></td>
<td><img src="chart6.png" alt="Activity Chart" /></td>
<td><img src="chart7.png" alt="Participation Chart" /></td>
<td><img src="chart8.png" alt="Wellbeing Chart" /></td>
</tr>
</tbody>
</table>
STRUGGLE QUESTIONS

- Where do we put the intermediate and final ratings, and conclude episodes so that we can collect the most useful data?

- What data are we analysing? (related to pathways, SLT/disorder codes)

- Need for All Wales electronic system
QUESTIONS?
RCSLT Therapy Outcome Measures Event (TOMs)

17th July 2018
#RCSLTTOMsWales
Clinical coding: why does it matter and how can we use it?

TOMs Event
17 July 2018

Christine Dowle
RCSLT Trustee for Wales

Kathryn Moyse
RCSLT Outcomes and Informatics Manager
What is clinical coding?

“What clinical coding is the translation of medical terminology that describes a patient’s complaint, problem, diagnosis, treatment or other reason for seeking medical attention into codes that can then be easily tabulated, aggregated and sorted for statistical analysis in an efficient and meaningful manner”

What is clinical coding?
What is coded data used for?

**National level**: monitoring health trends and research purposes, e.g.
- studying frequency and occurrence of conditions
- identifying at risk populations based on demographic, diagnostic or environmental factors

**Local level**: support operational and strategic planning, e.g.
- identifying needs of the local population to support local health care planning, staffing levels, casemix
- conducting clinical audit, including outcome measurement
Clinical terminology & classification systems

- A **clinical terminology** is a collection of descriptive terms for use in clinical practice – including terms describe the care and treatment of patients, diagnoses, symptoms, surgical procedures, treatments, medicines, healthcare administration. Clinical terminologies support the recording of information in a consistent way by using a ‘common language’ in electronic health records. E.g. SNOMED CT

- A **classification system** groups diseases and other health issues into categories based on similar properties. E.g. ICD-10
SNOMED CT

- Systematized Nomenclature of Medicine Clinical Terms
- standard **clinical terminology** used internationally
- vocabulary of clinical phrases for use within health and care systems
- in the UK, SNOMED CT is managed by the UK Terminology Centre (UKTC), an organisation within NHS Digital
- provides a comprehensive set of clinical terms, which are linked to show relationships between terms
SNOMED CT – an example: heart disease

56265001
Fully specified name: heart disease (disorder)
Preferred term: heart disease
Synonym: cardiac disorder
Synonym: cardiopathy
Synonym: morbus cordis
Synonym: disorder of heart
SNOMED CT – hierarchical structure

Parents
- Cardiac finding (finding)
- Disorder of body cavity (disorder)
- Disorder of cardiovascular system (disorder)
- Disorder of mediastinum (disorder)

Children (44)
- Abnormal fetal heart beat first noted during labor AND/OR delivery in liveborn infant (disorder)
- Acquired cardiac septal defect (disorder)
- Acute heart disease (disorder)
- Anomalous bands of heart (disorder)
- Athlete's heart (disorder)
- Cardiac abnormality due to heart abscess (disorder)
- Cardiac arrhythmia (disorder)
- Cardiac complication (disorder)
- Cardiac complication of anesthesia during the puerperium (disorder)
- Cardiac complication of procedure (disorder)
- Cardiac disease in pregnancy (disorder)
ANY QUESTIONS?
ICD-10

- The International Statistical Classification of Diseases and Related Health Problems (ICD) 10th revision (eleventh revision due in 2018)
- classification system of clinical terms developed by the World Health Organization (WHO)
- developed to support statistical reporting about health and enable international comparisons
- also a structured, hierarchical system
ICD-10 – an example: heart disease

IX Diseases of the circulatory system
- I00-I02 Acute rheumatic fever
- I05-I09 Chronic rheumatic heart diseases
- I10-I15 Hypertensive diseases
- I20-I25 Ischaemic heart diseases
- I26-I28 Pulmonary heart disease and diseases of pulmonary circulation
- I30-I52 Other forms of heart disease
  - I30 Acute pericarditis
  - I31 Other diseases of pericardium
  - I32 Pericarditis in diseases classified elsewhere
  - I33 Acute and subacute endocarditis
  - I34 Nonrheumatic mitral valve disorders
  - I35 Nonrheumatic aortic valve disorders
  - I36 Nonrheumatic tricuspid valve disorders
  - I37 Pulmonary valve disorders

<table>
<thead>
<tr>
<th>I52*</th>
<th>Other heart disorders in diseases classified elsewhere Excl.: cardiovascular disorders NOS in diseases classified elsewhere (I98-*)</th>
</tr>
</thead>
</table>
| I52.0* | Other heart disorders in bacterial diseases classified elsewhere
Meningococcal carditis NEC (A39.3†) |
| I52.1* | Other heart disorders in other infectious and parasitic diseases classified elsewhere
Pulmonary heart disease in schistosomiasis (B65.†) |
| I52.8* | Other heart disorders in other diseases classified elsewhere
Rheumatoid carditis (M05.3†) |
What is the relationship between SNOMED CT and ICD-10?

- SNOMED CT = terminology
- ICD-10 = classification system
- ‘Cross maps’ exist to translate SNOMED CT into ICD-10 codes
ANY QUESTIONS?
The ROOT uses ICD-10 codes – why??
The ROOT uses ICD-10 codes – why??
**How are ICD-10 codes used in the ROOT?**

*Communication and swallowing disorder descriptor(s) – e.g. R47.0 Dysphasia/aphasia*

*Medical diagnosis – e.g. I64 Stroke, not specified*
### Communication and swallowing disorder descriptors

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eating disorders</td>
<td>F50</td>
</tr>
<tr>
<td>Specific speech/phonological/articulation disorder</td>
<td>F80.0</td>
</tr>
<tr>
<td>Expressive language disorder</td>
<td>F80.1</td>
</tr>
<tr>
<td>Receptive language disorder</td>
<td>F80.2</td>
</tr>
<tr>
<td>Social (pragmatic) communication disorder</td>
<td>F80.82</td>
</tr>
<tr>
<td>Developmental disorder of speech and language, unspecified</td>
<td>F80.9</td>
</tr>
<tr>
<td>Elective mutism</td>
<td>F94.0</td>
</tr>
<tr>
<td>Feeding disorder of infancy and childhood</td>
<td>F98.2</td>
</tr>
<tr>
<td>Stuttering [stammering]</td>
<td>F98.5</td>
</tr>
<tr>
<td>Cluttering</td>
<td>F98.6</td>
</tr>
<tr>
<td>Dysphagia, unspecified</td>
<td>R13.10</td>
</tr>
<tr>
<td>Dysphagia, oral phase</td>
<td>R13.11</td>
</tr>
<tr>
<td>Dysphagia, oropharyngeal phase</td>
<td>R13.12</td>
</tr>
<tr>
<td>Dysphagia, pharyngeal phase</td>
<td>R13.13</td>
</tr>
<tr>
<td>Dysphagia, pharyngoesophageal phase</td>
<td>R13.14</td>
</tr>
<tr>
<td>Cognitive communication deficit</td>
<td>R41.841</td>
</tr>
<tr>
<td>Dysphasia/aphasia</td>
<td>R47.0</td>
</tr>
<tr>
<td>Dysarthria/anarthria</td>
<td>R47.1</td>
</tr>
<tr>
<td>Dyslexia/alexia (secondary to organic lesion)</td>
<td>R48.0</td>
</tr>
<tr>
<td>Speech articulation impairment due to praxia/dyspraxia</td>
<td>R48.2</td>
</tr>
<tr>
<td>Dysphonia</td>
<td>R49.0</td>
</tr>
<tr>
<td>Hypernasality</td>
<td>R49.21</td>
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<tr>
<td>Hyponasality</td>
<td>R49.22</td>
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<tr>
<td>Other voice and resonance disorders</td>
<td>R49.8</td>
</tr>
<tr>
<td>Illness, unspecified</td>
<td>R69</td>
</tr>
<tr>
<td>Nothing abnormal detected</td>
<td>Z71.1</td>
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</tbody>
</table>

### Medical diagnoses - frequently used ICD10 codes

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malignant neoplasm of head, face and neck</td>
<td>C76.0</td>
</tr>
<tr>
<td>Neoplasm of uncertain or unknown behaviour of oral cavity and digestive organs</td>
<td>D37</td>
</tr>
<tr>
<td>Neoplasm of uncertain or unknown behaviour of middle ear and respiratory and intrathoracic organs</td>
<td>D38</td>
</tr>
<tr>
<td>Neoplasm of Larynx</td>
<td>D38.0</td>
</tr>
<tr>
<td>Neoplasm of uncertain or unknown behaviour of brain and central nervous system</td>
<td>D43</td>
</tr>
<tr>
<td>Dementia in Alzheimer’s Disease</td>
<td>F00</td>
</tr>
<tr>
<td>Unspecified dementia</td>
<td>F03</td>
</tr>
<tr>
<td>Alzheimer’s disease</td>
<td>G30</td>
</tr>
<tr>
<td>Vascular dementia</td>
<td>F01</td>
</tr>
<tr>
<td>Frontotemporal dementia</td>
<td>G31.0</td>
</tr>
<tr>
<td>Lewy-Body Dementia</td>
<td>G31.83</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>F20</td>
</tr>
<tr>
<td>Organic personality disorder</td>
<td>F07.0</td>
</tr>
<tr>
<td>Acute and transient psychotic disorders</td>
<td>F23</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>F31</td>
</tr>
<tr>
<td>Depression</td>
<td>F32</td>
</tr>
<tr>
<td>Phobic anxiety disorder</td>
<td>F40</td>
</tr>
<tr>
<td>Obsessive Compulsive Disorder</td>
<td>F42</td>
</tr>
<tr>
<td>Unspecified mental disorder of adult personality and behaviour</td>
<td>F69</td>
</tr>
<tr>
<td>Huntington’s disease</td>
<td>G10</td>
</tr>
<tr>
<td>Early-onset cerebellar ataxia (Friedreich’s ataxia)</td>
<td>G11.1</td>
</tr>
<tr>
<td>Motor Neurone disease</td>
<td>G12.2</td>
</tr>
</tbody>
</table>
Groups of service users
<table>
<thead>
<tr>
<th>Start of reporting period:</th>
<th>23/06/2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender:</td>
<td>All</td>
</tr>
<tr>
<td>TOMs scale:</td>
<td>Augmentative and Alternative Co</td>
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<tr>
<td>Impairment score low:</td>
<td>0.0</td>
</tr>
<tr>
<td>Age range low:</td>
<td>0</td>
</tr>
<tr>
<td>Communication and swallowing disorder descriptor(s):</td>
<td>(F80.0) Specific speech articulation</td>
</tr>
<tr>
<td>Medical diagnosis:</td>
<td>Not Specified (13). Stroke, not sps</td>
</tr>
<tr>
<td>Show national:</td>
<td></td>
</tr>
<tr>
<td>End of reporting period:</td>
<td>23/06/2018</td>
</tr>
<tr>
<td>Matched:</td>
<td>All Data</td>
</tr>
<tr>
<td>Interims:</td>
<td>With or without interims</td>
</tr>
<tr>
<td>Impairment score high:</td>
<td>5.0</td>
</tr>
<tr>
<td>Age range high:</td>
<td>150</td>
</tr>
<tr>
<td>Communication and swallowing disorder descriptor(s) progressive:</td>
<td>Include All</td>
</tr>
<tr>
<td>Communication and swallowing disorder descriptor(s) comorbidity:</td>
<td>Include All</td>
</tr>
<tr>
<td>Medical diagnosis progressive:</td>
<td>Include All</td>
</tr>
<tr>
<td>Medical diagnosis comorbidity:</td>
<td>Include All</td>
</tr>
</tbody>
</table>
Communication and swallowing disorder descriptor(s): R13 Dysphagia

Medical diagnosis: I64 Stroke, not specified

Communication and swallowing disorder descriptor(s): R13 Dysphagia

Medical diagnosis: F03 Unspecified dementia
ANY QUESTIONS?
WORKSHOP
In your groups...

- Reflect on service users you have worked with recently and discuss which ICD10 codes you would use if recording information about them using the ROOT.
  - What worked well?
  - What were the challenges?
  - What would you need to make this easier?

- If you are already using ICD10 codes in your service, you may wish to share some of your experiences to date and discuss ways forward
FEEDBACK
Interested in finding out more information?

- Visit NHS Wales Informatics Service webpages on Clinical Coding and Classification
- Access free resources from NHS Digital on terminology and classification, including webinars and e-learning
- Visit RCSLT webpages and resources, including Bulletin articles on clinical terminology (March 2017 and April 2017)
- Contact kathryn.moyse@rcslt.org for more information about the RCSLT SNOMED review group

The importance of standardised terminology

Whether in everyday conversations or in our clinical work, we’re all very aware that there are different ways of saying the same thing. That’s not always a problem, but if we use the same words to mean different things, or don’t use synonymous terms accurately or consistently, confusion can arise and what we say can be misinterpreted.

That’s why, in the world of healthcare, standardised clinical terminologies are so important. These sets of standardised vocabularies are integrated into electronic healthcare applications to facilitate the most accurate use of terminology. If you are using an electronic patient record system, the chances are that it will contain various drop-down selection of terms, which are taken from a clinical terminology.

Why is it so important?

Using a standardised vocabulary is important in facilitating the precise capture of medical data, allowing clinicians to communicate to a high standard. Managers interested in data analysis will find that a single clinical terminology will allow for a more accurate identification of clinical processes.

SNOMED CT: adopting a ‘common language’

Last month, we looked at clinical terminology and the potential benefits of adopting a ‘common language’ across the world of healthcare, including an introduction to SNOMED CT (Systematized Nomenclature of Medicine – Clinical Terms) as an example of a standardised clinical terminology used internationally. Here, we examine SNOMED in more depth, as well as the RCSLT’s approach to reviewing the subsets of terms related to speech and language therapy.

Consistent words and phrases

Using a standardised vocabulary facilitates the precise recording of clinical information and supports effective and accurate record keeping, which has implications for improving the quality of healthcare. It aims to consistently represent the words and phrases used in healthcare, and the relationships between these terms, which describe the care and treatment of patients and cover areas such as diagnoses, symptoms, surgical procedures, treatments and medications, as well as terms used for healthcare administration. This terminology is being incorporated into electronic healthcare applications - those of you who use electronic patient record systems may be using SNOMED CT without even realising it.

A review of the terminology

The RCSLT has been working with the UK Terminology Centre to develop subsets containing clinical terms related to speech and language therapy, and has piloted a new approach to involve members in the development and maintenance of relevant terminology. Updates to SNOMED CT subsets are made every six months, including the addition, removal and amendment of clinical terms.

The review group, which comprises SLTs
RCSLT Therapy Outcome Measures Event (TOMs)

17th July 2018
#RCSLTTOMsWales