4 Smith GB, Prytherch DR, Watson D *et al.* S_pO_2 values in acute medical admissions breathing air – implications for the British Thoracic Society guideline for emergency oxygen use in adult patients? *Resuscitation*. Submitted for publication.

Response

We thank Professor Smith and colleagues for their interest in our paper. We note with interest that their unpublished work has confirmed our hypothesis that the sensitivity and specificity of existing early warning systems (EWS) are reduced amongst patients with underlying respiratory disease compared with unselected medical patients. We agree that further refinements to our proposed modified scoring system that allocates EWS points based on oxygen saturation will be required. We are currently testing a few different models of EWS oxygen scoring for respiratory patients and general medical patients, and we look forward to working with the Royal College of Physicians team and with Professor Smith and colleagues on developing evidence-based EWS models that will enhance the care and safety of patients with chronic respiratory disease who require hospital admission.

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Interventional procedures: physician involvement enhances clinical coding

Editor – The study by Hogarth *et al* (*Clin Med* April 2012 pp189) demonstrates marked improvement in coding and financial outcomes by better collaboration between clinicians and coders in the setting of electrophysiology and device procedures.[1] This is also generalisable to other interventional procedures, particularly as they tend to attract higher tariff and are typically performed in high volume as they generally require expertise in particular centres with sufficient patient flow, and hence the potential for financial disparity if these are miscoded is much higher. The principal requirement for success here is for better collaboration between clinicians and coders, although this can be achieved in different ways.

Indeed there is an unmet need for this, as the Audit Commission has noted that coding inaccuracies seem to be particularly prevalent in interventional specialties with significant national variation between 0.3% and 52% across acute trusts in England.[2] In the field of interventional pulmonology, endobronchial ultrasound-guided transbronchial needle aspiration (EBUS-TBNA) is performed in high volume in a number of centres. EBUS-TBNA attracts a far higher specific tariff than conventional fibreoptic bronchoscopy: nearly seven times more (£3404 (E63.2 + T87.4) versus £504 respectively).[3]

We (as well as the Audit Commission) have also previously demonstrated significant inaccuracies in coding in the field of interventional pulmonology, with >15% coding inaccuracy in a single centre for EBUS-TBNA and >68% inaccuracy for local anaesthetic thoracoscopy, with estimated financial discrepancies of at least £65,000 for one procedure in one centre annually.[4,5] We have managed to prevent all EBUS-TBNA coding errors by electronically notifying all procedures anonymously to a key member of the coding team after each procedure session, verified by independent cross-checking of the tariff applied and a monthly checklist from the coding team.[6] This has now resulted in estimated savings of £78,000 for the last 165 EBUS-TBNA procedures (projected from the original error rate and cost saving).

In summary, small changes in collaborative behaviour between clinicians and coders in interventional specialties have the potential to make large cost savings even for one procedure alone, and can reduce financial disparity and are worthy of consideration. We therefore endorse the intervention by Hogarth *et al* and suggest this may be of particular relevance to other interventional specialties.

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2 Audit Commission. *PbR Data Assurance Framework 2007/08: findings from the first year of the national clinical coding audit programme*. Audit Commission: London, 2008. http://www.audit-commission.gov.uk/SiteCollectionDocuments/AuditCommissionReports/NationalStudies/PbRreport.pdf [Accessed 29 June 2012].
3 Department of Health. *Confirmation of Payment by Results arrangements for 2010/11*. London: DH, 2010. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_112284 [Accessed 29 June 2012].
4 Medford AR, Agrawal S, Free CM *et al.* A performance and theoretical cost analysis of endobronchial ultrasound-guided transbronchial needle aspiration in a UK tertiary respiratory centre. *QJM* 2009;102:859–64.
5 Medford AR, Agrawal S, Free CM *et al.* Retrospective analysis of Healthcare Resource Group coding allocation for local anaesthetic video-assisted 'medical' thoracoscopy in a UK tertiary respiratory centre. *QJM* 2009;102:329–33.
6 Medford ARL, Pillai A. Does greater physician involvement with interventional procedure coding improve coding outcome? Thorax 2011;66(Suppl IV):A143–4[P187].

Rocket scientists need not apply

Editor – We wholeheartedly agree with your recent editorial.[1] Like the hospitals studied by Barton *et al*[2] we fortunately have few serious medication incidents (mainly due to pharmacy intervention), but a good deal of 'low level crime' in terms of legibility and allergy documentation, in addition to other areas. The causes are varied. Clinician training in practical pharmacology (one to two years part time versus five years) is minimal