2. Educating clinicians on the importance of coding and making them responsible for coding their procedures.
3. Weekly meetings between the coding department and a clinician to discuss difficult cases and educate the department on different procedures.

By addressing these fundamental areas of coding, we were able to produce a significant difference in coding accuracy.

Reference

1. Carr ERM, Pillai A. Audit of coding of operations. *Clin Governance Bull* 2007; 6: 20–1.

AUTHOR'S RESPONSE

doi 10.1308/003588410X12518836439641
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We agree with the suggestion of close co-operation and communication between surgeons and clinical coding administrative staff for improved accuracy of clinical coding systems. The findings of their audit are reassuring. However, of note, is the issue of the increased time commitment required on the part of the surgeons in fulfilling these suggestions.

COMMENT ON

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C Brown, AR Naylor. Improving the provision of carotid endarterectomy in line with UK Government targets requires more than just motivated surgeons. *Ann R Coll Surg Engl* 2009; 91: 326–9

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Improving access to expedited carotid endarterectomy

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We would like to highlight that, although the new UK National Institute for Health and Clinical Excellence (NICE) guidelines for reducing waiting times aim for a 2-week

turnaround time, many primary care trusts, including ours, have shortened this time further, in line with the national stroke strategy guidelines,¹ to only 48 h from time of symptoms to surgery. This will require a more co-ordinated process of disease detection and surgical provision, beyond that suggested in this article.

In our trust, we have started to run a transient ischaemic attack (TIA) clinic every day with ring-fenced duplex slots. If a patient has a significant stenosis, our stroke physicians will admit the patient on that day, organise an MRI (also ring-fenced) and refer immediately to us for assessment. This reduces any delay in booking patients for admission through the normal channels. Carotid endarterectomy is then performed in emergency theatres. This avoids knock effects for 18-week targets for patients who would otherwise be cancelled. Although we realise that this model needs to be improved upon, it provides a way to move towards attaining the 48-h target for treatment.

Reference

1. <http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081062 [Accessed 6 May 2009].

AUTHOR'S RESPONSE

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As the authors will have noted, the concluding section of the discussion section in our paper anticipated most of the beneficial changes in practice you highlight, including daily TIA clinics, immediate transfer of patients to the surgical unit, inter-consultant transfer of patients, *etc.* The only difference seems to be your preference for performing expedited carotid surgery in the emergency theatre, while we prefer to allocate two 'ring-fenced' half-day lists per week in the vascular theatre. The latter ensures access to experienced vascular anaesthetists and theatre staff. Since our paper was published, approximately 75% of all symptomatic patients currently undergo surgery within 14 days of the index event.

A much bigger problem is that there is still much public ignorance about the importance of presenting early. The best way of addressing this issue would be to have someone