Document Title:	**CLINICAL CODING**		
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Document type: (Policy/ Guideline/ SOP)	Guideline	**To be followed by:** (Target Staff)	All Clinical Coding Staff
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Developed in response to:	Information Governance Toolkit National Audit Commission recommendations to DH HSCIC Requirements SLA Requirements		
Contributes to HSC Act 2008 (Regulated Activities) Regulations 2014(Part 3); and CQC Regulations 2009 (Part 4) **CQC Fundamental Standards of Quality and Safety:**			17,19

Issuing Division/Directorate:	Informatics		
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Hospital Sites: (tick appropriate box/es to indicate status of policy review i.e. joint/ independent)	☑ MEHT □ BTUH □ SUH		
Consultation:	(Refer to page 2)		
Approval Group / Committee(s):	n/a	**Date:**	n/a
Professionally Approved by: (Asset Owner)	Caroline Holmes, Head of Clinical Coding, Records and Data Quality, MSB Group	**Date:**	19th November 2018
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Executive and Clinical Directors (Communication of minutes from Document Ratification Group	**Date:** December 2018	**Distribution Method:**	Intranet, Staff Focus, website

Consulted With:	Post/ Approval Committee/ Group:	Date:
Team Leaders	Clinical Coding, MEHT	20th November 2018
Julie Reynolds	Clinical Coding Manager and Approved Clinical Coding Trainer, Basildon Hospital	
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Caroline Holmes	Head of Clinical Coding, Records and Data Quality, MSB Group	19th November 2018

Related Trust Policies (to be read in conjunction with)	MSBPO-18001 Information Governance and Management Policy 04011 Appraisal Performance Review Policy

Document Review History:			
Version No:	**Authored/Reviewer:**	**Summary of amendments/ Record documents superseded by:**	**Issue Date:**
1.0	Sue Browne		9th March 2007
2.0	Caroline Holmes		27th September 2012
3.0	Caroline Holmes		6th October 2018
4.0	Helena Green	Full review	3rd December 2018

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1.0 Purpose

1.1 To provide accurate, complete and timely coded clinical information to support mandatory coding requirements and the information required for Commissioning Minimum Data Sets (CMDS), Central Returns of behalf of the Trust and to support local benchmarking tools, such as Healthcare Evaluation Data (HED).

1.2 To adhere to national standards and classification rules and conventions as set out in ICD-10 Volumes 1 - 3, OPCS-4.8 Volumes 1 - 2, National Clinical Coding Standards ICD-10 5th Edition, Clinical Coding Instruction Manual OPCS-4.8 and publications of the Coding Clinic.

1.3 To input onto the electronic Lorenzo via 3M Medicode, accurate and complete coded information within the designated time scales to support the information and business requirements of the Trust.

1.4 To provide accurate, consistent and timely information to support clinical governance and to support requirements arising for Block/Payment by Results (PbR) activities.

1.5 To ensure all staff involved in the Clinical Coding process receive regular training to maintain and develop their Clinical Coding skills, regardless of experience and length of service.

1.6 To ensure continual improvement of clinically coded information within the Trust through systematic audit and quality assurance procedures.

1.7 To ensure all staff are aware of the Trust's security and confidentiality policies when using patient identifiable information.

2.0 Guideline Statement

2.1 This guideline has been published with the intention of promoting good practice and consistency of information produced during the Clinical Coding process within the Trust. It has been designed to incorporate the requirements of the Information Governance Framework to ensure information produced during the coding process is accurate and adheres to local and national policies and to meet the requirements of Block/PbR.

2.2 All procedures involved in the capture of information for Clinical Coding purposes are clearly defined, to ensure clarification of, and compliance with local coding processes. All policies and procedures adhere to national and international standards, Clinical Coding rules and conventions, as set out by NHS Digital.

2.3 All quality assurance procedures for the Clinical Coding Team are detailed in this guideline including audit and data quality measures to ensure continual improvements in the standard and quality of coded data within the organisation.

2.4 All changes to Clinical Coding policies and procedures will be incorporated into regular reviews of this guideline and its associated procedures to ensure all contributors are in agreement with the current practice. Any alterations to Clinical Coding practice must have change and implementation dates to ensure consistent practice across the Trust and comply with national standards and classification coding rules and conventions.

2.5 All Clinical Coding policy and procedure decisions made between the department and individual clinicians are fully described, agreed and signed by the relevant staff. This policy and associated procedures must be in accordance with national standards or classification coding rules and conventions.

2.6 All training plans for members of the Clinical Coding Department are clearly defined and documented.

2.7 This guideline details communication arrangements in relation to Clinical Coding updates, resolution to queries, and changes in coding practice, aimed at ensuring effective dissemination to all coding staff and information users.

2.8 All Clinical Coding staff will be trained in confidentiality and security issues, both local policy and statutory rules, as part of the Trust's mandatory training programme. Breaches of data confidentiality or security must be reported via DATIX.

3.0 Scope

3.1 This guideline should be adhered to by all permanent, agency, bank and voluntary staff of the Trust.

3.2 This guideline is intended to cover all inpatient, day case and outpatient Clinical Coding for activity recorded on the MEHT Lorenzo system. It does not include Plastic Surgery activity carried out and recorded on PAS systems within Colchester Hospital University NHS Foundation Trust and Southend University Hospital NHS Foundation Trust.

3.3 The guideline outlines good practice and identifies the roles and responsibilities of both the Trust and staff in terms of Clinical Coding.

4.0 Responsibility for Clinical Coding

4.1 The **Chief Executive** is responsible for the Trust's performance in respect of Clinical Coding.

4.2 The **Senior Information Risk Owner (SIRO)** acts as an advocate for Clinical Coding on the Trust Board. The SIRO works closely with the Head of Clinical Coding, Records and Data Quality to ensure the Trust's coding processes and systems are fit for purpose.

4.3 The **Clinical Coding Team** is responsible for:

- Extracting patient diagnosis and treatment information and translating this information into the appropriate coded format, using the classification rules and conventions as set out in the WHO ICD-10 Volumes 1-3, National Clinical Coding Standards ICD-10 and OPCS-4.8 books (volumes I and II);

- Coding to the deepest level of clinical detail as required by national standards, including information about co-morbidities to ensure a rich source of clinical detail for extraction and analysis;

- Ensuring patient case notes are available to ensure the highest quality patient care;

- Contacting the relevant clinician for clarification if there is conflicting information documented ;

- Maintaining a high level of expertise in coding through the attendance of external training events and by becoming qualified as an Accredited Clinical Coder by successfully obtaining the National Clinical Coding Qualification;

- Keeping abreast of changes in Clinical Coding, such as the updates to OPCS and ICD and act as the centre of excellence and expertise on such matters within the Trust;

- Acting as the centre for expertise for all coding related matters e.g. responding to coding queries, provision of necessary codes for audit and providing information coding conventions and structures;

- Providing an overview of Clinical Coding to all new doctors as part of their Trust induction process;

- Undertaking all necessary internal and external audits in line with local and national requirements including the Data Security and Protection Toolkit;

- Ensuring all new coding staff attend the Clinical Classification Service Coding Standards Course within six months of appointment;

- Ensuring all experienced staff attend a Clinical Classification Service Coding Standards Refresher Course at least every three years;

- Ensuring all Clinical Coders attend relevant specialist training courses as available;

- Maintaining a record of all courses attended by members of the Clinical Coding Team;

- Reviewing the Clinical Coding Policies and Procedures on an agreed basis;
- Collecting notes from Wards on a daily basis (Monday to Friday) and locating notes from other departments when required;
- Tracking in all case notes electronically that arrive in the Clinical Coding Department on the Lorenzo tracking system;
- Filing case notes in alphabetical order onto the shelving where the records are stored for coding;
- Answering the phone and emails requesting urgent notes. Ensuring the notes are pulled and coded;
- Ensuring any case notes that need to be returned are given to the Coder for coding and sent back as soon as practical.

4.4 All **Clinical staff** are responsible for:

- Ensuring clinical information contained in case notes and on discharge summaries is written clearly and legibly and as soon as possible after the event;
- Printing their name, position and date on every entry in the case notes;
- Clearly recording details of all procedures including those carried out the ward including where necessary laterality, approach and use of image control;
- Documenting the reason for any planned procedures not being carried out such as contraindication, the patients decision or some other reason;
- Detailing all diagnoses in the medical record and on the discharge summary including where possible a definitive diagnosis, current and relevant co-morbidities, causes of any injuries, any drugs involved in an overdose and the organisms causing any infections and details of drugs the organisms may be resistant too;
- Avoiding the use of ambiguous abbreviations;
- Trying to avoid using the terms ‘likely’, ‘impression’, ‘query’ or ‘possible’ as these cannot be coded.

4.5 **Ward Staff** are responsible for ensuring case notes and discharge summaries are complete and filed correctly and are available for Clinical Coding as possible after the discharge.

5.0 Clinical Coding Procedures

5.1 National Standards and IT Systems

5.1.1 The coding systems used are:

- Diagnosis – ICD-10 – International Classification of Diseases and Related Health Problems 10th Revision 2016 5th Edition;
- Procedures – OPCS Classification of Interventions and Procedures Version 4.8.

5.1.2 The Trust currently uses Healthcare Resource Grouper (HRG) Version 4+. The PAS in use is DXC Lorenzo which interacts with 3M's Medicode encoder software.

5.2 Case notes

5.2.1 The majority of the inpatient and day case activity undertaken at MEHT is coded centrally using case notes and admission records. There are some exceptions where coding is undertaken on the wards or in other departments such as the emergency short stay wards and the bereavement office.

5.2.2 Case notes and other relevant paperwork are collected from wards daily by Clinical Coding Assistants.

5.2.3 The Coder extracts from the case notes all relevant information relating to the patients diagnosis and treatment. This is then translated into the appropriate coded format and entered onto electronic patient records.

5.2.4 Unless otherwise stated, the main source document for Clinical Coding is the case notes. These contain:

- Clinical notes
- Operation sheets
- GP Letters
- Discharge summaries (where applicable)

5.2.5 Where applicable, coders also supplement information abstracted from the case notes with pathology or radiology results, found on the relevant IT system.

5.2.6 In order to meet the Trust targets there are exceptional occasions where coding is undertaken without using case notes or proformas e.g. a patient's discharge summary in isolation. This is done with the aim of not compromising data quality and coding standards.

5.3 Other sources of Coding

5.3.1 Day Therapies and Day Diagnostics – a proforma has been designed by the Clinical Coding Department to capture all relevant information to facilitate the coding process. The proforma includes information regarding the primary and

secondary diagnoses, primary and secondary procedures and this should be clearly documented on the form by the clinical staff.

5.3.2 Chemotherapy – activity carried out in the Chemotherapy Suite is recorded on patient attendance sheets. Coders use this information to undertake procedure coding. Diagnosis details are obtained from Lorenzo. Each sheet is signed by the clinical staff.

5.3.3 Endoscopy – activity is coded for the electronic Endoscopy Reports produced by the Unisoft Reporting Tool. Coders use information from the reports along with the Endoscopy Unit Admission Document to undertake procedure and diagnosis coding.

6.0 Outpatient Procedure Coding

6.1 Outpatient procedures are coded using OPCS-4.8

6.2 Where outpatient procedures are carried out at the Trust, the codes are recorded on Outcome Forms by clinical or nursing staff, and input into Lorenzo by administrative staff.

6.3 Where new codes are required the Clinical Coding Manager will ensure that appropriate coding support is provided to managerial, administrative, IT and clinical staff, in the creation of appropriate systems and processes for recording.

6.4 In future there may be a requirement to record ICD-10 codes for certain outpatient diagnoses.

7.0 Clinical Coding Timescales

7.1 At the time of writing the Trust standard agreed with Commissioners for completing Clinical Coding is:

- 98% of episodes to be coded within 4 days of the National SUS Flex Inclusion Date
- 100% of episodes to be coded within 4 days of the National SUS Freeze Inclusion Date

7.2 The Trust is always striving to improve on the coding completion dates and works to improve efficiencies and upon these deadlines.

8.0 Details of Local Policies

8.1 A local policy folder (electronic and hard copy) is kept in the Coding Department with details of any ‘Consultant specification’ coding and local Clinical Coding policies. Example of local policy format is shown in Appendix 1.

8.2 All Coders sign and date each policy to confirm they have read and understood it. Auditors, contractors, bank coders and any new Coders are shown and expected to adhere to these policies.

8.3 The clinician responsible for the procedure should confirm all local policies by signing it.

8.4 All local polices will be reviewed annually.

9.0 The Audit Process

9.1 Clinical Review

9.1.1 The Clinical Coding Auditor Manager attends the Trust's Mortality Review Group and works with the clinicians to review clinical coding on a regular basis.

9.1.2. In addition, clinicians contact the Clinical Coding Team when they have any concerns or queries.

9.2 Internal Audit

9.2.1 The Trust currently has two Clinical Classifications Service Approved Auditors one of which is the department Clinical Coding Auditor Manager.

9.2.2 Internal audit will be performed on a regular basis.

9.2.3 They will be checked for accuracy using the same source information.

9.2.4 The results of the audit are documented and shared with the coder concerned.

9.2.5 The audit should be seen as an objective appraisal, designed to support the Coders in identifying areas where best practice is or is not achieved.

9.3 External Audit

9.3.1 The Trust may be subject to annual Block/PbR audit of Clinical Coding carried out by external auditors co-ordinated by the Department for Health on behalf of commissioners. In preparation for this audit, benchmarking websites (which compares the Trusts Clinical Coding with comparable cases at other hospitals) are reviewed, and the areas for audit are agreed with the Commissioners.

9.3.2 In addition, at least once a year the Trust commission an audit by an external Clinical Classifications Service Approved Auditor.

10.0 Query Mechanism

10.1 Any queries must reference current Clinical Coding material such as the Clinical Coding Instruction Manual ICD-10 and OPCS-4.8 books (volumes I and II),

National Clinical Coding Standards and NHS Digital Clinical Coding guidelines must be made.

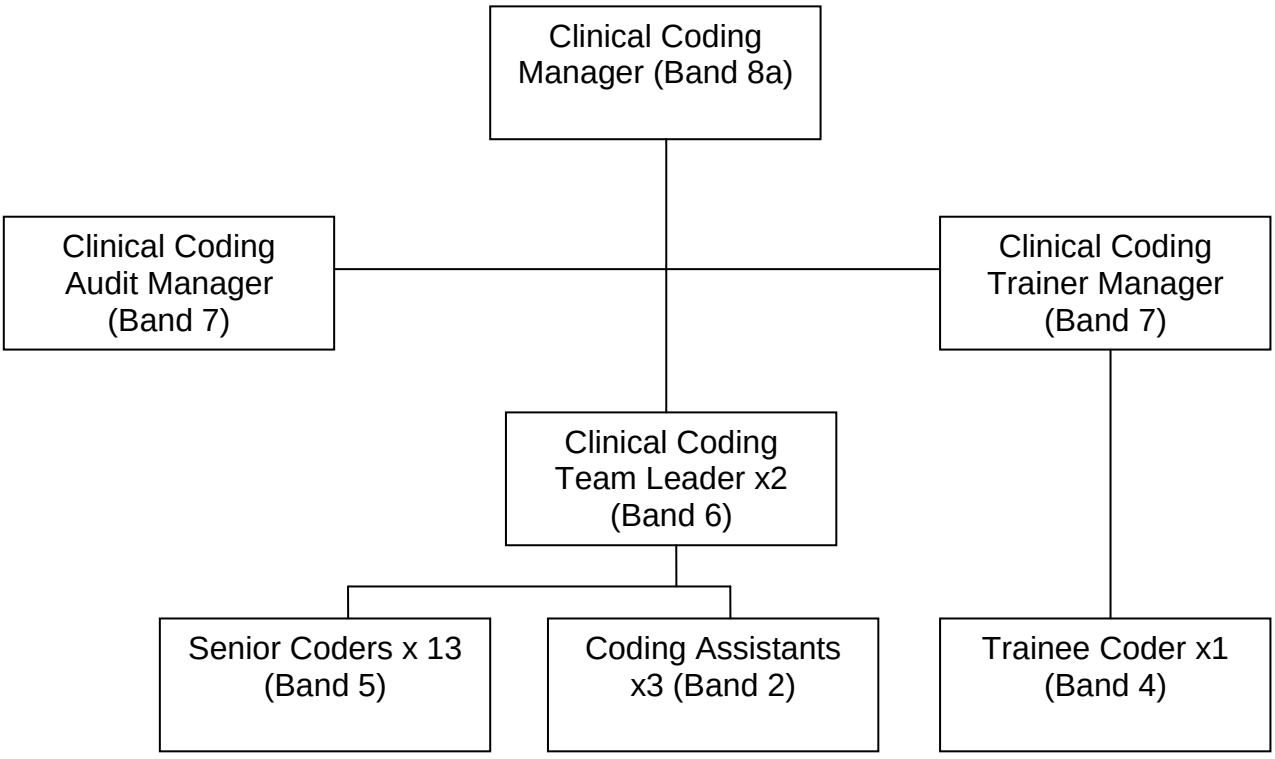
10.2 The departments Clinical Coding Trainer Manager and Clinical Coding Auditor Manager determine whether the query can be resolved internally and if necessary they liaise with appropriate clinician on applicable ICD and OPCS codes.

10.3 All unresolved queries are referred to the NHS Digital Helpdesk, using the process and form detailed on the NHS Digital website.

10.4 Monthly Team Meetings and email are used to share query resolutions and examples of good practice.

11.0 Clinical Coding Team Structure

11.1 The Clinical Coding Team at MEHT is centrally based at Broomfield Hospital. The department structure is as follows:



11.2 The Clinical Coding Team code approximately 120,000 Finished Consultant Episodes per annum.

12.0 Training

12.1 All new Trainee Clinical Coders will be trained by the Clinical Coding Trainer Manager in the use of:

- National Clinical Coding Standards
- ICD-10, International Statistical Classification of Diseases and Related Health Problems
- OPCS-4.8 books (volumes I and II), Office of Population Censuses and Surveys
- Basic Anatomy and Physiology Instruction Manual
- The Coding Clinic Collection

12.2 They will attend a Clinical Classifications Service Coding Standards Course within 6 months of appointment.

12.3 Other support provided includes:

- Training on the relevant computer based systems including Lorenzo and 3M Medicode.
- One to one and 'on the job' support from the Clinical Coding Trainer Manager with support from other experienced Clinical Coders in the department.
- Training lasting for as long as necessary, and until the Trainee Clinical Coder is coding with confidence and accuracy.
- An expectation that within three years of starting coding all Clinical Coders are expected to take the National Clinical Coding Qualification.
- Talks from clinicians to the team on relevant clinical topics.
- Sharing of clinical coding guidance from NHS Digital and other sources as necessary
- Staff who are new to the organisation will also attend the Trust induction programme.

12.4 Thereafter:

- All Coding staff will attend Clinical Coding Refresher Courses run by an approved NHS Digital Trainer
- Attendance on regular NHS Digital approved specialist training courses wherever available and funding permitted
- Attendance on relevant computer training courses to update IT skills.
- Attendance at other relevant training courses including health and safety, fire training, manual handling, security and confidentiality etc.
- Annual Appraisal and opportunities given to all applicable staff to participate in the National Clinical Coding Qualification (UK)
- Annual review of job descriptions to ensure they are regularly updated and amended as necessary to meet the changing role of coding staff.

12.5 Any member of staff who is to undertake National Clinical Coding Qualification (UK) will be supported in attending any necessary Coding Workshops and Revision Course where available.

12.6 A Training Needs Analysis is maintained and accessible electronically to the Coding Team Leaders.

13.0 Appraisals

13.1 These are carried out by line managers on an annual basis, in compliance with the Trusts Appraisal Policy.

14.0 Provision of Training and Support to Non-Coding Staff

14.1 The Clinical Coding Manager and the Team Leaders are responsible for the provision of advice and support in the use of coded data to non-coding staff. Information and support are provided as required on an ad hoc basis.

15.0 Security and Confidentiality

15.1 The importance of establishing the Trust's commitment to data quality should be addressed at the commencement of employment. Users of the Lorenzo and other systems must attend formal training, which is organised by the Trust's Lorenzo trainer or delegated trainer. Users will only be issued with a password by the trainer once adequate training has been completed.

15.2 All staff at the commencement of employment must sign a confidentiality agreement.

15.3 The environment in which users work is important in terms of data quality.

15.4 Supervision of staff using computer systems must allow working practices that enhance quality of work, such as:

- Adequate breaks
- Refresher training
- Reasonable workload
- Access to training materials – hard copy or on the Intranet
- Work stations which comply with health and safety legislation

15.5 All data entry systems should have an audit trail and that should be turned on and used. Any training issues identified in audit must be addressed promptly.

16.0 Emergency Coding

16.1 There are occasions when there no access to computer systems for reasons including system upgrades and system failure. If these issues are expected to last for longer than 60 minutes, Coders are expected to use the Emergency Coding Proforma (Appendix 2).

16.2 Once system access is restored Coders will enter this information in the appropriate electronic system.

17.0 Equality Impact Assessment

17.1 The Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.
(Refer to Appendix 3)

18.0 Review

18.1 This guideline will be reviewed every three years and in response to any significant changes to OPCS or ICD classifications.

19.0 Communication of the Guideline

19.1 The guideline will be uploaded to the intranet and website - this is a Corporate/Governance responsibility.

19.2 The Clinical Coding Manager is responsible for all local communications specifically individually email, team meetings and notice boards.

20.0 Breaches of Guideline

20.1 Any breaches of the guideline should be recorded in accordance with the Incident Reporting and Investigations Policy.

20.2 If necessary, breaches of the guideline may be investigated in accordance with the Trust's Incident Policy and Serious Incident Requiring Investigation Policy.

20.3 Failure to comply with this guideline is likely to result in disciplinary action being taken against the employee.

21.0 References

ICD-10
International Classification of Diseases (ICD) and Related Health Problems 10th Revision 2010 Edition

OPCS Version 4.8
Office of Population Censuses and Surveys (OPCS) Classification of Interventions and Procedures Version 4.8 (April 2017)

Commissioning Minimum Data Sets (CMDS)
https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets

Data Security and Protection Toolkit
https://www.dsptoolkit.nhs.uk/

HED
https://www.hed.nhs.uk/

Clinical Coding Toolbox
https://hscic.kahootz.com/connect.ti/t_c_home/view?objectId=298067

Mid Essex Hospital Services NHS
NHS Trust

Appendix 1

Clinical Coding Policies and Procedures

NAME OF POLICY	Coding Policy Number:	XXX
	Created on:	XXX
	Version:	XXX
	Date of Issue:	XXX
	Date of Review:	XXX

Details:

Policy Agreed By:

Clinical Coding Representative:

Name:	Position:
Signature:	Date:

Clinical Representative:

Name:	Position:
Signature:	Date:

Local Policy Seen & understood by (Policy Number_____):

Name of Coder	Signature of Coder	Date

Appendix 2

Emergency Coding Form

Coded by:

Patient Number	Patient Name	Episode Dates	Diagnosis	Procedures	Procedure Dates

Appendix 3: Preliminary Equality Analysis

This assessment relates to: (please tick all that apply)

A change in a service to patients		A change to an existing policy	✓	A change to the way staff work	
A new policy		Something else (please give details)			

Questions	Answers
1. What are you proposing to change?	Updating guideline to reflect latest terminology, systems, processes and guidance.
2. Why are you making this change? (What will the change achieve?)	To ensure the guideline is accurate and meaningful.
3. Who benefits from this change and how?	Clinical Coding Team and stakeholders.
4. **Is anyone likely to suffer any negative impact as a result of this change?** If **no**, please record reasons here and sign and date this assessment. If **yes**, please complete a full EIA.	No – no change to current practice within the Trust
5. a) Will you be undertaking any consultation as part of this change? **b) If so, with whom?**	Yes – to seek professional approval from those stated in on cover sheet

Preliminary analysis completed by:

Name	Helena Green	**Job Title**	Clinical Coding Manager	**Date**	19th November 2018