NHS
Mid and South Essex
University Hospitals Group

Document Title:	**CLINICAL CODING POLICY**		
Document Reference/Register no:	MSEPO-20213	**Version Number:**	1.0
Document type: (Policy/ Guideline/ SOP)	Policy	**To be followed by:** (Target Staff)	All staff
Ratification Issue Date: (Date document is uploaded onto the intranet)	30 March 2020	**Review Date:**	29 March 2023
Developed in response to:	National Guidance/Recommendations, Best Practice		
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
Issuing Division/Directorate:	Informatics		
Author/Contact: (Asset Administrator)	Helena Green, Clinical Coding Manager		
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):	Joint Information Governance Steering Group	**Date:**	19 March 2020
Professionally Approved by: (Asset Owner)	Caroline Holmes, Deputy Director of Clinical Coding, Data Quality & Health Records	**Date:**	11 March 2020
Ratification Group(s):	Joint Document Management Group	**Date:**	24 March 2020
Executive and Clinical Directors (Communication of minutes from Document Ratification Group	**Date:** April 2020	**Distribution Method:**	Trust Intranet/ Internet

Consulted With:	Post/ Approval Committee/ Group:	Date:
Julie Reynolds	Clinical Coding Site Manager (Basildon) and NHS Digital Approved Trainer	March 2020
Karen Welham	Clinical Coding Site Manager (Southend)	March 2020
Matt Barker	Group Head of Information Governance	March 2020

Related Trust Policies (to be read in conjunction with)	(Refer to the main body of the text) Data Quality Audit Policy

Document Review History:			
Version No:	**Authored/ Reviewer:**	**Summary of amendments/ Record documents superseded by:**	**Issue Date:**
1.0	Helena Green	Newly created combined into MSE Group wide policy. Supersedes MEHT: 07015 Clinical Coding Policy; SUHFT: CM65 Clinical Coding Policy; BUHT: newly created	30 March 2020

Contents

1.0 Introduction

1.1. The principles of this policy outline the responsibilities and practice of the clinical coding process for all inpatient, day case activity and outpatient activity. It applies to all staff within the MSE Group who is involved in the clinical coding function.

1.2. Clinical coding is a process which translates the medical terminology into diagnostic codes using ICD-10 and surgical procedures using OPCS-4.9. The Clinical Coders must adhere to national standards and classification rules and conventions as set out in ICD-10 Volumes 1 - 3, OPCS-4.9 Volumes 1 - 2, National Clinical Coding Standards ICD-10 5th Edition, Clinical Coding Instruction Manual OPCS-4.9 and publications of the Coding Clinic.

1.3. Clinical Coding provides coded clinical information to support mandatory coding requirements and the information required for Commissioning Minimum Data Sets (CMDS), Central Returns on behalf of the Trust and to support local benchmarking tools, such as Healthcare Evaluation Data (HED).

1.4. It is, therefore, essential that the Trust's clinical coding is completed to the required standards and within agreed deadlines.

2.0 Scope

2.1. This policy has been created to promote good practice and consistency of the information during the clinical coding processes. It is also designed to ensure information produced during the coding process is accurate and adheres to local and national policies and national standards.

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

2.3. This policy is intended to cover all inpatient, day case and outpatient Clinical Coding for activity recorded within the MSE Group on Medway and Lorenzo.

3.0 Definitions

TERM	DEFINITION
SUS	Secondary Uses Service (run by NHS Digital) which distributes hospital data within the NHS and provides a data quality report on completeness of data sent
HRG	Healthcare Resource Group – a group of health related activities that have been judged to consume a similar level of resources
ICD-10 5th Edition 2016	International Statistical Classification of Disease and related health Problems – Tenth revision for diagnostic coding
OPCS 4.9	Office of Populations, Censuses and Surveys – Classification

	of Interventions and Procedures
Medicode	Clinical coding encoder which allows codes to be allocated to text entries
Clinical Indicators	Measures of clinical management that create a basis for quality Improvement
CMDS Commissioning Minimum Data Sets	Patient level data sets delivering person based information on activity undertaken by the Trust, used within commissioning and invoicing processes
MSE Group	3 Merged NHS Trusts with main sites at Broomfield, Southend and Basildon.
Payment by Results (PbR)	Tariff based payment system
DSPT	The Data Security and Protection Toolkit is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards.
NHS Digital	NHS Digital
HED	Healthcare Evaluation Data
Medway	Patient Administrative System used by Southend and Basildon sites
Lorenzo	Electronic Patient Record used by Broomfield site

4.0 Roles and Responsibilities

4.1 **Role & Responsibilities within the Trust (Committees)**
Duties are:

4.1.1 Joint **Information Governance Steering Group**– is responsible for the review and approval of clinical coding policies and procedures; and the supervision of compliance with the clinical coding requirements of the Data Security and Protection Toolkit (DSPT).

4.2 **Role & Responsibilities of Individuals within the Trust**
Duties are:

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

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

4.2.3 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-4.9 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;
- 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.

4.2.4 All **Clinical staff** are responsible for:
- Ensuring clinical information contained in case notes and on discharge summaries is clear and legible and is available 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 on 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 patient's decision or another specified 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.

5.0 Clinical Coding Procedures

5.1. 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 4.9.

5.2 The Trust currently uses Healthcare Resource Grouper (HRG) Version 4+. The Trust currently uses the following systems and encoders:

Site	PAS	Encoder
Broomfield	DXC Lorenzo	3M Medicode
Basildon	Medway / Electronic Medical Record (EMR)	3M Medicode
Southend	Medway / Clinical Electronic Document (CED)	3M Medicode

5.3 Coding Sources

5.3.1 The full health record is the source document for coding purposes. These contain:
- Clinical notes;
- Operation sheets;
- GP Letters;
- Discharge summaries.

5.3.2 The Coder extracts all relevant information relating to the patients diagnosis and treatment from the health record. This is then translated into the appropriate coded format and entered onto the sites Medway/Lorenzo system via the 3M encoder software.

5.3.3 Where applicable, coders also supplement information from the health record with pathology or radiology results, found on the relevant IT systems.

5.3.4 In order to meet the Trust targets there are exceptional occasions where coding is undertaken without using the patients full medical record e.g. a patient's discharge summary in isolation. This is done with the aim of not compromising data quality. and coding standards.

6.0 Outpatient Procedure Coding

6.1 Outpatient procedures are coded using OPCS-4.9.

6.2 Where outpatient procedures are carried out at the Trust, the codes are recorded on the relevant sites Medway/Lorenzo system by administrative staff.

7.0 Clinical Coding Timescales

7.1 The Trust target 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 on each site with details of any 'Consultant specification' coding and local Clinical Coding policies.

8.2 All Coders on the relevant site to the policy 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 are reviewed every three years.

9.0 The Audit Process

9.1 Clinical Review

9.1.1 Clinical Coding Auditors attend the site and Group Mortality Review meetings 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.

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 Payment by Results (PbR) audit of Clinical Coding carried out by external auditors co-ordinated by the NHS Digital 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 a 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-4.9 books (volumes I and II), National Clinical Coding Standards and NHS Digital Clinical Coding guidelines must be made.

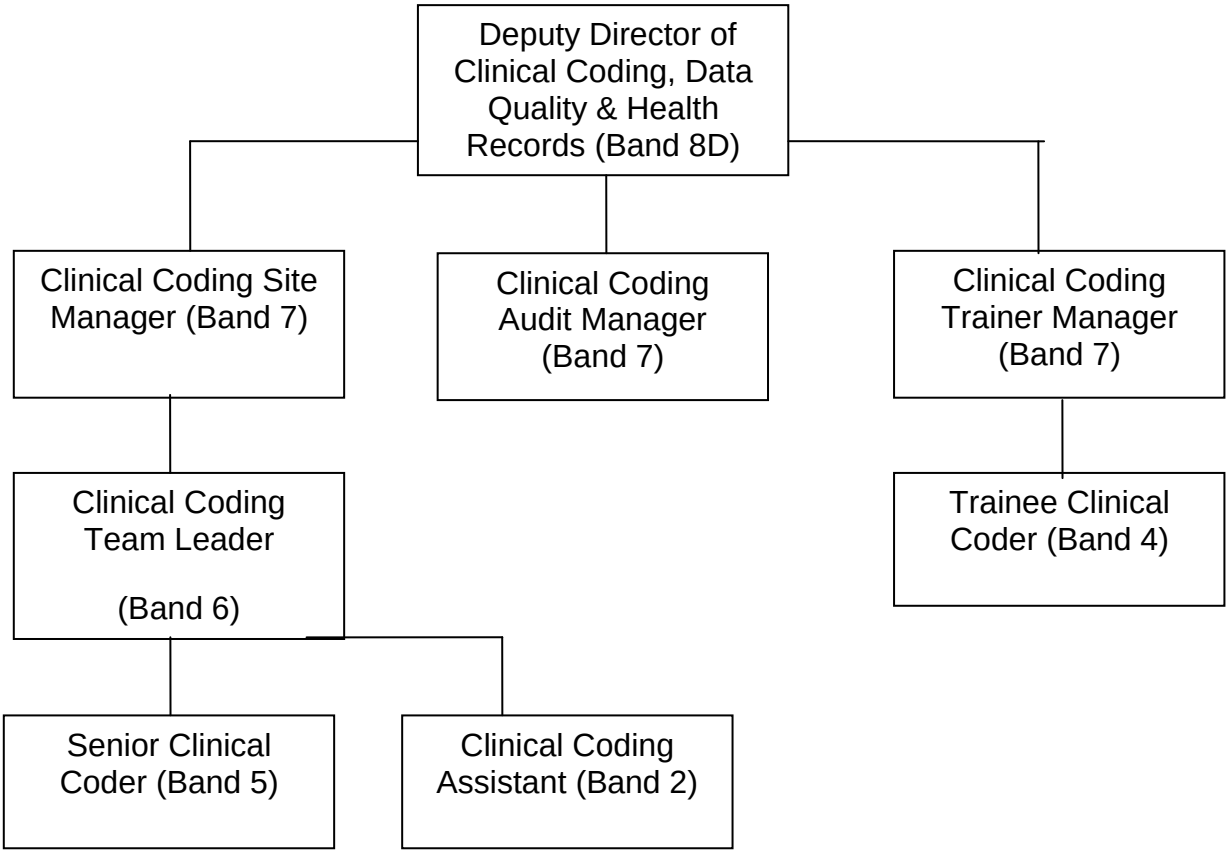
10.2 The Trusts Clinical Coding site managers, Trainers and Auditors determine whether the query can be resolved internally and if necessary they liaise with the appropriate clinician on applicable ICD and OPCS codes.

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

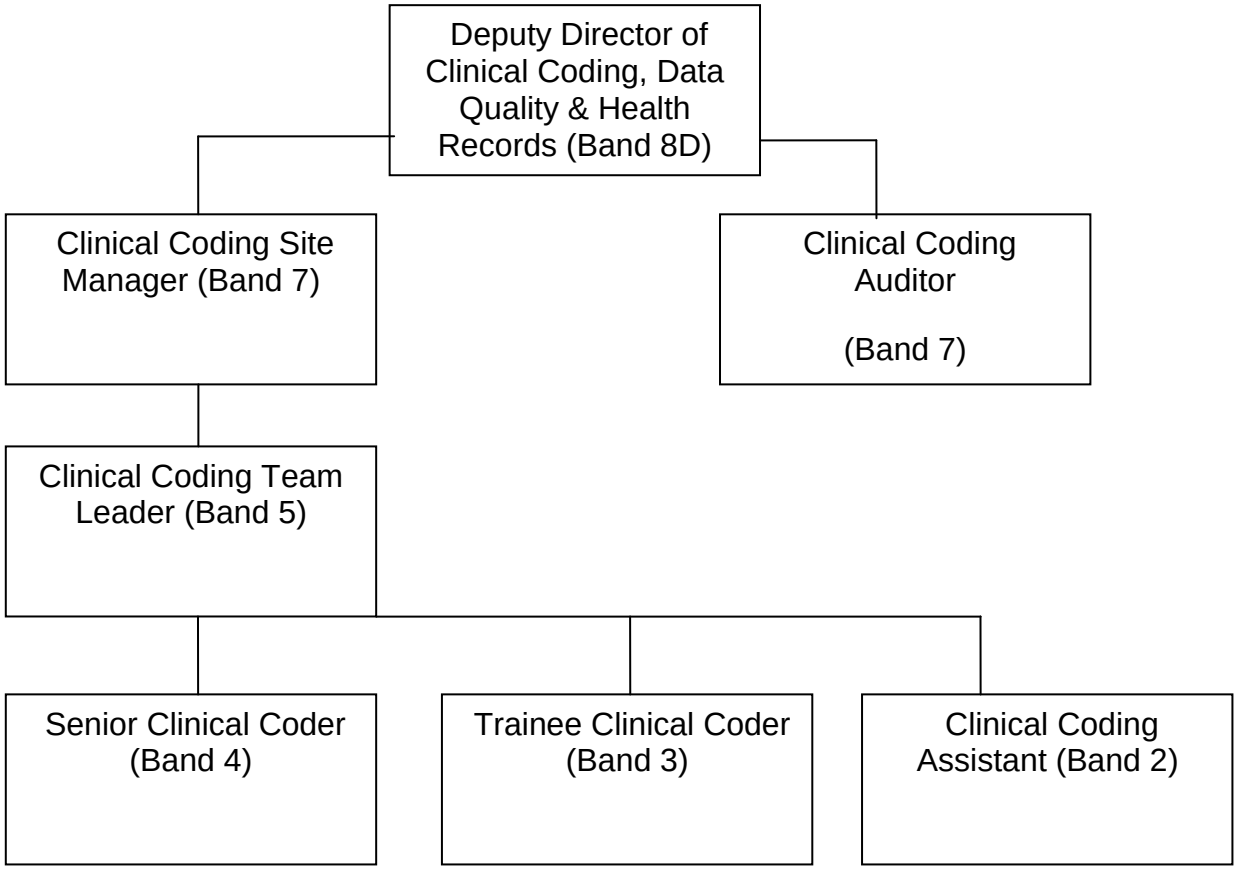
10.4 Team Meetings and email are used to share query resolutions and examples of good practice.

11.0 Clinical Coding Team Structure

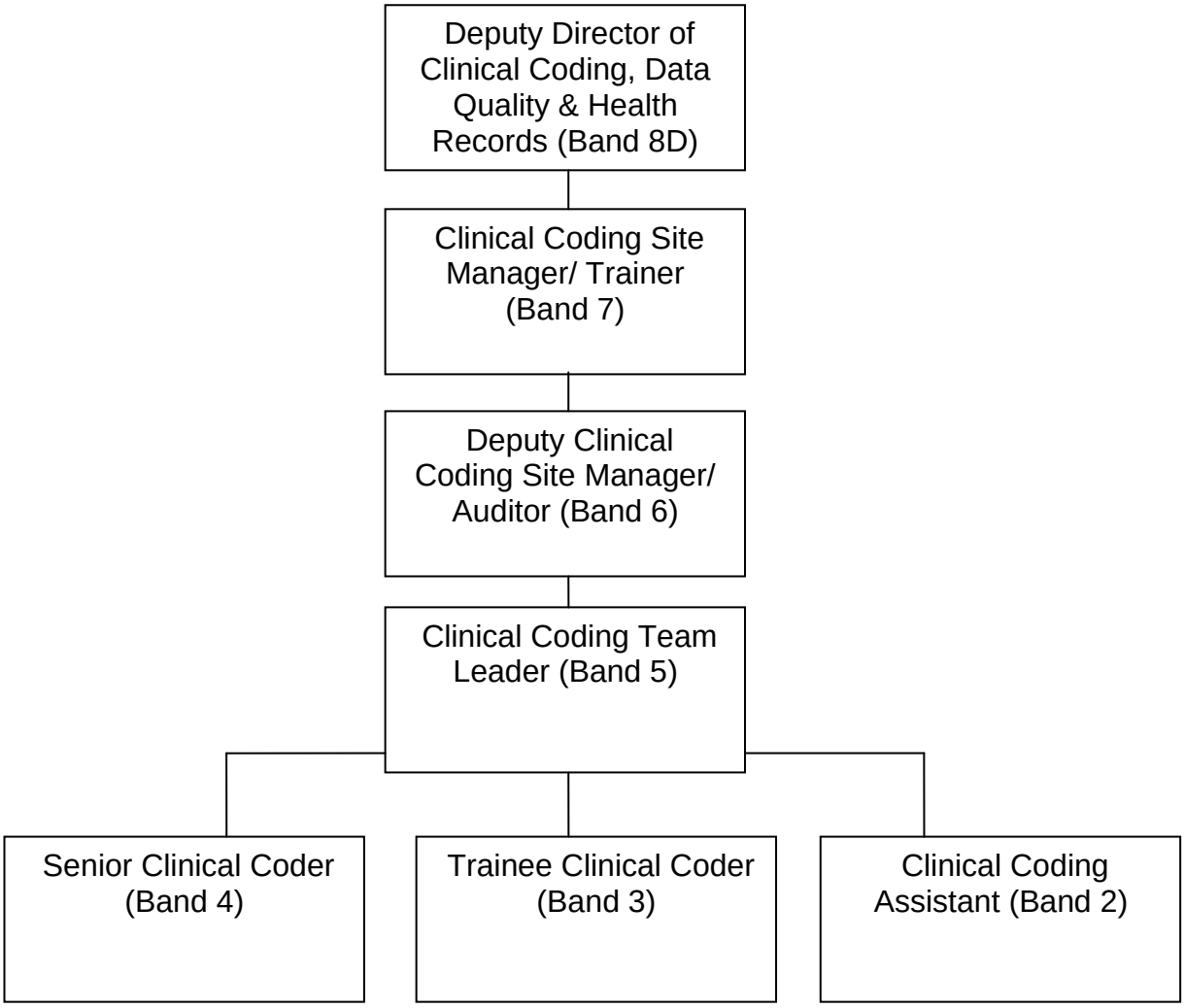
11.1 The department structure for the Clinical Coding team at the Broomfield site is as follows:



11.2 The department structure for the Clinical Coding team at the Southend site is as follows:



11.3 The department structure for the Clinical Coding team at the Basildon site is as follows:



12.0 Training

12.1 All new Trainee Clinical Coders will be trained by the MSE Group Clinical Coding Trainers in the use of:

- National Clinical Coding Standards;
- ICD-10, International Statistical Classification of Diseases and Related Health Problems;
- OPCS-4.9 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 appointments.

12.3 Other support provided includes:

- Training on the relevant computer based systems;
- One to one and 'on the job' support from Clinical Coding Trainers 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.

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 Site Managers, Trainers, Auditors and 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.

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 Equality Impact Assessment

16.1 The Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.
(Refer to Appendix 1)

17.0 Review

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

18.0 Communication of the Policy

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

18.2 The Site Clinical Coding Manager is responsible for all local communications specifically; emailing team communications, scheduling and holding team meetings and updating notice boards.

19.0 Breaches of Policy

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

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

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

Appendix 1: Preliminary Equality Analysis

This assessment relates to: Clinical Coding Policy / MSEPO-20213

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)	Combined MSE Group wide policy		

Questions	Answers
1. What are you proposing to change?	Nothing
2. Why are you making this change? (What will the change achieve?)	To combine 3 site policies into one Group policy
3. Who benefits from this change and how?	All staff working with the clinical coding team
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
5. a) Will you be undertaking any consultation as part of this change? **b) If so, with whom?**	Yes See page 2

Preliminary analysis completed by:

Name	Helena Green	**Job Title**	Clinical Coding Manager (Broomfield)	**Date**	10 March 2020