Cumbria Partnership NHS Foundation Trust

Clinical Coding Policy

Reference	POL/002/093
Version	2
Date Ratified	14/09/2018
Next Review Date	31/12/2019
Accountable Director	Joint Associate Director of Digital Health Care
Policy Author	Data Quality Manager

Please note that the Intranet / internet Policy web page version of this document is the only version that is maintained.

Any printed copies or copies held on any other web page should therefore be viewed as "uncontrolled" and as such, may not necessarily contain the latest updates and amendments.

Policy On A Page

SUMMARY & AIM

This policy has been created with the intention of promoting good practice and consistency of information produced during the clinical coding process at The Cumbria Partnership Foundation Trust, and supports our statutory duties as set out in the NHS Constitution. It has also been designed to incorporate the requirements of the Data Accreditation process to ensure information produced during the coding process is accurate and adheres to National Clinical Coding Standards and the rules and convention associated with the ICD10 and OPCS 4 classifications.

TARGET AUDIENCE:

Clinical Coders and Clinicians and should be read in conjunction with the Data Quality Policy available on the intranet.

TRAINING:

Colleagues involved in the Clinical Coding process will receive the relevant training from accredited coders.

KEY Requirements

All staff at the Cumbria Partnership Foundation Trust are required to understand the principles and processes for assigning clinical codes to medical terminology.

TABLE OF CONTENTS

Contents

1. Summary

The World Health Organisation (WHO) states that 'International Classification of Diseases and Related Health Problems (ICD) is to permit the systematic recording, analysis, interpretation and comparison of mortality and morbidity data collected in different countries or areas at different times. The ICD is used to translate diagnosis and other health problems from words into alpha-numeric code which permits easy storage, retrieval and analysis of data.

The OPCS (Office of Population Censuses and Surveys) Classification of Interventions and Procedures (OPCS-4) is a statistical classification for clinical coding of interventions and procedures undertaken in the NHS reflecting current clinical practice.

2. SCOPE

The scope of this policy is to:

a) Provide accurate, complete, timely coded clinical information to support commissioning, local information requirements and the information required for Commissioning Data Set (CMDS) and Central Returns on behalf of Cumbria Partnership NHS Foundation Trust (the Trust).

b) Input onto the Trust electronic patient systems, accurate and complete coded information within the designated time scales to support the information requirements and commissioning of the Trust.

c) Provide accurate, consistent and timely information to support clinical governance and the Data Accreditation process.

d) 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.

e) Establish a system of continual improvement of clinical coded information within the Trust through systematic audit and quality assurance procedures.

f) Ensure all staff are aware of the Trust's security and confidentiality policies when using patient identifiable information.

g) Conform with information governance guidance and standards

3. Introduction

This document has been produced with the intention of promoting good practice and consistency of clinical coding within Cumbria Partnership NHS Foundation Trust. This document should be used by all members of staff involved in following clinical coding procedures.

This policy conforms to national requirements and Trust policy and procedures which affect the coding process such as patient administration, patient discharge, the recording of deaths, clinical record documentation, clinical record flow, filing and storage.

Clinical coding is the translation of medical terminology describing the reason for patient's encounter such as a patient's complaint, problem, diagnosis, treatment or other reason for medical attention into statistical code to support both statistical and clinical uses.

Clinical coding has many uses. It records clinical activity using information such as clinical diagnosis, symptoms and procedures recorded in patient files. The information is also used to manage and plan future services and contributes to medical knowledge and the development of new methods of treatment. Statistically the information is used to study the incidence of disease and health care planning and directing funding to the correct resources.

It is imperative that clinical and administrative staff provide accurate and timely clinical coding information to meet the timescales for data production deadlines.

All clinical coding policy and procedure decisions made between the team and individual clinicians are fully described, agreed and signed by the relevant personnel within this document. All policies or procedures agreed within the documentation do not contravene national standards or classification coding rules and conventions

.

4. Statement of Intent

All procedures involved in the capture of information for clinical coding purposes are clearly defined in this document to ensure compliance and clarification of individual coding processes.

All quality assurance procedures for staff involved in clinical coding are detailed in the document including audit and data quality measures to ensure continual improvements in the standard and quality of coded data in the Trust.

All changes to clinical coding policies and/ or procedures are detailed in the document in the appropriate manner to ensure that all contributors are in agreement with the current practice. Any alterations to clinical coding practice have change and implementation dates provided within this document and comply with national standards and classification coding rules as set out by the Health and Social Care Information Centre (HSCIC).

All policies or procedures agreed by the Trust do not contravene national standards or classification coding rules and conventions.

All training plans for those involved in the clinical coding process are clearly defined and recorded in this document.

Details of communication arrangements are comprehensive to ensure effective dissemination of information regarding coding, resolutions to queries and changes in coding practice to all staff involved in coding and users of this information.

All confidentiality and security issues incurred during the coding process are detailed in this document to ensure adherence to local and national policies.

5. Definitions

5.1 Clinical Coding

The translation of medical terminology as written by the clinician to describe a patient's complaint, problem diagnosis treatment or reason for seeking medical attention into a coded format which can be easily tabulated, aggregated and sorted for statistical analysis in an efficient and meaningful manner (Clinical Coding Instruction Manual)

5.2 Primary diagnosis definition:

The first diagnosis field(s) of the coded clinical record (the primary diagnosis) will contain the main condition treated or investigated during the relevant episode of healthcare. Where a definitive diagnosis has not been made by the responsible clinician the main symptom, abnormal findings, or problem should be recorded in the first diagnosis field of the coded clinical record.

5.3 Co-morbidities

For the purpose of coding, co-morbidity is defined as:

- Any condition which co-exists in conjunction with another disease that is currently being treated at the same time of admission or develops subsequently and that affects the management of the patient's current consultant episode.

- Co-morbidity is coded according to the ICD-10 diagnosis classification and national clinical coding rules and standards

- It is the responsibility of the responsible consultant to identify and report in the medical record any relevant co-morbidity that co-exists at the time of admission for the hospital.

6. Duties

The Trust is responsible for:

- Ensuring that Cumbria Partnership NHS Foundation Trust has in place a policy and procedure for clinical coding
- Ensuring that a process is in place to monitor the compliance and effectiveness of the clinical coding policy and procedure
- Ensuring a clinical coding team is in place

Joint Associate Director of Digital Health Care is responsible for**:**

The implementation of this policy and for ensuring compliance with this policy

Clinical Directors/Professional Leads / Heads of Service and Care Group Managers are responsible for:

Ensuring that the appropriate standards relating to the capture of diagnosis and procedural coding information is maintained across all services

- Ensuring staff capture the relevant data to enable tracking and monitoring of appropriate nationally and locally defined targets for clinical coding
- Ensuring a high level of accuracy in data capture

Team leaders and Service Managers are responsible for ensuring that:

Appropriate administrative staff are adequately briefed to provide the coding team with initial coding summaries in a timely manner and support the facilitation of access to or provision of full records upon request from which to complete the coding process.

*Discharge summaries should be complete within 2 working days of an inpatient discharge

Clinical Coders are responsible for

- The receipt and collation of discharge summaries or records from clinical teams
- The extraction of primary diagnosis, secondary diagnoses, co-morbidities and treatment information and its translation into the appropriate coded format using the classification rules and conventions as set out in the current WHO ICD10 and OPCS -4 classifications and supplemented by national guidance and standards.
- Inputting diagnostic, procedures/intervention codes for discharged in patient episodes
- Providing advice and guidance to clinical staff over the completion of discharge summaries and general advice to all on the interpretation of clinical coding policies and procedures
    - Reviewing and implementing changes to clinical coding procedures in accordance with national policy and guidance
    - Ensuring that their training is maintained to Data Security and Protection Toolkit standards.

Business Applications Delivery Manager is responsible for:

The Business Applications Delivery Manager has responsibility for ensuring that the systems and processes to manage clinical coding and to comply with clinical coding policy and procedures are in place.

The Data Quality Manager is responsible for ensuring that:-

- Staff involved in clinical coding are appropriately trained
- That the policy and procedures relating to clinical coding are implemented
- That staff on the wards are aware of the importance of timely discharge information

Clinical staff are responsible for:

Ensuring the completion of discharge summaries and or letters as appropriate upon an inpatient's discharge with specific information relating to:

- primary diagnosis
- Secondary diagnosis (co-morbidities)
- Primary procedures/interventions
- Secondary Procedures/interventions

All relevant information regarding treatment must be recorded in the patient file in line with the Trust's and professional record keeping standards.

Clinical staff will also be required on occasion to take part in the validation of clinical coding and the information derived from the recording of clinical activity.

Administration staff:

Staff supporting clinical teams particularly ward clerks and medical secretaries are responsible for assisting clinicians in the timely completion and submission of discharge summaries as appropriate and making case notes available to tight deadlines for the clinical coding team to complete the coding process.

Information Governance is responsible for:

Providing assurance over the clinical coding policy and resultant risk to the Executive Management team.

7. Policy

Clinical coding standards and quality assurance

Clinical coding should be complete, timely, and consistent and should accurately reflect the patient's stay in hospital by capturing the diagnosis, associated comorbidities and procedures/interventions where applicable.

All inpatients receiving health care from the Trust will have a definitive diagnosis recorded where appropriate, when there is no definitive diagnosis all signs and symptoms will be recorded.

Quality assurance procedures including audit measures are included maintaining the high standard and quality of clinically coded data in the Trust.

8. Coding process and source documentation

The system used to code all inpatient wards at the Cumbria Partnership NHS Foundation Trust is RiO. All mental health episodes should be coded using the discharge summary or letter, the medical progress notes are available and are routinely used to add information and specificity. Every effort should be made to find as much information relating to the episode as possible.

The source document for the community wards will be the coding front sheets which are emailed to the shared clinical coding mailbox from the ward clerks at the Individual hospitals.

The clinical coding or administrative staff with responsibility for capturing clinical coding will interpret and translate this information to be entered in a coded format onto RiO within 2 working days of an inpatient discharge.

Clinical teams and support staff are to ensure the timely availability of all discharge details required to complete coding for each patient upon discharge.

8.1 Monitoring of events for coding

The clinical coding team will utilise patient system reports to monitor discharges and outstanding episodes of care. Any delay to the receipt of discharge summaries or clinical coding sheets will result in the coding team contacting appropriate service managers to remind them of the requirements.

8.2 Validation of clinical coded information

As clinical coding is undertaken the clinical coding team will verify that both initial and full diagnosis provided by clinical staff match the type of service providing care to the patient. Anomalies will be taken up and verified with clinical staff.

Routine validation and verification of coding within the clinical coding team will help to identify mis-sequenced or misinterpreted entries to be corrected and re-entered as necessary.

Any validation errors in codes assigned identified retrospectively on Secondary Users Service records (identified from data set submissions) will be examined and corrected accordingly by the clinical coding team.

The clinical coding lead will undertake routine observation and adhoc checking of the work of other clinical coding staff to assess consistency and accuracy, advising on errors and inconsistencies that have been identified.

In line with the requirements of the Information Governance Toolkit an external audit will be undertaken by an accredited auditor of coded records on at least an annual basis and prior to the final submission of commissioning data sets by the Trust. This will be a minimum of 50 finished consultant episodes.

This will validate the effectiveness and completeness of the coding process and determine codes are complete and accurately reflect the patients stay in hospital and adhere to NHS Classifications Service National Coding Standards and rules and conventions.

Three elements of coded accuracy will be tested:

- Individual codes – do they accurately reflect the clinical statements
- Totality of codes - do they represent all the relevant clinical details
- Sequencing of codes - are the codes in the correct sequence as defined by the conventions an rules of the classification

Communications in clinical coding

The application of consistent and uniform standards relating to how coded clinical data is recorded is crucial for reliability and comparability across NHS organisations, for commissioning and PbR requirements

The clinical coding team will:-

- Maintain for reference current volumes of ICD10 and OPCS-4 clinical coding instruction manuals

- Note and observe any Information Standards Notices (ISNs) that affect clinical coding

The ***Coding Clinic*** provides:-

- Standards on coding issues which need nationwide clarification, modification or development to ensure consistent application of coding across the NHS This includes resolutions from the UK Coding Review panel
- Information on new diagnosis and procedures which have a significant impact on data users
- Educational and technical theory and practical examples of classification conventions including national clinical coding standards

Where there is uncertainty over the use or interpretation of diagnosis or conditions or where a certain clinical intervention needs to be recorded, the clinical coding team will liaise with appropriate clinicians over the use of applicable ICD-10 OPCS-4 codes.

Clinical advice given or coding agreed must not contravene the rules and conventions of the classifications or national standards and all relevant staff must be made aware of and comply with these practices.

Clinical coding queries

Any internal clinical coding queries arising from everyday coding of patient files, from new initiatives to recording ad hoc procedures, from anomalies picked up in data sets and errors or queries identified from external audit should be addressed and agreed in a consistent manner.

Patient confidentiality must be maintained throughout any consideration or exchange of information.

Reference should first be made to all current clinical coding material, the coding manuals, *Coding Clinic* supplemented and NHS Classifications Service clinical coding guidelines. Where this does not provide a clear or definitive answer the query should be discussed with senior coding colleagues and appropriate clinical professionals for an opinion.

Any subsequent local agreement must not contravene the rules and conventions of the classifications or national standards.

Where a query remains unresolved, it may be necessary to refer to the national clinical coding query service. This involves the completion a standard pro-forma and anonymisation of information in relation to specific individuals as required.

Any changes to coding practice as a result of audit recommendations or any other means must be agreed in conjunction with the clinical coding team. Any differences in opinion must be clarified through further discussion with auditors and through the national clinical coding query service.

Query resolutions, particularly where a precedent is set, will be recorded, maintained and shared accordingly by the clinical coding team and with clinicians and services as appropriate.

Clinical coding department, structure and training

The Trust will maintain a complement of clinical coding staff sufficient to cover finished consultant episodes, also recognising additional workload associated with local coding arrangements.

All new clinical coding staff will undergo a 12 month induction and training programme. This will include attendance on the clinical coding foundation course and the clinical coding mental health foundation course, in house support and monitoring by the clinical coding lead until judged to be competent.

All clinical coding staff will be offered the opportunity though the annual appraisal and performance review process to undertake the National Clinical coding qualification to become an accredited clinical coder as part of their personal development plan

Attendance on relevant specialist clinical coding training courses and relevant computer training courses including electronic patient record systems to update and maintain IT skills will be completed.

The clinical coding lead will ensure that clinical coding refresher training is planned and delivered as required using NHCIC accredited clinical coding trainers.

Job specifications that contain roles in clinical coding will be regularly reviewed and updated to ensure that they reflect the changing role of coding staff.

Staff involved in clinical coding must ensure that they remain up to date with changes to national, regional and local standards and conventions as communicated through the Coding Clinic, appropriate web sites and responses to queries raised locally, regionally and nationally.

9. Training

Training for compliance with this policy will be identified through the clinical coding training plan

10. Monitoring compliance and Effectiveness

The Health Records and Data Quality Manager will monitor coding completeness. The Data Quality team will liaise with the clinical coding staff over anomalies and missing or potentially erroneous data.

Clinical coding completeness will be reported as a regular performance indicator to the Health Records and Data Quality Group and the Performance Improvement Group.

The Trust will ensure that an annual clinical coding audit across community, mental health and learning disability inpatient services is undertaken and acted upon in order to provide internal assurance that the clinical coding function is performing to expectations and external assurance in relation to meeting Information Governance toolkit requirements covering clinical coding. The expectation is that the Trust will work to ensure that the minimum level 2 of the Information Governance tool kit standard 514 is maintained and will work to achieve level 3 as set out in

Table1 below

The results will be reported to the Information governance Group and the Information Governance Board

Table 1: Information Governance Standard 514 clinical coding audit accuracy score

Coding Type	Level of attainment	
	Level 2	Level 3
Primary diagnosis	>=85%	>=90%
Secondary Diagnosis	>=75%	>=80%
Primary procedure	>=85%	>=90
Secondary Procedure	>=75%	>=80

11. Review and Revision arrangements (including Archiving)

This policy will be developed in consultation with the Information Governance Service and will be signed off through the Policy Monitoring Group

The policy will be available on the Trust intranet site in a read only format

A read only copy will be available in the Policy Folder on the Trust intranet

12. References/ Bibliography

NHS clinical coding classifications available at:
https://digital.nhs.uk/services/terminology-and-classifications/clinical-classifications

NHS Classifications Service and Clinical Coding Toolbox –Delen available at:
https://hscic.kahootz.com/connect.ti/t_c_home/view?objectId=298067

World health Organisation 2016 ICD-10 5th edn.

Health and Social Care Information Centre 2014 OPCS-4 .7 edn.

13. Related Trust Policy/Procedures

CO/POL/002/007 Information Governance Strategic Management Framework
CO/POL/002/064 Data Quality Policy

Aspect being monitored	Monitoring Methodology	Reporting		
		Presented by	Committee	Frequency
What	How	Who	Where	How often
Quality of Coding	DQ Audit and External Audit	DQ Manager	IG Performance/*IG Board	Monthly/Quarterly

ABBREVIATION	DEFINITION
ICD	International Classifications of Diseases
OPCS	Office of Population Censuses and Surveys

14. DOCUMENT CONTROL

Equality Impact Assessment Date	23/08/2018
Sub-Committee & Approval Date	*IG Board 21/9/2018*

History of previous published versions of this document:

Version	Ratified Date	Review Date	Date Published	Disposal Date
0.1	25/10/2013	30/12/2013		
1.0	16/12/2013		09/12/2013	

Statement of changes made from version

Version	Date	Section & Description
1.1	23/08/2018	• Minor changes throughout document, to bring up to date.
		•
		•

List of Stakeholders who have reviewed the document

Name	Job Title	Date
All members of TWCGG	Various	-