The Royal Wolverhampton NHS Trust

OP92
Clinical Coding Policy

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1.0 Policy Statement

1.1 Clinical Coding is the process of converting clinical statements into a nationally and internationally recognised format for use by the Trust for a number of purposes including commissioning and payment for services, data reporting for Hospital Episode Statistics (HES) and benchmarking of services.

1.2 The data submitted to the national data clearing house Secondary Users Service (SUS) is further utilised by various 'watchdog' organizations such as Healthcare Evaluation Data (HED), Summary Hospital Level Mortality Indicator (SHMI), Hospital Standardised Mortality Ratio (HSMR) and CHKS (Capita).

1.3 Clinical Coding has a variety of uses and represents the activity performed by the Trust it is therefore vital that the data created and submitted must be accurate, complete and timely.

1.4 This document lays out which procedures the department will employ in order to accomplish the necessary accuracy, completeness and timeliness while maintaining strict patient confidentiality in line with Caldicott guidelines.

1.5 This policy will apply to Clinical Coding done throughout The Royal Wolverhampton NHS Trust. Any Clinical Coding done in Outpatients, Inpatients and the Community is included in this policy.

In adhering to this Policy, all applicable aspects of the Conflicts of Interest Policy must be considered and addressed. In the case of any inconsistency, the Conflict-of-Interest Policy (OP109) is to be considered the primary and overriding Policy.

2.0 Definitions

2.1 **ICD** - International Classification of Diseases and Health Related Problems. This is issued by the World Health Organisation; the Trust will ensure the most up to date version is used after each/any update.

2.2 **OPCS - Office of Population Censuses and Surveys** Classification of Interventions and Procedures which is issued by the Stationery Office in the UK. The Trust will always use the most up to date version.

2.3 **Patient record** is defined as all information held on the medical treatment of a given patient by the Trust.

This includes all paper based and electronic information in any system to which clinical personnel routinely add information and from which data regarding the diagnoses and treatment of patients can be extracted. Such records will by necessity be auditable.

2.3.1 **Auditable** is a term applied to source documentation. It means that the information remains available permanently and may be accessed to prove the validity of a coding assignment when necessary.

2.4 **National Clinical Coding Standards** are defined as the instruction, advice and information issued by NHS Digital in its Clinical Coding instruction manuals for ICD (International Classification of Diseases) and OPCS (Classification of Interventions and Procedures) as well as information in the periodically issued Coding Clinics where such instructions have not been superseded by newer instruction.

2.5 **Local Agreement/Policy** is an agreed code or process at a local level. This is done when there is a need to code a diagnosis or procedure where no national guidance is available. No local agreement may violate a national guideline for any reason. This is agreed and documented by the Coding Manager and Medical/Clinical Director.

2.5.1 Where a local agreement has been created and guidance is later issued by the national body, such guidance will immediately replace any local agreement for all future instances.

2.6 **Audit** refers to the latest version of NHS Digital Clinical Coding Audit Guidelines. An Audit will be carried out in accordance with these guidelines and those mandated by the Data Security & Protection Toolkit.

2.7 **Finished Consultant Episode (FCE)** - a subdivision of a hospital spell in which a specific consultant has responsibility for a patient's care. A hospital spell can be comprised of one or more FCEs.

2.8 **Caldicott** refers to confidentiality principles laid down in the NHS code of practice.

3.0 Accountabilities

3.1 **Chief Financial Officer** Ultimate responsibility for adherence to this policy and the lead Director who will report to the Trust Board on Clinical Coding.

3.2 **Specific Responsibilities of Directors** Medical Director, Chief Nurse and Chief Operating Officer have a responsibility for ensuring the implementation of this policy and its procedural development within the Divisions, and to directly manage the performance of divisions.

3.3 **Head of Clinical Coding & Data Quality** is responsible for the adherence to the policy and will investigate/correct or cause to be investigated/corrected any violations of the policy.

3.4 **The Coding Team Manager/s** are responsible for maintenance of the training log and assuring all coders are up to date in specialty coding and working towards qualification from the national body.

3.5 **Clinical Coding Personnel** must be accredited as competent in the knowledge and use of national standards for coding. In order to assure the Trust that this is the case, all coders will undertake yearly training and development opportunities in the field of coding.

Once every 2 to 3 years coders will attend refresher and update training. All coders will work towards undertaking and passing the National Clinical Coding Accreditation (NCCQ/ACC).

3.5.1. It is the policy of the Clinical Coding Department/team that all personnel will become accredited as coders as a condition of employment in the case of new coders and as a condition of passing incremental salary 'gateways' in the case of coders who have been employed for a longer period.

3.5.2 All coders must undertake offered training and show competence by evaluation at the end of such training.

3.5.3 All coders must rotate through the various coding 'teams' in order to become competent in all areas of coding within the Trust.

3.6 **Group and Directorate Managers** are responsible for aiding any investigations, implementing local processes to address any coding or data quality issues affecting the clinical coders' function.

3.7 **Consultants and all other Clinical Staff** are responsible for making sure that all data entered into the patient record is complete and legible. All records must include all diagnoses, co-morbidities and procedures that have occurred.

Consultants are responsible for the quality of the clinical information gathered by the doctors whom they supervise on the patients for whom the Consultants have clinical responsibility.

3.8 **All Staff Members** are responsible for making sure that any patient record and the data contained therein is accurate, complete and available for the Clinical Coding Department to be able to fulfill their job role.

4.0 Policy Detail

4.1 Diagnostic Coding

All diagnostic coding will be done using the latest version of ICD following all its rules and conventions.

4.2 Procedure Coding

All procedure coding will be done using OPCS (Classification of Interventions and Procedures) following all its rules and conventions.

4.3 Outpatient Clinical Coding

Non-admitted activity is not comprehensively Clinically Coded at the Trust. Where specific procedures are undertaken (e.g., chargeable under Payment by results), the relevant OPCS codes will be agreed with the Head of Clinical Coding & Data Quality and/or Clinical Coding manager. The possible procedure codes will be selectable on the clinic outcome form and the OPCS code entered onto the Patient Administration System by the Data Input Clerk

4.4 All information on the diagnosis and treatment of patients in the Trust which is held in any medium will be used by the Clinical coders in order to create the most complete, and accurate record of the patient's stay in hospital.

4.5 Emergency Department Attendances

Emergency Department Attendances SNOMED_CT codes are applied to activity during the clinical episodes by the clinician responsible for the patient's care. There are also local administrative staff who ensure good data coverage retrospectively. This provides indicative coding information for payment and activity information but is not recorded to Classification standards

4.6 Community/Primary Care

Community/Primary Care attendances/activities applied during the clinical episodes by the clinician responsible for the patient's care, these are then subsequently mapped into SNOMED_CT codes There are also local administrative staff who ensure good data coverage retrospectively. This provides indicative coding information for payment and activity information but is not recorded to Classification standards

4.7 Performance Indicators

Every whole-time equivalent coder will code from 7000 up to 7500 finished consultant episodes yearly. This is in line with NHS Digital Guidance. The accuracy of this coding must be 90% at audit. Any coder who codes fewer episodes or with less than 90% accuracy will be supported to improve to the standard. Continued failure to meet the standard will be considered a matter of capacity and capability to fulfill the function of the job.

4.8 No coder will make any agreement with a Consultant or other clinical personnel regarding the coding of any specialty.

All such agreements will be made only by the Head of Clinical Coding & Data Quality in conjunction with a Clinical Director.

4.8.1 All original signed local agreements will be held in the Clinical Coding Policy and Procedures Document in the Coding Office. Other copies may be held electronically.

4.9 Regular audit of all coded specialties will be carried out on a rolling monthly basis. Audit will be carried out using the most recent version of NHS Digital Methodology and reported to the Clinical Director and Directorate Manager for the specialty in question. A 200 case note Data Security and Protection Audit will be commissioned by the Trust in line with Data Security and Protection Toolkit requirements yearly.

4.10 All coders will have training in Caldicott principles and will maintain these standards while carrying out their duties. Any breach of confidentiality will be considered a disciplinary offence.

4.11 Clinician involvement in the verification of Clinical Coding is mandated by the Data Security and Protection toolkit. In order to comply with this requirement all coded episodes of patients who decease in hospital will be forwarded to the Consultant in charge of the patient at the time of their death. This will necessarily include patients from all areas. The coding will be verified by the Consultant with any changes noted. The changes will then be made on the PAS system.

5.0 Financial Risk Assessment

1	Does the implementation of this policy require any additional Capital resources	No
2	Does t h e implementation of this policy require additional revenue resources	No
3	Does t h e implementation of this policy require additional manpower	No
4	Does the implementation of this policy release any manpower costs through a change in practice	No
5	Are there additional staff training costs associated with implementing this policy which cannot be delivered through current training programmes or allocated training times for staff.	No
	Other comments	

6.0 Equality Impact Assessment

An Equality Impact Assessment was completed. No issues identified.

7.0 Maintenance

The policy will be reviewed every three years by the Information Governance Steering Group. The policy will be reviewed and ratified earlier if there are changes to coding guidance which affect the policy and operations of the Clinical Coding Department. The Head of Clinical Coding & Data Quality will be ultimately responsible for the contents of this policy.

8.0 Communication and Training

8.1 The Clinical Coding policy will be available on the Trust Intranet.

8.2 Details of training courses attended and scheduled are held by the Clinical Coding Divisional Manager in a training and development electronic file.
The Trust recognises the need for Clinical Coders to participate in all the relevant training courses. This is to endorse national standards, rules, and conventions of ICD and OPCS. Also, to create an awareness of the importance and eventual use of the data e.g., Clinical Governance, local management and national statistics etc.

There is an induction and training programme for all new clinical coding staff which includes attendance on the Clinical Coding Standards Course and specialist workshop training, with continual in-house training via ACC qualified mentorship. Attendance is also required on the Trust's own induction course which covers Security and Confidentiality, Health and Safety, Risk Management etc.

The Trust in accordance with the Data Security & Protection Toolkit will maintain the following:

- Attendance is required on a Clinical Coding Standards Course within six months of appointment for all new coding staff;
- Attendance is required on the Clinical Coding Refresher Training Course every three years for experienced Clinical Coding staff;
- Attendance is required on updated Clinical Coding specialty workshops as necessary.

All training will be delivered by an NHS Classifications service approved Clinical Coding Trainer using only materials developed by the NHS Classifications service as specified in the IG Toolkit requirement 510.

Attendance is required on relevant computer training courses to update IT skills and to reinforce Information for Health objectives.

All Clinical Coding staff are required by contract to sit and attain the National Clinical Coding Qualification (UK) within a reasonable time scale (i.e., two years).

8.3 Training Programme for Healthcare Professionals

As the medical staff change over regularly, training in their responsibilities to clinical coding and ensuring data quality is now incorporated into the induction process. A slot at every induction course has been allocated specifically to Clinical Coding. Training is delivered by the Clinical Coding Manager by way of a presentation, handouts and a question-and-answer session.

The Clinical Coding department aim to train and highlight to all healthcare professionals the importance of clinical coding and the impact incorrect coding can have on the trust, initiatives such as attending ward rounds to assist in the real-time completion of discharge summaries and regular communication with key staff are at the forefront of the coding departments desired outcomes.

9.0. Audit

At regular intervals prior to the Secondary Users Service (SUS PbR) Submission Timetable the Information and Data Quality departments will provide the Clinical Coding Department with various files taken from the PAS system consisting of ICD and OPCS coding for the current deadline month (CDS format-based file), which has been entered onto the PAS System for all Specialties by the Clinical Coders since the last validation point.

The ICD and OPCS code columns are then checked for inappropriate codes or errors as a team. The errors are then reviewed and discussed in a team meeting and PAS is amended accordingly.

The Head of Clinical Coding & Data Quality is involved in the discussion of accuracy of coding in the Mortality Review meeting.

Criterion	Lead	Monitoring method	Frequency	Committee/ Group
Data Security & Protection Toolkit	Head of Clinical Coding and Data Quality	Data Security & Protection Toolkit	Yearly	Information Governance Steering Group
Regular audit of all coded specialties	Head of Clinical Coding and Data Quality	NHS Digital Audit Methodology	Monthly basis, rolling program across specialties	Clinical Director and Directorate Manager for the specialty in question.
Clinician Involvement	Medical Director/Head of Clinical Coding and Data Quality	Initially reports from paper returns moving to Web based reporting	Bi-Monthly	Mortality Review Group (MRG)

10.0 References

- Data Security & Protection Toolkit https://www.dsptoolkit.nhs.uk/
- NHS Digital https://digital.nhs.uk/
- Data Protection Act 2018 https://www.gov.uk/data-protection/the-data-protection-act
- Freedom of Information Act 2000 https://www.gov.uk/make-a-freedom-of-information-request/the-freedom-of-information-act
- Department of Health Confidentiality NHS Code of Practice (2003) Confidentiality: NHS Code of Practice Supplementary Guidance: Public Interest Disclosures (2010): https://www.gov.uk/government/publications/confidentiality-nhs-code-of-practice
- Caldicott 2 Principles 2020
- Data Protection Act 2018
- OP91 Data Quality Policy
- OP41 - Induction & Mandatory Training Policy
- OP97 - Confidentiality Code of Conduct for Staff
- OP07 - Health Records Policy
- OP12 - IT Security Policy
- OP13 - Information Governance & Data Protection Policy

Document Control

<table>
<tr><td>Policy number and Policy version:
OP92 V4</td><td>Policy Title
Clinical Coding Policy</td><td colspan="2">Status:

Final</td><td>Author: Head of Clinical Coding & Data Quality

Director Sponsor: Chief Finance Officer</td></tr>
<tr><td rowspan="5">Version / Amendment History</td><td>Version</td><td>Date</td><td>Author</td><td>Reason</td></tr>
<tr><td>1</td><td>March 2012</td><td rowspan="3">Head of Clinical Coding & Data Quality</td><td>3 Yearly Review</td></tr>
<tr><td>2</td><td>Sept 2015</td><td>3 Yearly Review</td></tr>
<tr><td>3</td><td>May 2019</td><td>3 Yearly Review</td></tr>
<tr><td>4</td><td>Oct 2022</td><td></td><td>3 Yearly Review</td></tr>
<tr><td colspan="5">Intended Recipients: All Trust Staff</td></tr>
<tr><td colspan="5">Consultation Group / Role Titles and Date: Information Governance Steering Group (IGSG) Mar 2019, Information Governance Action Group (IGAG) March 2019 Data Quality Subgroup Feb 2019, Policy Committee June 2019</td></tr>
<tr><td colspan="2">Name and date of Trust level group where reviewed</td><td colspan="3">Information Governance Steering Group, Oct 2022
Activity & Data Quality Subgroup Oct 2022
Trust Policy Group – November 2022</td></tr>
<tr><td colspan="2">Name and date of final approval committee</td><td colspan="3">Trust Management Committee – January 2023</td></tr>
<tr><td colspan="2">Date of Policy issue</td><td colspan="3">February 2023</td></tr>
<tr><td colspan="2">Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated)</td><td colspan="3">November 2025(every 3 years)</td></tr>
<tr><td colspan="5">Training and Dissemination: rolling program by Head of Clinical Coding & Data Quality</td></tr>
<tr><td colspan="5">To be read in conjunction with: OP91 Data Quality Policy.</td></tr>
<tr><td colspan="5">Initial Equality Impact Assessment (all policies): Completed Yes Full Equality Impact assessment (as required): Completed / NA If you require this document in an alternative format e.g., larger print please contact Policy Administrator 8904</td></tr>
<tr><td colspan="2">Monitoring arrangements and Committee</td><td colspan="3">Information Governance Steering Group.</td></tr>
<tr><td colspan="5">Document summary/key issues covered. This Policy is designed to ensure that the importance of Clinical Coding to the Royal Wolverhampton NHS Trust is disseminated to</td></tr>
</table>

appropriate staff. It will describe the meaning of Clinical Coding, who is responsible for its maintenance and how it will continue to improve in the future.	
Key words for intranet searching purposes	Clinical Coding

Implementation Plan template for Strategy / Policy / procedural documents

To be completed showing all implementation requirements and attached to the policy when submitted to the appropriate committee for consideration / approval.

Title of document:	Clinical Coding Policy – OP92		
Reviewing Group	Trust Policy Committee		**Date reviewed:**
Previous document already in use?	Yes	**Implementation lead: Print name and contact details**	Joanne Cotterell Head of Clinical Coding & Data Quality Ext 5543
If yes, state name, in what format and where located?	Clinical Coding Policy – OP92 Organisational Policies		

Implementation issues to be considered (add additional issues where necessary)		
Implementation Issue	**Action Summary**	**Action lead / s (Timescale for completion)**
Strategy; **Consider** (if appropriate) 1. Development of a pocket guide of strategy aims for staff 2. Include responsibilities of staff in relation to strategy in pocket guide.	NA	NA
Training; Consider 1. Mandatory training approval process 2. Completion of mandatory training form	Review Training Requirements for all areas involved with Clinical Coding	Head of Clinical Coding & Data Quality
Development of Forms, leaflets etc; Consider 1. Any forms developed for use and retention within the clinical record **MUST** be approved by Health Records Group prior to roll out. 2. Type 3. Quantity required 4. Where they will be kept / accessed 5. Where stored when completed	NA	NA
Strategy / Policy / Procedure communication; Consider 1. Key communication messages from the policy / procedure, who to and how?	Updated Policy awareness • Add to updated policy list on intranet site • All users bulletin to raise awareness	Head of Clinical Coding & Data Quality (Oct 2022)
Financial cost implementation Consider 1. Business case development	NA	
Other specific Policy issues / actions as required e.g., Risks of failure to implement, gaps or barriers to implementation		