University Hospitals of Derby and Burton NHS Foundation Trust

TRUST POLICY FOR CLINICAL CODING

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POL-IG/1778/09	5	Final	Celine Barrett **Job Title** Head of Coding

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	1	11.6.09	Jane McFarlane	Updated to comply with NHSLA standards
	2	16 4 13	Melanie Holmes	Updated to comply with NHSLA standards
	3	1.3.16	Jane McFarlane	Updated to comply with NHSLA standards
	4	18.2.19	Celine Barrett	Update on Creation of UHDB
	5	18.2.22	Celine Barrett	

Intended Recipients: All staff within the Clinical Coding Department, the Associate Director – Medical Directors Office, Executive Medical Director and Clinical staff. This Policy is also made available to external clinical coding auditors as required.		
Training and Dissemination: Via the intranet and internally by the Clinical Coding Management team and Clinical Coding Team Leaders.		
To be read in conjunction with: Clinical Coding procedures relating to National Coding Standards for ICD10 (International Statistical Classification Of Diseases) and OPCS4 (Classification of Interventions and Procedures)		
In consultation with and Date: Information Governance Steering Group		
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Contact for Review	Celine Barrett
Executive Lead Signature	Executive Medical Director
Approving Executive Signature	Executive Medical Director

Trust Policy for Clinical Coding

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1. Introduction

This document has been formulated with the intention of promoting good practice and consistency of information produced during the clinical coding process in University Hospitals of Derby and Burton NHS Foundation Trust. Policies relating to Clinical Coding need to conform to the NHS Digital Clinical Coding Classifications Service advice for the content and format of such policies as these form part of the NHS Digital clinical coding audit process. Coded information must be accurate and adhere to NHS Digital Clinical Coding Classifications Service Clinical Coding Standards.

It is vital that this Policy is implemented and adhered to by all personnel involved in the clinical coding process.

2. Purpose and Outcomes

NHS Trusts must ensure that the accuracy of their coded data meets the required levels to achieve the Data Quality section of Data Standard 1 in the Data Security and Protection Toolkit.

Coded information supports a wide range of work in the NHS on a national level but also ensures that local business functions can run smoothly and be well informed. Coding must be therefore accurate, complete and timely to ensure there is no funding loss. Clinically coded data also supports commissioning, local information requirements and information required for the Commissioning Minimum Data Set (CMDS) and Central Returns. Coders are reliant on clear and complete clinical information from clinicians to ensure the most appropriate code is allocated and entered onto the Trust's Patient Administration System.

Due to the introduction of Payment by Results and the NHS 09 / 10 Standard Contract for Acute Trusts for submitting patient data, coding departments must ensure that deadlines for the completion of coding are 30 days post discharge; the Trust would lose funding as a result of late completion of coding. To enable these deadlines to be met and to avoid any backlog, coding must be completed within 3 working days of discharge. It is therefore necessary to ensure effective and timely casenote flows.

3. Definitions Used

'Secondary Uses Service' – a system for processing data flows necessary to support Payment by Results

4. Key Responsibilities / Duties

Associate Director – Medical Directors Office

Overall responsibility for the Clinical Coding Department which is part of the Medical Director's Office portfolio.

Head of Coding

The Head of Coding is and Accredited Clinical Coder, responsible for the strategic management of the clinical coding department, ensuring that deadlines are met and that this Policy is understood and applied by relevant staff.

Clinical Coding Manager

The Clinical Coding Manager is an Accredited Clinical Coder and HSCIC Approved Clinical Coding Auditor. This role deputises for the Head of Coding.

As an HSCIC Approved Clinical Coding Auditor there is responsibility for ensuring a robust programme of internal clinical coding audit is in place to monitor progress towards achieving high quality clinically coded data.

Clinical Coding Team Leader

Responsible for ensuring members of the coding team fulfil the requirements of the Policy.

Clinical Coding Staff

All staff involved in the allocation of codes to describe diagnoses and procedures have a responsibility to ensure that these are accurate and conform to National Coding Standards.

Information Governance Steering Group

This group is responsible for approving clinical coding audit reports generated from monthly clinical coding audits and ensuring that any relevant actions detailed on the associated action plans are implemented.

Medical staff

Responsibility to ensure that all clinical documentation relating to a hospital stay is accurate, timely and consistent.

5. Implementing the clinical coding Policy

5.1 All procedures involved in the capture of information for coding purposes are outlined in the locally held clinical coding procedures file.

5.2 Casenotes in conjunction with information held within the patient's electronic patient record on Meditech (Burton Site) and other clinical information systems (Derby site) are used as the source of information for the majority of specialities. The electronic patient record only is the source of information for the following specialities / areas.

Burton Site

- All specialities except Ophthalmology, Plastics and ENT

Derby Site

- Endoscopy
- SAU / SAUV
- MAU
- SCBU
- NICU
- PICU
- Puffin

- Sunflower
- Dolphin
- CDC
- CCSV
- Oncology
- CDU
- SPOD
- EDC
- MDU
- RDC
- PHS
- Ward 204 OAU
- Ward 207 OAU
- Obstetrics
- PAU

5.3 Information relating to agreed clinical coding deadlines is held locally, copies are held in all coding offices. The Clinical Coding Team Leader monitors the system to ensure deadlines are achieved. The impact on coding due to late entries on the Patient Administration System or incorrect admission, transfer and discharge details is huge – any such issues are highlighted to the relevant Data Quality Support Officer for escalation.

5.4 Incomplete coding reports are generated daily Monday – Friday to ensure that focus on deadlines is maintained. The clinical coders are each responsible for checking these to ensure no episodes remain uncoded at deadline.

5.5 A weekly report is generated by the Clinical Coding Leads which shows any episodes where an 'ungroupable' (U) HRG code has been generated. Immediate action to rectify any such episodes is required to avoid funding loss.

5.6 Every effort is made to ensure that clinicians are aware of their responsibility to provide accurate and clearly documented information relating to diagnoses and procedures. A system of validating coded information with consultants is in place.

5.7 All quality assurance procedures relating to clinical coding audit are documented locally and adhere to the most up to date NHS Digital Clinical Coding Audit Methodology for Approved Clinical Coding Auditors. Any changes to codes are documented in the Clinical Coding Instruction Manuals for both ICD10 and OPCS4

5.8 In the case of queries, any decisions on the most appropriate code to use are made between the Clinical Coding department and relevant clinicians. Documentation relating to these is held within the coding department; changes to current practice are disseminated to clinical coders at regular team meetings.

5.9 Training plans for all members of the clinical coding team are held locally and updated regularly. Only clinical coding training courses approved by NHS Digital are commissioned by the Trust; all training is therefore carried out by NHS Digital Approved Clinical Coding Trainers and all courses are endorsed by NHS Digital.

5.10 The Trust is committed to supporting coders achieving Accredited Clinical Coder status.

5.11 Job descriptions and person specifications are held within the department for all clinical coding staff.

6. Monitoring Compliance and Effectiveness

The clinical coding department aims for 100% accuracy when recording diagnoses and procedures. The required levels to support the Data Quality section of Data Standard 1 in the Data Security and Protection Toolkit are.

Mandatory Level	90% primary diagnoses and procedures correct
	80% secondary diagnoses and procedures correct
Advisory Level	95% primary diagnoses and procedures correct
	90% secondary diagnoses and procedures correct

Internal audits are carried out on a random sample of at least 50 finished consultant episodes (FCEs) each month. In addition, an audit of 200 FCEs is carried out once yearly to fulfil Data Standard 1 in the Data Security and Protection Toolkit.

NHS Trusts are audited regularly, based on national benchmarking analysis of hospital activity data. Copies of audit reports are sent to relevant members of the Executive Team, Information Governance Steering Group and relevant clinicians. These are also available for sharing with the Clinical Commissioning Group on request. Conclusions and recommendations are included in these reports; the Head of Coding develops an action plan based on these.

7. References

This should refer to procedures, manuals, external publications, regulations, law etc. And indicate where these can be obtained from (web site details). They must be in Harvard Style.

Source of data	**Date of publication / issue**	**Detail of requirement**
NHS Digital	National Clinical Coding Standards ICD10 5th edition 2021 edition	Accurate data for quality information
	National Clinical Coding Standards OPCS4 2021 edition	Accurate data for quality information