Leicestershire Partnership NHS Trust

Clinical Coding Policy and Procedure

This Policy describes good practice and consistency of information produced during the clinical coding process in LPT. This document should be used by the clinical coding team to document coding policy and procedures within the trust, which have been agreed with personnel involved in the coding process, including relevant clinicians.

Key Words:	Clinical Coding	
Version:	2	
Adopted by:	Trust Policy Committee	
Date this version was adopted:	30 October 2019	
Name of Author:	Clinical Coding Manager	
Name of responsible Committee:	Data Privacy Group	
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Review date:	March 2021	
Expiry date:	1 October 2021	
Target audience:	All Clinical Staff and Clinical Coders	
Type of Policy	Clinical ✓	Non Clinical ✓
Which Relevant CQC Fundamental Standards?		

Contents

Version Control and Summary of Changes

Version number	Date	Comments (description change and amendments)
0.1	21/12/2012	Frist Draft
0.2	02/05/2013	Second draft following extensive comments and amendments
1.0	09/07/2013	Approved by Records and Information Governance Group and to be forwarded to Policy Group
1.0	05/12/2013	Supported by Policy Group
1.1	27/02/2017	Draft reviewed policy for consultation
1.1	12/09/2017	Final Draft for Policy Support Team Review
1.2	October 2017	Final Adopted
2	Sept 2019	Final for Approval

For further information contact:
Clinical Coding Manager
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Equality Statement
Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all. This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

Due Regard

LPT will ensure that Due regard for equality is taken and as such will undertake an analysis of equality (assessment of impact) on existing and new policies in line with the Equality Act 2010. This process will help to ensure that:

- **Strategies, policies and services are free from discrimination;**
- **LPT complies with current equality legislation;**
- **Due regard is given to equality in decision making and subsequent processes;**
- **Opportunities for promoting equality are identified.**

Please refer to due regard assessment (Appendix 4) of this policy.

Definitions that apply to this Policy

Clinical Coding	Clinical Coding is the translation of medical Terminology that describes a patients complaint , problem, treatment or other reasons for seeking medical attention into codes that can then be easily tabulated, aggregated and sorted for statistical analysis in an efficient and meaningful manner
Co-morbidities	Any condition which co-exists in conjunction with another disease that is currently being treated at the time of admission or develops subsequently. That affects the management of the patients current episode
ICD-10	**ICD-10** is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization (WHO). It codes for diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases.[1]
Primary Diagnosis	The main condition treated or investigated during the relevant episode of healthcare
Mental Health Minimum Data set	The Mental Health Minimum Data Set facilitates the collection of person-focussed clinical data and the sharing of such data to underpin the delivery of mental health care. It is structured around the clinical process and includes an outcome assessment (Health of the Nation Outcome Scale (Working Age Adults), or HoNOS (Working Age Adults)). It records the key role played by partner agencies, particularly social services.
OPCS-4	In UK Health care, **OPCS Classification of Interventions and Procedures** (OPCS-4) is a procedural classification for the coding of operations, procedures and interventions performed during in-patient stays, day case surgery and some out-patient attendances in the National Health Service (NHS). Responsibility for revision and maintenance is currently with NHS Connecting for Health (NHS CFH).
Payment by Results	Payment by Results (PbR) is the transparent rules-based payment system in England under which commissioners pay healthcare providers for each patient seen or treated, taking into account the complexity of the patient's healthcare needs. PbR promotes efficiency, supports patient choice and increasingly incentivizes best practice models of care.
Due Regard	Having due regard for advancing equality involves: • Removing or minimising disadvantages suffered by people due to their protected characteristics. • Taking steps to meet the needs of people from protected groups where these are different from the needs of other people. • Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

1.0. Purpose of the Policy

This policy details the procedures regarding the clinical coding of all clinical care. It outlines the responsibilities of clinical and administrative staff and the timescales in which coding should be completed.

This policy is for use by all Trust staff involved in the coding of patient activities and should be read in conjunction with the Trust's Information Lifecycle and Records Management Policy and Data Quality Policy, available on the Trusts intranet.

2.0. Summary and Key Points

- To provide accurate, complete, timely coded clinical information to support Commissioning, local information requirements and the information required for Mental Health Minimum Data Set (MHMDS) and central returns on behalf of the Trust represented by the clinical coding service.

- To adhere to National Standards and classification rules and conventions as set out in the WHO ICD-10 5th rev Volumes 1-3, OPCS4.8, Clinical Coding Instruction Manual and the Coding Clinics.

- To input onto the trust information system accurate and complete clinical coding information within 10 days of discharge/transfer to support the information requirements of the Trust and the commissioning requirements of the CCG.

- To provide accurate, consistent and timely information to support clinical governance and data quality.

- To ensure all staff involved in the clinical coding process receive regular training/awareness sessions to maintain and develop their coding skills.

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

3.0. Introduction

This document sets out the Trust's current procedure for monitoring and improving the quality of clinical coded data. It is has been designed to ensure information produced during the coding process is accurate, timely and adheres to local and national polices and achieves national standards

The procedure outlined in this document is intended to support the Trust's Clinical coding process. This procedure covers the diagnostic coding of inpatient episodes and treatment/procedural coding. All in-patient areas of the Trust are covered in this procedure

This document should be used by the clinical coding team to document coding policy and procedures within the trust, which have been agreed with personnel involved in the coding process, including relevant clinicians.

4.0 Duties and Responsibilities

The responsibility for the adoption of the policy and procedure and its enforcement belongs to the Chief Executive of the Trust. To assist the Chief Executive with the discharge of this responsibility, the Head of Data Privacy has been delegated lead responsibility for developing and implementing this procedure.

4.1 Medical Director and Clinical Directors

- To raise awareness and support the new process for obtaining diagnosis and to Convert into an ICD-10 code.

- To emphasise the need for, the medical team to give a Primary and Secondary diagnosis including any relevant co –morbidities pertains to the episode of care as outlined in Clinical coding instruction manual

4.2 Consultants, SpR's/Staff Grades and SHO's

Medical staff must document accurate clinical information and assign primary diagnosis codes

- The majority of ICD-10 codes use 4th character, and this **must** be included or will automatically default to 9

4.3 Clinical Coding Manager

The Clinical Coding Manager will ensure that the systems and processes for capturing and monitoring coding activity is fit for purpose and supports the patients' journey.

- Manage the validation programme to support clinicians in accurate coding of clinical information
- Undertake a programme of internal audits to ensure compliance with coding conventions and in preparation for the annual Data Security and Protection Toolkit Clinical Coding Audit.
- Ensure that clinical coding staff have undertaken appropriate training and remain up to date

4.4 Clinical Coders

It is the clinical coder's responsibility for capturing all relevant diagnoses with ICD-10 and OPCS 4.8 codes for a patient's episode of care. To the highest degree of specification, in line with the rules, conventions and national standards as set out in clinical coding instruction manuals.

Using the four step coding process.

- Clinical Coders will verify codes and agree amendments with medical staff.
- Clinical Coders will assign secondary diagnosis codes and any OPCS-4 codes.
- Clinical Coders will assign primary diagnosis codes where these have been omitted from a Finished Consultant Episode (FCE). This will be obtained from

information provided in the patient's records within 48 hours of patients discharge.
- For any missing diagnosis, the relevant Consultant responsible for that episode of care will be contacted for a diagnosis.

5.0 Clinical Coding Procedures

Clinical coding must be consistent with the appropriate National Standards:

- ICD-10 5th rev for diagnostic coding
- OPCS4.8 for procedure coding

The recommended source document for coding is the service user's EPR

Discharge summaries are included in the electronic patient record (EPR) and should always be referred to as the primary diagnosis is stated on there

There is not an encoder in use in the Trust

The NHS data dictionary defines FCE as "The time a service user spends in the continuous care of one consultant using hospital site or nursing home bed(s) of one healthcare provider in the case of shared care, in the care of two or more consultants. Where the care is provided by two or more consultants within the same episode, one consultant will take overriding responsibility for the service user and only one Consultant episode (hospital provider) is recorded. This therefore includes all hospital admissions including those for respite care. An episode finishes when either the service user is discharged or the responsibility for care passes between consultants. Therefore clinical coding need to be performed if either:

- The service user is discharged
- The service user dies
- The service user is transferred between consultants
- The service user is transferred to another provider for treatment (e.g. to the acute Trust for medical or surgical treatment). This process should be recorded as a discharge and planned readmission on the administration system. The service user is regarded as having been discharged and the consultant episode finished whatever the length of transfer. This excludes service users who attend day care sessions with another provider.

If a service user is transferred between consultants then the initial consultant's team must record a clinical code on the date of transfer, not wait until the service user is discharged.

On discharge the service user should have a clinical code assigned by a clinician within 48 hours of discharge and this should then be entered on the system within 5 days of discharge.

Service users who are resident on the ward for more than twelve months must have a clinical code recorded every twelve months after their annual CPA review, or for the end of the financial year.

All inpatient treatments must be coded at the time of diagnoses coding, for example ECT with the appropriate dates.

The clinical coding target is 100% coding completion of all FCE's within 5 working days of month end to enable reports to be run for mandatory submissions such as CDS (Commissioning Data Set) and the MHMDS (Mental Health Minimum Data Set).

6.0 Point of Coding Activity

Leicestershire Partnership Trust provides an integrated service to mental health and community resulting in a partially devolved clinical coding function.

The Trust employs a Clinical Coding Manager and a Clinical Coder whose primary focus is the coding of Inpatient activity both in mental health services and community settings.

The coding of community work (in mental health services) is undertaken by clinicians.

7.0 Validation of Clinical Coded Data

An internal audit will be undertaken on a quarterly basis, led by the Clinical Coding Manager. Each Audit will consist of a random sample of 50 FCEs spread across all specialties, unless otherwise specified.

External audits will be undertaken on a yearly basis to fulfil Information Governance requirements by an NHS Digital approved auditor.

Outcomes from all audits will be shared with the Information Management Team, clinicians; Clinical Directorates and Trust (appropriate delegated sub-committee) and where recommendations are made these will be implemented and documented.

Coding staff will receive ongoing guidance and assessment from the Clinical Coding Manager to ensure that National Standards are adhered to and any training issues addressed.

Coding staff will ensure that they received the Coding Clinics and newsletters from Trud and any amendments are carried out under the guidance of the Coding Manager and if applicable the Head of Information.

8.0 Monitoring Completeness and Timeliness of Clinical Coding

An ongoing process for the monitoring of FCE's that remain uncoded will be followed. A daily report run from the reporting tools will be printed, for those without a primary diagnosis the coder will assign the relevant code. In absence of this information the coder will contact the relevant clinician'

Following approval from the medical director that the Coding Manager can enter co-morbidity codes that have been missed onto the appropriate systems and where there is a discrepancy discuss the assignment of the code with the relevant clinician.

After discharge on a daily basis the team will have a list of daily discharges and this also includes and patient transfers

The Information Management department will produce a monthly list of missing or incorrect primary diagnosis which will be checked by the clinical coder, or clinical coding manager.

A monthly validation report will be sent to each inpatient clinician who will have all discharged patients coding on for the previous month. Clinicians are invited to respond to either confirm or query the coding

9.0 Security and confidentiality

LPT takes the confidentiality of its patients and service user's data very seriously. To this end this Policy and procedure document sets out steps that should be taken and awareness clinical coding staff must have when carrying out their duties.

Such internal measures should include details of:

- Clinical Coders as users of Electronic Patient Records must attend formal training
- All data entry systems should have an audit trail and allow the identification of users accessing the system and /or uploading clinical coding data, to include times of when such transactions occurred.
- No data will be shared with others outside LPT unless approved by the clinical coding manager who should ensure that any such release of data is anonymised and non-patient identifiable.
- Any training issues identified in audit must be addressed promptly by clinical coding manager.

10.0 Training needs

There is a need for training identified within this policy. In accordance with the classification of training outlined in the Trust Learning and Development Strategy this training has been identified as mandatory training for all those who enter codes into an electronic patient record

- All new coding staff will attend the standards course within six months of employment.
- All staff will attend NHS Digital Refresher Workshop every 3 years.

For coding queries that cannot be resolved internally, reference should be made to the National Coding Query mechanism provided by NHS Digital. Information received back should be documented and shared with the appropriate staff

A record of the event will be recorded on ULearn

The governance group responsible for monitoring the training is Data Privacy Group

11.0 Monitoring Compliance and Effectiveness

Ref	Minimum Requirements	Evidence for Self-assessment	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
	Requirement to record primary, secondary diagnosis and co-morbidities	Sections 4.1; 4.2; 4.4	Clinical Coding Audit	Records and Information Governance Group	Annually
	Timely recording of diagnoses and co-morbidities	Sections 5.0;	Coding Validation	Data Quality Groups	Monthly
	All inpatient treatments must be coded at the time of diagnoses		Coding Validation	Data Quality Groups	Monthly
	All staff who code are trained		Clinical Coding Audit	Records and Information Governance Group	Annually

12.0 Standards/Performance Indicators

TARGET/STANDARDS	KEY PERFORMANCE INDICATOR
100% timely recording of ICD-10 Codes	The clinical coding target is 100% coding completion of all FCE's within 5 working days of month end
All Finished Consultant Episodes are accurately recorded including co-morbidities	Data Security and Protection Toolkit Clinical Coding Audit

13.0 Review

The Clinical Coding Manager is responsible for ensuring this document is reviewed and, if necessary, revised in the light of legislative, guidance or organisational change. Review shall be at intervals of no greater than 2-years. Any revisions to this document shall be agreed through the approval process indicated on the title page.

14.0 Archiving

The Policy Support Administrator is responsible for ensuring that superseded versions of policies and procedures are retained in accordance with the Records Management Code of Practice for Health and Social Care, 2016.

15.0 References and Bibliography

This policy was drafted with reference to the following:

National/Regional Clinical Coding Query Service Proforma

If you have a local proforma and mechanism it should be included here. If this is not available and your Trust uses the NHS Classifications Service proforma this can be found at:

www.digital.nhs.uk/standards/data/clinicalcoding/data_quality/query_mech

Key Guidance Documents:

The Clinical Coding toolbox – available on line at:

Other useful links:

Primary diagnosis definition

Health Service Guideline HSG (96) 23, 20th September 1996;

Mandated and implemented across the NHS from 1st April 1997.

SNOMED Clinical Terms:

http://www.connectingforhealth.nhs.uk/systemsandservices/data/uktc/snomed

Dictionary of Medicines and Devices: available online at:

www.dmd.nhs.uk/

The World Health Organisation ICD10 available online at:

www.who.int/classifications/icf/en/

The Information Centre – What are Healthcare Resource Groups (HRGs)? Available online at:

http://www.ic.nhs.uk/services/the-casemix-service/new-to-this-service/what-are-healthcare-resource-groups-hrgs

DOH - PbR Code of Conduct – available online at:

Code of Conduct for Payment by Results (Gateway No: 6058),

Patient Confidentiality and Access to Health Records available online at:

http://www.dh.gov.uk/en/Managingyourorganisation/Informationpolicy/Patientconfidentialityandcaldicottguardians/index.htm

Training Requirements **Appendix 1**

Training Needs Analysis

Training Required	YES ✓	NO
Training topic:	Clinical Coding	
Type of training: (see study leave policy)	☐ Mandatory (must be on mandatory training register) ✓ Role specific ☐ Personal development	
Division(s) to which the training is applicable:	✓ Adult Mental Health & Learning Disability Services ✓ Community Health Services ✓ Enabling Services – Clinical Coding Team ✓Families Young People Children ☐ Hosted Services	
Staff groups who require the training:	All clinicians who enter ICD-10 and OPCS Codes as well as clinical coders	
Regularity of Update requirement:	Every 3 years	
Who is responsible for delivery of this training?	Specialist Clinical Coding Trainers	
Have resources been identified?	Yes	
Has a training plan been agreed?	No	
Where will completion of this training be recorded?	✓ ULearn ☐ Other (please specify)	
How is this training going to be monitored?	Through the annual Information Governance Toolkit Clinical Coding Audit	

Appendix 2

The NHS Constitution

The NHS will provide a universal service for all based on clinical need, not ability to pay. The NHS will provide a comprehensive range of services

Shape its services around the needs and preferences of individual patients, their families and their carers	☐
Respond to different needs of different sectors of the population	✓
Work continuously to improve quality services and to minimise errors	✓
Support and value its staff	☐
Work together with others to ensure a seamless service for patients	✓
Help keep people healthy and work to reduce health inequalities	✓
Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance	✓

Stakeholders and Consultation **Appendix 3**

Key individuals involved in developing the document

Name	Designation
Tina Bradley	Clinical Coder
Sam Kirkland	Head of Data Privacy

Circulated to the following individuals for comment

Name	Designation
Members of Data Privacy Group	
Members of IM&T Delivery Group	

Section 1	
Name of activity/proposal	Clinical Coding Policy & Procedure
Date Screening commenced	August 2019
Directorate / Service carrying out the assessment	Enabling/Clinical Coding
Name and role of person undertaking this Due Regard (Equality Analysis)	Kim Dawson, Clinical Coding Manager
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS: The Policy and Procedure sets out the activity in relation to clinical coding against both local and national requirements	
OBJECTIVES: Clinical coding supports the care process through the conversion of diagnoses and procedures to codes set out in a classification set published by the World Health Organisation and therefore underpins all clinical activity outputs. This in turn converts activity to cost for the purposes of commissioning services	

Section 2	
Protected Characteristic	**If the proposal/s have a positive or negative impact please give brief details**
Age	Positive as this is part of the greater understanding for commissioning services
Disability	Positive as this is part of the greater understanding for commissioning services
Gender reassignment	Positive as this is part of the greater understanding for commissioning services
Marriage & Civil Partnership	No impact
Pregnancy & Maternity	Positive as this is part of the greater understanding for commissioning services
Race	Positive as this is part of the greater understanding for commissioning services
Religion and Belief	No impact
Sex	Positive as this is part of the greater understanding for commissioning services
Sexual Orientation	Positive as this is part of the greater understanding for commissioning services
Other equality groups?	

Section 3			
Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please <u>tick</u> appropriate box below.			
Yes		No	
High risk: Complete a full EIA starting click here to proceed to Part B		Low risk: Go to Section 4.	√

Section 4
If this proposal is low risk please give evidence or justification for how you reached this decision:
The purpose of clinical coding is to support the outputs of clinical care and ensure that through the conversion of codes to financial currency, the correct level of care can be

commissioned			
Signed by reviewer/assessor		**Date**	
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed		**Date**	

Appendix 5

DATA PRIVACY IMPACT ASSESSMENT SCREENING

Data Privacy impact assessment (DPIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet Individual's expectations of privacy.
The following screening questions will help the Trust determine if there are any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.

Name of Document:	Clinical Coding Policy and Procedure	
Completed by:	Kim Dawson	
Job title	Clinical Coding Manager	**Date** 30 July 2019

Screening Questions	**Yes / No**	**Explanatory Note**
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.	No	
2. Will the process described in the document compel individuals to provide information about them? This is information in excess of what is required to carry out the process described within the document.	No	
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?	No	
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?	No	
5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.	No	
6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?	No	
7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.	No	
8. Will the process require you to contact individuals in ways which they may find intrusive?	**No**	

If the answer to any of these questions is 'Yes' please contact the Data Privacy Team via Lpt-dataprivacy@leicspart.secure.nhs.uk
In this case, adoption of a procedural document will not take place until review by the Head of Data Privacy.

Data Privacy approval name:	Sam Kirkland, Head of Data Privacy

Date of approval	25 September 2019

Acknowledgement: This is based on the work of Princess Alexandra Hospital NHS Trust