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, ICD-10, National Classification

Version: 3.1

Approved by: Data Privacy Group

Ratified By: Finance and Performance Committee

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Review date: 1st March 2028

Expiry date: 31st July 2028

Type of Policy: Clinical and non-clinical.

Contents

Policy On A Page

SUMMARY & AIM

What is this policy for?

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 document sets out the Trust's Clinical Coding process and compliance with Clinical Classification and Terminology standards.

KEY REQUIREMENTS

What do I need to follow?

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

The coding of community work within all directorates is delivered by clinicians at the point of care assigning SNOMED CT concepts. This is overseen and validated for compliance by the Clinical Coding Assurance Team.

Full and accurate coding of activity in the NHS can be essential for service delivery, achieving targets, resource management, clinical governance, and performance management. Coded clinical data which is validated and audited is more likely to be recognised as an accurate reflection of hospital activity.

TARGET AUDIENCE:

Who is involved with this policy?

All staff who have responsibility for adding coded information to the electronic health record. This document sets out the Trust's current procedure for monitoring and improving the quality of clinical coded data. It 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.

TRAINING

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 ICD-10 codes into an electronic patient record.

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

All staff who select SNOMED CT codes that will be configured within the Electronic Health Record system for entering by clinical staff must have completed the appropriate SNOMED CT training. Training compliance will be monitored, and a record held by the Coding Assurance Team.

1.0 Quick look summary

Please note that this is designed to act as a quick reference guide only and is not intended to replace the need to read the full policy.

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
2.1	October 2021	No material changes to the policy and presented for final approval
3	March 2025	Updates to reflect the introduction of SNOMED CT and changes to the Coding Assurance Process
3.1	March 2025	Updates

For Further Information Contact:
Clinical Coding Manager

1.2 Key individuals involved in developing and consulting on the document

- Sarah Ratcliffe, Head of Data Privacy
- Kim Dawson, Clinical Coding Assurance and Data Quality Manager
- Trust Policy experts – see checklist for list of current contact details

1.3 Governance

Level 2 or 3 approving delivery group
Data Privacy Group

Level 1 committee to ratify policy
Finance and Performance Committee

1.4 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.

If you would like a copy of this document in any other format, please contact lpt.corporateaffairs@nhs.net

1.5 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 procedures 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.

1.6 Definitions that Apply to this Policy

Consent	A patient's agreement for a health professional to provide care. Patients may indicate consent non-verbally (for example by presenting their arm for their pulse to be taken), orally, or in writing. For the consent to be valid, the patient must: • be competent to take the particular decision; • have received sufficient information to take it and not be acting under duress.
Co-mor-bidities	For the purposes of coding, co-morbidity is defined as: • Any condition which co-exists in conjunction with another disease that is currently being treated at the time of admission or develops subsequently, and • affects the management of the patient's current episode
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.
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.
ID-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.

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.
Primary Diagnosis	The primary diagnosis definition must always be applied when assigning codes on the coded clinical record: i) 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. ii) ii) 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 iii) All other relevant diagnoses must be coded in addition to the primary diagnosis. The NHS Executive Health Service Guideline HSG (96)23 published 20 September 1996 mandated the implementation of this standardised primary diagnosis definition for clinical coding. The application of the NHS-mandated definition for primary diagnosis is crucial to ensure the information now regularly exchanged between NHS organisations is consistent, comparable, and meaningful to the many users within the NHS as well as to the WHO.
SNOMED CT	Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT) is a structured clinical vocabulary for use in an electronic health record. It is the most comprehensive and precise clinical health terminology product in the world, forming an integral part of the electronic care record. It represents care information in a clear, consistent, and comprehensive manner.

2.0 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 document sets out the Trust's Clinical Coding process and compliance with Clinical Classification and Terminology standards.

Clinical Coding is 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 coded format. The use of codes ensures the information derived is standardised to facilitate ease of data retrieval and directly comparable between patients with similar morbidities.

This policy describes how the Trust will continually seek to improve local data collection and processing to ensure that the highest quality Clinical Coding standards are achieved. The policy demonstrates the local approach for adherence to Clinical Coding classification standards.

This policy explains how Coding knowledge is communicated and how local standards complement the external regulations that facilitate consistency of Coding across organisational boundaries.

3.0 Policy Requirements

- To provide accurate, complete, timely coded clinical information to support commissioning, local information requirements and the information required for central returns on behalf of the Trust represented by the clinical coding service.

- The International Classification of Diseases 10th Revision, commonly known as ICD-10, has been devised by the World Health Organisation (WHO) and its codes, which cover all reasons for patients' admissions to hospital, and are widely used internationally.

- SNOMED CT is a structured clinical vocabulary for use in an electronic health record. It is the most comprehensive and precise clinical health terminology in the world.

- The codes included in the Office of Population Censuses and Surveys 4th Revision, commonly known as OPCS4, cover all operative procedures and interventions that patients have undergone during their hospital stay. These codes are used in the UK only.

- To input onto the trust information system accurate and complete clinical coding information

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

- Focused data quality audit on clinical coding is a crucial part of a robust assurance framework and guidance the Data Security and Protection Toolkit stipulates that it must be audited either via a continuous programme or via a single audit annually.

4.0 Introduction

- Full and accurate coding of activity in the NHS can be essential for service delivery, achieving targets, resource management, clinical governance, and performance management. Coded clinical data which is validated and audited is more likely to be recognised as an accurate reflection of hospital activity.

- Guidance from the Data Security and Protection Toolkit (DSPT) stipulates that an organisation must ensure that all its clinical coders are sufficiently trained so that they maintain the highest standards of clinical coding.

- This document sets out the Trust's current procedure for monitoring and improving the quality of clinical coded data. It 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.

- 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.

5.0 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.

5.1 Medical Leadership

The Medical Director, Deputy Medical Directors and Associate Medical Directors are responsible for ensuring that medical staff provide the requisite information in TPP SystmOne.

5.2 Frontline Medics

- Consultants and doctors providing direct clinical care in mental health settings are responsible for detail about a condition that a clinical coder is not trained to interpret, such as the level of impairment a condition has on a person's behaviour or traits / features that manifest themselves during the course of a disorder that will alter the fourth character.

- All consultants and doctors are responsible for the completion of GP discharge summaries which align to nationally mandated headings.

- Consultants and doctors should be available to the clinical coder (by telephone or email) to ensure that any queries are answered in a timely manner.

- Clinical inpatient staff are responsible for maintaining accurate and comprehensive record keeping throughout a patient's episode in hospital in line with Trust policy; this will form the source data for the clinical coder.

5.3 Administrative Staff Supporting Clinical Inpatient Services

Administrative staff should ensure that discharge summaries are completed comprehensively, accurately and in a timely manner in line with relevant policy.

5.4 Head of Data Privacy

The Head of Data Privacy is responsible for the strategic management of the Clinical Coding Assurance Team and for setting the direction of operational activity.

5.5 Classification and Terminology Assurance and Data Quality Manager

- Will ensure that the systems and processes for capturing and monitoring coding activity are fit for purpose and support the patient's journey.
- Ensure the whole Coding team is trained according to recommended standards and frequency. Maintain local records of staff training.
- Ensure that staff that configure electronic health record systems through the selection of codes have undertaken appropriate training and remain up to date.
- Operational management of Clinical Coding Department, ensuring that this policy is well communicated, and all Clinical Coders are fully compliant with policy standards.

- Receipt and dissemination of relevant documentation relating to Clinical Coding across the Trust to endorse consistency and accuracy of coded information.
- Responsible for planning and delivery of the Clinical Coding service to run efficiently and effectively for the Trust.
- Responsible for on-going development of the service to ensure coded data is accurate, complete, and timely.
- Ensure that all policy decisions in relation to Clinical Coding at the Trust are made as a result of joint collaboration and understanding between the Clinical Coding department, clinicians who record clinical information and those who use coded information.
- Development of competent and trained Clinical Coding staff who are supported in their work, encouraging all staff to gain Accredited Clinical Coder (ACC) status.
- Provide a primary source of expertise regarding Coding standards and practice to other Trust managers and to clinicians. This includes engagement with clinicians through education, training, using benchmarking and audit to raise standards of data capture.
- To act as an audit and assurance function for coded data to support the Trust to meet mandatory and nest practice coding requirements. Reporting on a bi-monthly basis to Data Quality Group.

5.6 Classification and Terminology Specialist

- Promote and manage activities that encourage professional engagement between Clinical Coders and clinicians to collaborate and share learning.
- Ensure there is regular feedback to individual specialties (specific clinicians where appropriate) on the quality of their clinical information capture. Two-way communication is important to ensure that Coders feedback to clinicians on the quality of their clinical documentation and for clinicians to know how their work is coded. Discrepancies can then be reviewed to resolve any Coding errors.
- Hold the Accredited Clinical Coder qualification.
- Mentor trainee coders during work-based training. Supervise Trainee Coders as required, checking, validating and signing-off the Coding that the Trainees undertake.

5.7 Clinical Coders

- The Clinical Coding team are professionally skilled and trained in the consistent interpretation of clinical documentation. They are responsible for the translation of clinical diagnoses and procedures into coding schema for each patient's hospital stay.
- Work to high professional standards and manage their own coding workload, sharing specialist knowledge or mentoring other coders as required.
- Engage with clinicians and medical staff within their own area of responsibility (e.g., a specialty or CMG) to resolve coding queries.
- Maintain a commitment to their own professional development, continually improving coding expertise through formal training and self-study. All coders should

attend a minimum of 1 workshop each year for their own continual professional development.

5.8 Trainee Clinical Coders

- Undertake necessary formal training (21-day standards course) and work with trained Clinical Coders to enhance their understanding.
- Undertake self-study modules and take personal responsibility for learning.
- Code medical records under the supervision of experienced Senior Clinical Coders.

5.7 LHIS Change Team

- The Change Team is responsible for maintaining the 'TPP SystmOne Clinical Coding' guide and keeping the clinical coder up to date on any system specific configuration / updates that may impact on them performing coding.
- They are a point of contact for the clinical coder to assist with system related queries and can assist with configuring a suitable view to enable shortcuts and efficiencies associated with the trawl of a patient record.
- Responsible for ensuring that all configuration completed within the system meets national and local requirements set under this policy.

6.0 Clinical Coding Procedures

ICD-10 and OPCS 4.10 Clinical Coding is undertaken on the electronic patient record by staff (Clinical Coders) who have received adequate formal training and can apply coding in accordance with Clinical Classification Service (CCS) standards. Coding is applied to each individual Consultant Episode (CE) within the whole hospital stay (Hospital Spell). Coding will be applied after the patient is discharged from hospital.

SNOMED_CT codes are applied to activity during the clinical episodes by the clinician responsible for the patient's care. This provides indicative coding information for payment and activity information but is not recorded to Classification standards.

6.1 Clinical Engagement

High Quality Clinical Coding depends on clear and accurate source clinical information. This supports the production of a true picture of hospital activity and the care given by clinicians. Accuracy of medical documentation is essential when the patient is admitted and must be reviewed at every ward round for inpatients and during relevant contacts for outpatient and community contacts.

All Coders are encouraged to actively engage with clinical colleagues and share learning. This engagement is promoted and managed by the Classification and Terminology Assurance and Data Quality Manager and Senior Clinical Coders. Activities include

- Clinical review of medical records where there are examples of activity that the Clinical Coders are having difficulty coding.
- Circulating coding tips (e.g., what can/cannot be coded) to all doctors to clarify what information Clinical Coders are permitted to use.

6.2 Diagnosis and Procedures

Patient diagnoses must be documented as specifically as is known at the time of recording. The following table precisely shows the terms than can and cannot be used by Clinical Coders for applying appropriate ICD10 codes:

for applying appropriate ICD10 codes: *What CAN be coded*	*What CANNOT be coded*
Assumed Clinically relevant Compatible with Consistent with Definitive diagnosis (Δ) Impression (Imp) In keeping with Probable Presumed Symptoms – where no definitive diagnosis is made Treat as Working diagnosis	Differential diagnosis (Δ Δ) Likely Maybe Possible ? Suspected

Primary Diagnosis This is the main condition treated or investigated during the relevant episode of healthcare. Where there is no definitive diagnosis, the main symptom, abnormal finding, or problem should be selected as the main condition.

Secondary Diagnoses All relevant diagnoses must be applied. Where there is insufficient diagnostic information provided to the Coder, the relevant consultant/clinician should be contacted to obtain missing information.

Procedures and Interventions All operative procedures and interventions that patients have undergone during their hospital stay must be documented, including those undertaken by nursing staff and other professionals.

Co-morbidities, associated illnesses, and complications
Any relevant co-morbidities must be documented by the consultant/clinician. A co-morbidity is any condition which exists in conjunction with another disease. Any comorbidity that effects the management of the patient's current episode of care must be recorded. To comply with Classification standards, comorbidities that are not relevant should not be coded.

'Depth of Coding' refers to the number of diagnoses typically recorded for patients. The Trust will benchmark coding depth against peer organisations. Greater depth of coding does not necessarily indicate higher quality coding.

Instruction Manuals and Standards
All Clinical Coders employed directly by the Trust will use. Electronic versions of instruction Manuals available online via NHS England.

7.0 Point of Coding Activity

The Trust employs a Clinical Coding Manager and Clinical Coders whose primary focus is the coding of Inpatient activity both in mental health services and community settings. The coding of community work within all directorates is delivered by clinicians at the point of care assigning SNOMED CT concepts. This is overseen and validated for compliance by the Clinical Coding Assurance Team.

8.0 Validation of Clinical Coded Data

Outcomes from all audits will be shared with the clinicians; Clinical Directorates and Trust Data Quality Group 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.

9.0 Audit and Assurance Process

The following audit and assurance processes will be undertaken for ICD10, OPCS and SNOMED CT. Results of these activities will be provided in bi-monthly updates to the Data Quality Group:

Audit description	Lead	Frequency	Reporting Arrangements	Coding Scheme
Levels of coding completion	Individual coders	Daily	Clinical coding Exception report	ICD-10 OPCS -4.10
Coding Accuracy	Clinical Coding Assurance Team	Monthly	Error report to be completed by Clinical Coder	ICD-10 OPCS -4.10 SNOMED CT
Depth of Coding	Clinical Coding Manager	Quarterly	Bench Marking Data	ICD-10 OPCS- 4.10 SNOMED CT
Adherence to National Coding Standards	Clinical Coding Assurance Manager	Annually	External NHSE Auditor	ICD-10 OPCS 4.10
Assertions & Evidence Items for DSPT	Clinical Coding Assurance Manager	Annually	Annual Clinical Coding Report	ICD-10 OPCS 4.10
SNOMED CT Concept Hierarchy	Clinical Coding Manager	Daily	Exception Reports	SNOMED CT

Diagnosis	Clinical Coding Team	Monthly	Patient level Exception Report	SNOMED CT
SNOMED inactive code	Clinical Coding Assurance Team	Monthly	Exception Reports	SNOMED CT
Unmapped CVT3 Codes	Clinical Coding assurance Team	Quarterly	Exception Reports	SNOMED CT
Information Standard Notice compliance	Clinical Coding Assurance team	ADHOC	Exception Reports	SNOMED CT
Currency Models	Clinical Coding Assurance Team	On completion of Each Model	Exception Report	SNOMED CT
Training Compliance SNOMED CT	Clinical Coding Assurance Manager	Time frame determined by rescope of product	Assertions & Evidence. I.e.: Certificates Training matrix	SNOMED CT

11.0 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 the Classification and Terminology Assurance and Data Quality Manager

12.0 Training Needs

There is a need for training identified within this policy.

ICD-10

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 ICD-10 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.

A record of the event will be recorded.

SNOMED CT

All staff who select SNOMED CT codes that will be configured within the Electronic Health Record system for entering by clinical staff must have completed the appropriate SNOMED CT training. Training compliance will be monitored and a record held by the Coding Assurance Team.

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

12.0 Monitoring Compliance and Effectiveness

Ref	Minimum Requirements	Evidence for Self- assess-ment	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
01	Requirement to record primary, secondary diagnosis, and co-morbidities	4.1 ,4.2, 4.5	Clinical Coding Audit	Data Privacy / Quality Group	Annually

13.0 Standards / Performance Indicators

TARGET/STANDARDS	KEY PERFORMANCE INDICATOR
100% timely recording of ICD-10 Codes and OPCS 4.10	The clinical coding target is 100% coding completion of all CEs within 5 working days of month end
All Consultant Episodes are accurately recorded including co-morbidities	Data Security and Protection Toolkit Clinical Coding Audit
All SNOMED CT is accurately assigned at point of care by qualified clinical staff.	Output of National Data Submission

14.0 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 3 years. Any revisions to this document shall be agreed through the approval process indicated on the title page.

15.0 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, 2024.

16.0 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 online 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/

17.0 Consent

Clinical staff must ensure that consent has been sought and obtained before any care, intervention or treatment described in this policy is delivered. Consent can be given orally and / or in writing. Someone could also give non-verbal consent if they understand the treatment or care about to take place. Consent must be voluntary and informed, and the person consenting must have the capacity to make the decision.

In the event that the patient's capacity to consent is in doubt, clinical staff must ensure that a mental capacity assessment is completed and recorded. Someone with an impairment of or a disturbance in the functioning of the mind or brain is thought to lack the mental capacity to give informed consent if they cannot do one of the following:

- understand information about the decision
- remember that information
- use the information to make the decision
- communicate the decision

18.0 Fraud, Bribery and Corruption Consideration

The Trust has a zero-tolerance approach to fraud, bribery and corruption in all areas of our work and it is important that this is reflected through all policies and procedures to mitigate these risks.

Fraud relates to a dishonest representation, failure to disclose information or abuse of position in order to make a gain or cause a loss. Bribery involves the giving or receiving of gifts or money in return for improper performance. Corruption relates to dishonest or fraudulent conduct by those in power.

Any procedure incurring costs or fees or involving the procurement or provision of goods or service, may be susceptible to fraud, bribery, or corruption so provision should be made within the policy to safeguard against these.

If there is a potential that the policy being written, amended or updated controls a procedure for which there is a potential of fraud, bribery, or corruption to occur you should contact the Trusts Local Counter Fraud Specialist (LCFS) for assistance.

Appendices

Appendix 1Training Requirements

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	

Training Required	YES ✓	NO
Training topic:	SNOMED CT	

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 staff responsible for the selection of codes as part of the configuration of Electronic Health Record systems.
Regularity of Update requirement:	Every 3 years
Who is responsible for delivery of this training?	Specialist Clinical Coding Trainers and through the use of national training e-learning modules.
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 Data Quality Group reporting.

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	✓

Appendix 3 Stakeholders and Consultation

Key Individuals Involved in Developing the Document

Name	Designation
Sarah Ratcliffe	Head of Data Privacy
Kim Dawson	Classification and Terminology Assurance and Data Quality Manager

Circulated to the following individuals for comment

Name	Designation
Members of Data Privacy Group	

Appendix 4

Due Regard Screening Template

Section 1			
Name of activity/proposal	Clinical Coding Policy and Procedure		
Date Screening commenced	July 2021		
Directorate / Service carrying out the assessment	Enabling / Clinical Coding		
Name and role of person undertaking this Due Regard (Equality Analysis)	Kim Dawson Clinical Coding Assurance and Data Quality 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 c ommissioning 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 tick 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	Kim Dawson	Date	10/03/2025
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Signed by head of service	Sarah Ratcliffe	Date	10/03/2025

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 Assurance and Data Quality Manager	**Date**

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, ratification of a procedural document will not take place until review by the Head of Data Privacy.

Data privacy approval name:	Sarah Ratcliffe
Date of approval	10/03/2025

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