Cheshire and Wirral Partnership
NHS Foundation Trust

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ICD10 (International Classification of Diseases) Clinical Coding Policy

Lead executive	Medical Director
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Type of document	Policy
Target audience	All CWP staff
Document purpose	To provide staff with the ICD10 clinical coding standards and requirements.

Approving meeting	Information Governance & Data Protection Sub-Committee	Date 28-Nov-19
Implementation date	01-Jan-20	

CWP documents to be read in conjunction with	
HR6	Mandatory Employee Learning (MEL) policy
CP3	Health records policy
IM10	Information Governance Policy
IM3	Data Quality Policy
IM4	Standards of secondary use of information policy

Document change history	
What is different?	1. Policy author updated 2. Change name for the governing group 3. Update Performance & Redesign structure
Appendices / electronic forms	N/A
What is the impact of change?	Low

Training requirements	No - Training requirements for this policy are in accordance with the CWP Training Needs Analysis (TNA) with Education CWP.

Document consultation	
Clinical Services	Via Information Governance & Data Protection Sub-Committee
Corporate services	Via Information Governance & Data Protection Sub-Committee
External agencies	N/A

Financial resource implications	No

External references
1. ICD10 (international classification of diseases version 10)
2. Coding Clinic September 2013 [V3.1]
3. Information Governance Toolkit

Equality Impact Assessment (EIA) - Initial assessment	Yes/No	Comments
Does this document affect one group less or more favourably than another on the basis of:		
- Race	No	
- Ethnic origins (including gypsies and travellers)	No	
- Nationality	No	
- Gender	No	
- Culture	No	
- Religion or belief	No	
- Sexual orientation including lesbian, gay and bisexual people	No	
- Age	No	
- Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
Is there any evidence that some groups are affected differently?	No	
If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?		
Is the impact of the document likely to be negative? - If so can the impact be avoided? - What alternatives are there to achieving the document without the impact? - Can we reduce the impact by taking different action?	No N/A N/A N/A	
Where an adverse or negative impact on equality group(s) has been identified during the initial screening process a full EIA assessment should be conducted. If you have identified a potential discriminatory impact of this procedural document, please refer it to the human resource department together with any suggestions as to the action required to avoid / reduce this impact. For advice in respect of answering the above questions, please contact the human resource department.		
Was a full impact assessment required?	No	
What is the level of impact?	Low	

Contents

Quick reference flowchart - ICD10 clinical coding process

Patient journey
Coding is mandated by MHSDS for wards Coding is good practice for outpatient and community services Coding should be done as soon as symptoms are ascertained, reviewed if symptoms change and reviewed on discharge

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Clinical staff
Pick ICD10 code from the drop down menu on CareNotes (mandated field) There are two systems for coding on CareNotes – multi axial and standard CareNotes training manual

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Clinical staff
Pick ICD10 secondary codes (comorbidities list – see clinical coding web page) from the drop down menu on CareNotes (mandated field) There are two systems for coding on CareNotes – multi axial and standard CareNotes training manual

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Information team
Submit clinical codes as per MHSDS to the Department of Health

1. Introduction

This document has been published with the intention of promoting good practice and consistency of information produced during the clinical coding process at Cheshire and Wirral Partnership NHS Foundation Trust. It has also been designed to ensure information produced during the coding process is accurate and adheres to local and national policies, and to meet the requirements of the commissioning Dataset. This policy applies to all clinical staff who enter diagnosis , information into the electronic patient record (see clinical coding intranet net for further guidance and appendix 1 provides illustrations of the input screens).

2. Purpose

To provide accurate, complete and timely coded clinical information to support mandatory coding requirements of the Department of Health, Hospital Episodes Statistics (HES). Ensuring that data is also "fit for purpose" for use in PbR, Commissioning, and available to support local benchmarking information requirements.

To adhere to national standards and classification rules and conventions as set out in the WHO ICD10 Volumes 1-3, OPCS4 Manual, Clinical Coding Instruction Manual ICD10 and OPCS4 and publications of the Coding Clinic.

To input onto electronic patient record systems, accurate and complete coded information within the designated time scales to support the information and business requirements of the Trust.

To provide accurate, consistent and timely information to support clinical governance and the Information Quality Assurance process, and to support the commissioning of services and the requirements arising for Mental Health Services Data Set (MHSDS) and Patient Level Information Costings (PLICs).

To ensure all staff involved in the clinical coding process receive regular training to maintain and develop their clinical coding skills, regardless of experience and length of service, including outlying areas.

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

To ensure all staff are aware of the Trust's security and confidentiality policies when using patient identifiable information.

3. Duties and Responsibilities

All Coders should aim to have all closed episodes coded as quickly as possible, no longer than 10 days of month end, in line national data submission requirements

A list of uncoded episodes is circulated via report manager subscription on a weekly basis to the clinical directors.

4. Policy statement

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

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

All changes to clinical coding policies and/or procedures will be incorporated into regular reviews of this Policy and its associated procedures to ensure all contributors are in agreement with the current practice. Any alterations to clinical coding practice must have specified change and implementation dates to ensure consistent practice across the Trust and comply with national standards and classification coding rules and conventions. This will be disseminated via the shared learning communication process and uploaded to the clinical coding intranet site.

All clinical coding policy and procedure decisions made between the clinical coder and individual clinicians are fully described, agreed and signed by the relevant clinical director. The clinical coding function sits within the performance and information team; matters relating to clinical coding are reviewed in the Information Governance and Data Protection Sub Committee. This policy and associated procedures must be in accordance with national standards or classification coding rules and conventions.

The communication arrangements are detailed in section 4.3 to ensure effective dissemination of information regarding coding, resolutions to queries and changes in coding practice to all coding staff and clinicians.

All confidentiality and security issues incurred during the coding process are detailed in this document to ensure adherence to local and national policies, and have been agreed by the person responsible for the coding staff. Breaches of data confidentiality or security must be reported via Datix.

5. Clinical Coding Procedures

This section shows the procedures for in-patient/ day case clinical coding undertaken within the Trust Current Clinical Coding Practices include:

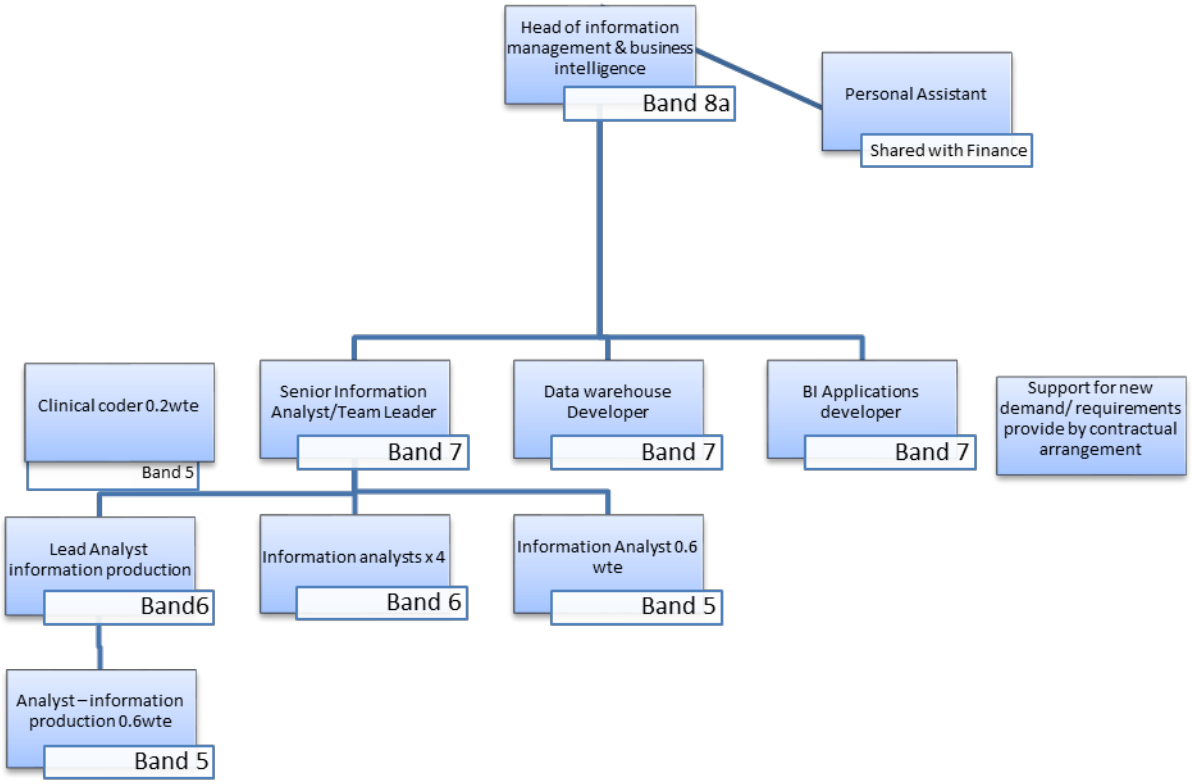
- Information regarding the patient's diagnosis and treatment is extracted from the case notes/ electronic patient record, Care notes system, proformas and discharge summaries by clinical coding staff.
- Information is then translated into the appropriate coded format and entered onto Care notes.
- Source documents for coding purposes at the Trust include discharge summaries, electronic patient record, case notes, test results (Histology), clinical correspondence, etc.

Outpatient Procedure Coding
Outpatient procedures are coded using OPCS4 via the ECT form (see appendix 2) on Care notes (see CP16 ECT policy). Codes are usually allocated by clinical or nursing staff, and input on electronic patient record by admin staff within the outpatient areas.

6. Role of the performance and information clinical coder

- Review undertaken of clinical coding monthly report
- Errors or omissions are amended in line with coding guidance
- Liaise with responsible clinician to advise of changes and rationale for change
- Review of findings produced and shared with clinicians
- Ensure clinical coding web page is maintained

7. Function within Performance and Redesign Departmental Structure



8. Validation of Coded Clinical Information

Individual Coders will contact clinicians regularly, where appropriate, for validation of coding whenever they are uncertain about the information within the electronic patient record. Errors and/or omissions are amended with full rationale for change discussed to ensure learning. A review of findings is shared with clinicians.

9. Audit Programme

Internal Audit provision is undertaken by MIAA and occurs on an annual basis to fulfil both the Information Governance Toolkit requirements and to audit consistently amongst the coders.

A random sample of case notes will be selected from each specialty.

They will be checked for accuracy using the same source information. It is good practice to involve the Clinician as the author of the information to be coded, with the coder that interpreted the information and assigned the codes. The audit should be seen as an objective appraisal, designed to support the coders in identifying areas where best practice is or is not achieved.

At the end of each audit a report will be generated, and any recommendations, will be discussed with all relevant parties. If any major changes to coding practice are identified, a change date is agreed with the performance and information team. An action plan is produced in response to each internal audit, identifying necessary actions, together with responsibilities and timescales for these.

In all instances, Coder error is flagged up to the individual concerned and to the line manager. The team manager and Health Records Manager is made aware of any systemic issues within the team or

coding process, as well as non-coding issues, that may have contributed to incorrect coding.

Objectives of Audit

- Review and analyse any coding errors found and endeavour to trace the source of errors.
- Compare the information provided to the coders at the time of coding with all the information available at the time of the audit.
- Review the information for accuracy and adherence to national standards.
- Identify area of coding practice that might require improvement.
- Review the quality and adequacy of the information source provided to the coders for the purposes of clinical coding.
- Promote interchange between clinicians and clinical coders.
- To make recommendations, if appropriate, to improve the quality of the coded clinical data.

10. Local Policies

All local clinical coding procedures at the Cheshire & Wirral Partnership NHS Foundation Trust will be made in agreement with clinical staff. Each time a local procedure is created or amended the Coder will be given a copy. A master copy of all the agreed policies can be found on the clinical coding intranet page.

11. Training

- The Trust will secure the services of trained coders, who have a responsibility to maintain competency in Mental Health specialty coding,
- The Clinical Coding Academy at Liverpool delivers Clinical Coding Refresher Courses.
- NHS Digital coding training materials
- Attendance on regular specialist training courses wherever available.
- Attendance at other relevant training courses including health and safety, fire training, manual handling, security and confidentiality etc.
- Annual appraisal and opportunities given to all staff.
- Annual review of job descriptions to ensure they are regularly updated and amended as necessary to meet the changing role of coding staff.
- All Clinical Coders will attend the Coding Refresher Courses every 3 years.

12. Training Records

Departmental training records will be kept detailing the courses that individual coders have attended during the course of the last 12 months. Further records of departmental training sessions courses will also be kept.

13. Clinical Coding Qualification Training

For any member of staff who is to undertake the clinical coding qualification will be assured they will be put forward to attend any necessary Coding Workshops and Revision Course where available.
A further in-house training programme will be put into place together with mock tests and revision sessions.

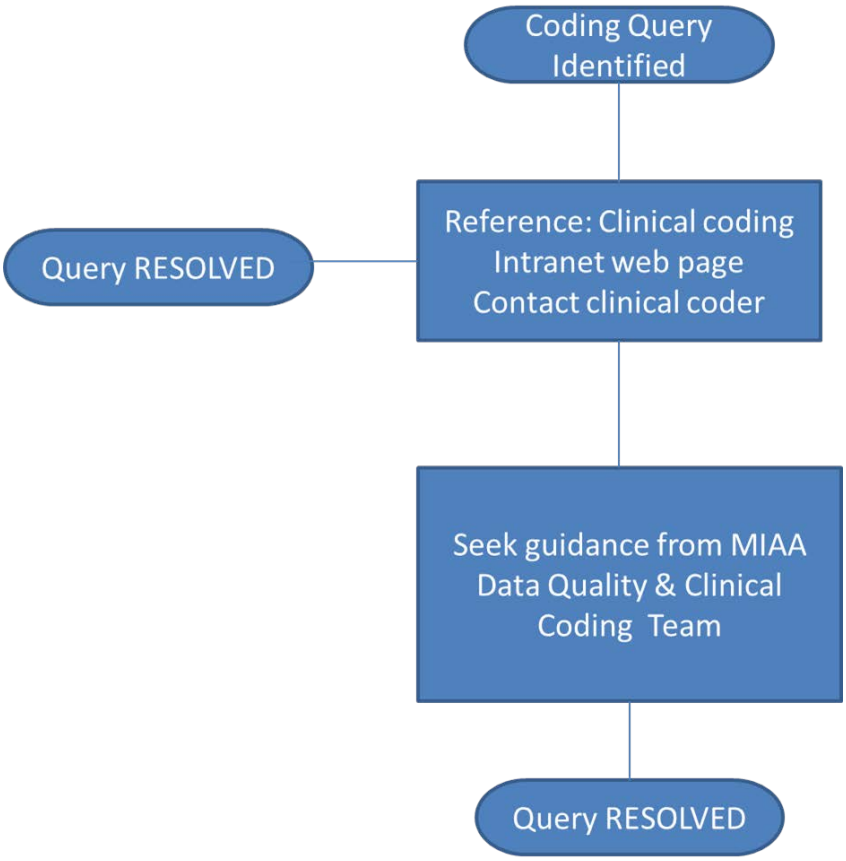
The coder shall be entitled to apply for up to two day study leave, to be undertaken Monday to Thursday, per month over a three month period prior to qualification date. The study leave must not take place during deadline week.

14. Communications in Clinical Coding

Any changes or new working practices will be discussed at the regular Departmental meetings. All staff will sign to acknowledge any changes/alteration in Coding practice.

Amendments to the Clinical Coding Instruction Manual ICD-10 and OPCS-4 and the Coding Clinics are distributed to staff when updates are received from NHS Connecting. Coding staff will be responsible for ensuring that changes are documented in their relevant books. On receipt of the Coding Clinics any changes will be notified and discussed with the performance and information team to assess the impact these changes will have on the Trust.

To ensure consistency and accuracy of coded information the following steps detail the mechanism that should be followed to resolve any coding queries.



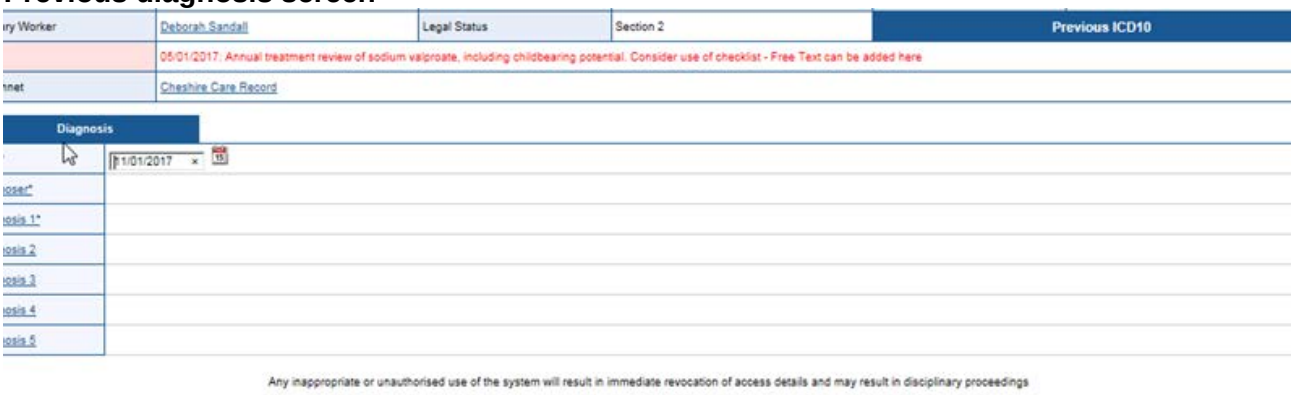
The clinical coder welcomes questions about coding from doctors in the Trust and encourages them to raise any concerns they might have about coding practices. Feedback from the clinicians is encouraged , to help the coders understand more fully the work of the specialty. An additional benefit would be that through interaction with coders, clinicians would gain an understanding of how important it is to include details diagnostic and procedure details in the patient's Electronic Patient Record.

15. Security and Confidentiality

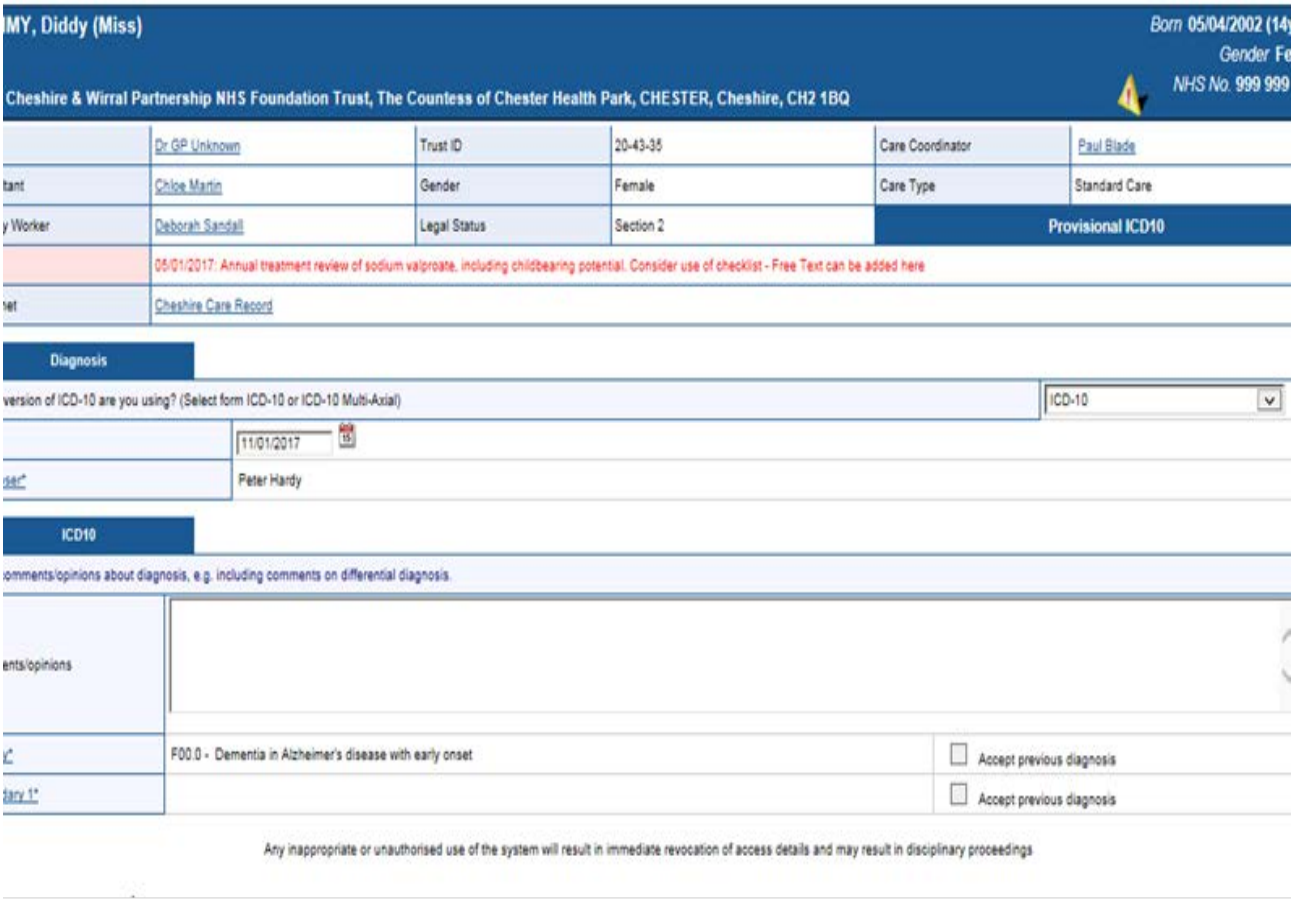
All coding staff need to be aware of the security and confidentiality policies within the trust. A copy of these can be found on the intranet under Caldicott, the issues contained within them should be highlighted as part of staff induction. New and existing staff should be reminded at the time of their appraisal that the content of the Caldicott and Data protection principles should be adhered to at all time

Appendix 1 - Diagnosis input screens

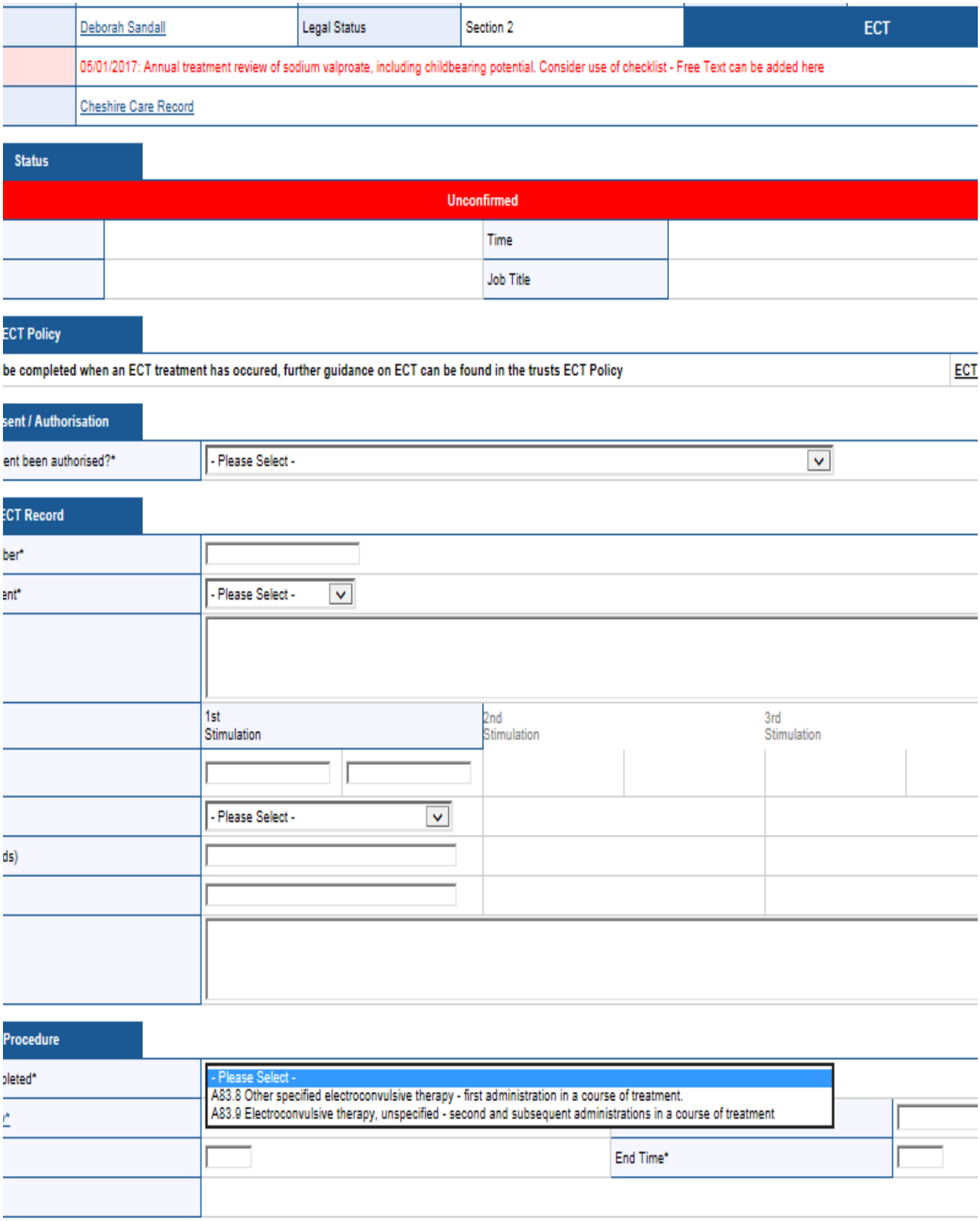
Previous diagnosis screen



Provisional diagnosis screen



Appendix 2 - ECT data entry form



Any inappropriate or unauthorised use of the system will result in immediate revocation of access details and may result in disciplinary proceedings