This is an official Northern Trust policy and should not be edited in any way

## Clinical Coding Manual

<table>
<thead>
<tr>
<th>Reference Number:</th>
<th>NHSCT/10/242</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target audience:</td>
<td>Clinical Coding Staff – Acute Hospital Services</td>
</tr>
</tbody>
</table>
| Sources of advice in relation to this document: | Elaine Coulter, General Manager Acute Operational Support  
Rebecca Getty, Assistant Director Acute Services Operational Support |
| Replaces (if appropriate): | N/A |
| Type of Document: | Directorate Specific |
| Approved by: | Rebecca Getty, Assistant Director Acute Services Operational Support |
| Date Approved: | 7 December 2009 |
| Date Issued by Policy Unit: | 14 January 2010  
(Replaced Staffnet May 2012 following minor update) |
| **NHSCT Mission Statement** | To provide for all the quality of services we would expect for our families and ourselves |
Clinical Coding Manual
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* Form F: Receipt of Coding Clinics
* Data Set Change Notices www.connectingforhealth.nhs.uk/dscn
* Appendix 1: Copy of Antrim Area Hospital – Chemotherapy Coding Proforma

References:

National/Regional Clinical Coding Query Service Proforma

Health Service Guideline: The Protection and Use of patient Information
Introduction

This document has been published with the intention of promoting good practice and consistency of information produced during the clinical coding process in the NHSCT. It is based on guidance from Connecting for Health and has been designed to incorporate the requirements of the Data Accreditation process to ensure information produced during the coding process is accurate and adheres to local and national policies.

Policies and procedures provide the framework for decision making and completion of tasks. This policy sets the boundaries within which action will take place, and reflects the philosophy of the service. This policy should be supported by local procedures which are designed to accomplish specific tasks in specified chronological order.

This Policy and associated procedures conform to national requirements already in existence and other local procedures which affect the coding process, such as patient administration, patient discharge, clinical record documentation, clinical record flow and filing, storage of records.

A procedure is a series of related steps designed to accomplish a specific task in a specified chronological order should be explicit about who is responsible for what, how, when and where.
Accountability

This Policy and Procedures Manual is the responsibility of:

Name: Elaine Coulter
Job Title: General Manager Acute Service Reform
Date: Revised April 2012

The person specified above will ensure that all policy decisions detailed in this policies and procedures manual are reviewed regularly (at least annually) to ensure that this document is updated and maintained in line with current Clinical Coding Dept practices.

The person specified will also ensure that Clinical Coding Staff are made aware of the contents of this manual and their responsibility to adhere to its guidance and recommendations.

Corporately the responsibility for this Policy and Procedure Manual for Clinical Coding Dept in the NHSCT lies with the Director of Acute Hospital Services. Through the line management structure they will ensure that all standards detailed in this policy and procedures manual are, as a result of joint collaboration and understanding between clinical coding staff and the persons involved in the creation or use of information used for coding purposes, fit for purpose and adhering to regional guidance, policy and target setting in respect of Clinical Coding standards.

This policy will be reviewed annually or more often if required to ensure the policies and procedures are kept in line with current activities and central guidance.

The Clinical coding Dept will also attempt to undertake regular audit and data quality checks of electronic and paper records, to ensure that the coding policy and associated procedures are followed.
Policy statement

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

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

3. 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.

4. All clinical coding policy and procedure decisions made between the clinical coding department and individual clinicians are fully described, agreed and signed by the relevant personnel within this document. All policies or procedures agreed within the documentation if they may not meet national standards or classification coding rules and conventions – will be described appropriately in the policy and procedure manual.

5. All training plans for members of the clinical coding department and those involved in the clinical coding process, such as information/administrative staff and clinicians, are clearly defined and documented in this document.

6. Details of communication arrangements are detailed to ensure effective dissemination of information regarding coding, resolutions to queries and changes in coding practice to all coding staff and users of the information.

7. 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.

8. 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.

9. Breaches of data confidentiality or security must be reported in the first instance to the Clinical Coding Manager/General Manager, who will assess circumstances and report instances of such breaches to both their line manager and also via the Trust’s Incident Management arrangements.
Statement of purpose

1. To provide accurate, complete, timely coded clinical information to support commissioning, local information requirements and the information required for KEPs minimum Data Set and any electronic datasets required of the trust (i.e. NICR datasets).

2. To adhere to national standards and classification rules and conventions as set out in the WHO ICD-10 Volumes 1-3, Clinical Coding Instruction Manual ICD-10 and OPCS-4.6 and publications of the Coding Clinic.

3. To input onto the NHS hospital computer systems, such as the Patient Administration System (PAS), Clinical information systems (i.e. Endoscribe, ward based systems such as NIPPERs, NIMATS, CIS etc), A&E Dept systems (i.e. NIRAES, Symphony) as required, accurate and complete coded information within the designated time scales to support the information requirements and commissioning of the Hospital Trust.

4. To provide accurate, consistent and timely information to support clinical governance and the Data Accreditation process.

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

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

7. To ensure all staff are aware of the Trust’s security and confidentiality policies when using patient identifiable information.
Clinical coding procedures

Current clinical coding practices include, for the majority of Inpatient episodes of care:

1. Information documented on Discharge Summary proformas by the clinical staff on the patient’s discharge, assessment or CompletedFinishedEpisode (see Note below re Clinical staff responsibilities with regard to clinical coding).

2. Clinical records and hand written Discharge Proformas are reviewed by clinical coding staff via ward visits to review recently discharged patients records of care.

3. Information regarding the patient’s diagnosis and treatment is extracted from the proforma and clinical records by clinical coding staff.

4. Information is then translated into the appropriate coded format and entered onto the electronic patient record system PAS or other specialist services systems (i.e. NIMATs, clinical information systems).

5. Source documents for coding purposes at the Trust include discharge summaries, clinical notes, test results, radiology test results, theatre notes, GP letters etc.

6. Proformas must include information regarding the primary and secondary diagnoses, primary and secondary procedures, and this should be clearly documented on the form by the clinical staff.

7. Any locally agreed policies for exceptional coding of activity should be discussed and agreed between Clinical Coding staff and clinicians involved in the delivery of the type of care. Once such coding algorithms or exceptions have been identified they should be documented (See FORM D) and this Policy and Procedure Manual updated. Copies of any locally agreed clinical coding processes should also be disseminated amongst Trust Clinical Coding staff by the person responsible for updating of the Policy and Procedure Manual.

For Daycase activity, the above process above will also apply, excepting that in some instances the source data for clinical coding may be retrieved by the Clinical coder from electronic systems such as Endoscribe, in conjunction with paper records of care.

Coding/Terming details

- The Trust currently uses ICD-10 4th edition for clinical coding of Diagnoses and OPCS 4.6 for Procedural coding.
**Coding aides:**

- ICD10 code books
- OPCS coding books

At present there are no electronic coding aides used within the NHSCT to assist in the attribution of clinical coding to finished consultant episodes, however there is a paper data collection proforma used to collate and record activity in the Chemotherapy unit, Laurel House, Antrim Area Hospital to assist with the collection of Chemo daycase and ward attender activity. A copy of this has been included at Appendix 1

- ICD 10 codes are also available for reference on the World Health Organisation website: [http://www.who.int/classifications/apps/icd/icd10online/](http://www.who.int/classifications/apps/icd/icd10online/)

**Point of coding:**

The coding process is normally instigated within 72 hours of discharge for both Inpatients and Daycases, with NHSCT Internal clinical coding target of 95% of Inpatient/Daycase episodes to have a primary diagnosis coding completed within one month of discharge.

The Regional target for Inpatient/Daycase coding is 95% of completed episodes in the previous month are coded and this rising to 100% within two months.

The table below at page 10 outlines the current processes for collection and recording of clinical coding information across the different sites in the trust, at ward/unit level. Along with the approximate levels of annual discharges these account for.

At present clinical coding staff are based at Antrim Area and Causeway Hospitals for Mid Ulster and Whiteabbey hospitals information is collected or posted to coding. This can result therefore in delays in coding whilst coders are off on annual leave/sick leave. The Clinical coding department manager will attempt to ensure coding is still met within regional targets; however given the limitations of cover for the current service this may not always be met.

Clinical coders at present on the Antrim Area hospital site are mainly allocated specialties to clinically code, however again as annual /sick leave dictates they may provide cover in other areas, as required.

In Causeway Hospital coders visit all wards except ICU each morning to obtain information from discharge letters. NIRADS and Histology systems enhance the information.

It should be recognised that there are not clinical coding staff en situ at all hospital sites within the NHSCT, therefore for some sites clinical coding may not be achieved until a discharge letter and chart are received by coding staff from the appropriate secretary.
Clinical Staff responsibilities in relation to Clinical Coding

There is an onus of responsibility on clinical staff at ward level to ensure that a discharge summary is completed for every patient on discharge. This includes patients who are being transferred to another facility outside of this trust and those who die.

They should attempt to ensure that the discharge summary gives clear and specific information relating to the following:

- Primary diagnosis
- Secondary diagnosis (co-morbidities)
- Primary procedures (with dates)
- Secondary procedures (with dates)
- Complications of treatment
- Other factors that may have delayed the patients discharge from hospital

To assist clinical staff in the production of useful discharge summaries a Discharge proforma has been introduced in the trust and its use is supported by Clinical Coding Department staff. Electronic discharge summaries are being phased in, in certain specialties.

For chemotherapy unit activity that currently takes place in Laurel House is recorded by Nursing and Clinical staff using a proforma, developed in conjunction with Clinical Coding Dept. The contents of this proforma should be completed in an accurate and timely fashion by nursing/clinical staff to ensure accurate reflection of diagnostic and procedural codes on PAS.

Clinical staff can also assist the clinical coding staff in abstraction of relevant information and assignment of correct codes, by supplying advice and clarification on patient diagnosis and treatment when this is requested.

When a new service is being set up in the trust in future a meeting should take place between the Clinical Coding Manager and the service leads to ensure that the considerations for good clinical coding are reviewed and that arrangements are put in place to allow timely and straightforward collection of such data as is required to allow the Clinical Coding Dept to accurately and comprehensively clinically code activity. A sample form is included at FORM C to allow signoff of any such agreements.
Mechanisms in place to address missed deadlines

- Clinical Coding Reminder reports from PAS
- Business Objects (DSS) reports

Clinical Coding Reports

- 31 day and 62 day target
- Daily Antrim Uncoded Intended Procedure
- Weekly Uncoded Intended Procedure – Trust Wide by site
- Weekly Coding Uncoded FCE 08/09, 09/10 – Trust wide by site and specialty
- Causeway Coding PTL
- Ad hoc queries

Equality, Human Rights and DDA

This policy has been drawn up and reviewed in the light of Section 75 of the Northern Ireland Act (1998) which requires the Trust to have due regard to the need to promote equality of opportunity. It has been screened to identify any adverse impact on the 9 equality categories and no significant differential impacts were identified, therefore, an Equality Impact Assessment is not required.

Alternative formats

This document can be made available on request on disc, larger font, Braille, audio-cassette and in other minority languages to meet the needs of those who are not fluent in English.

Sources of Advice in relation to this document

The Policy Author, responsible Assistant Director or Director as detailed on the policy title page should be contacted with regard to any queries on the content of this policy.
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<th>Hospital</th>
<th>Ward/Area of Service</th>
<th>Current Method of Clinical Coding</th>
<th>Point of Coding (Current)</th>
<th>Source Document(s)</th>
<th>Coding/Terming Details</th>
<th>Coding Aids</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antrim</td>
<td>C1 &amp; C2 Maternity</td>
<td>Coding reminder list used to check with ward clerk Daily visit to wards to collect PN casenotes and AN proformas</td>
<td>When charts are returned to hospital from community midwife</td>
<td>PN Paper Casenote delivery notes plus NIMATS printouts. A proforma. Clinicians must have diagnosis clearly documented.</td>
<td>Coded on NIMATS using ICD 10 and OPCS Coding report printed and put in notes</td>
<td>NIMATS default codes. Casenotes GP discharge letters when one is done e.g. C/S</td>
</tr>
<tr>
<td>Antrim</td>
<td>A1, A2 ENT &amp; SURG, A3, A4, B1, B2, B3, ACU, C3, C4, C5, C6.SSA, SSW, ESU, B4, EAU, AAE, MACU</td>
<td>Coding reminder list used to check with ward clerk Daily visit to wards review notes for co-morbidities check theatre notes add any additional information. Patients who had DCC coded to diagnosis AF ward clerk informs</td>
<td>Next working day or when proforma completed.</td>
<td>Operation &amp; clinical notes. Histologies from Belfast Link Lab and other systems.</td>
<td>Coded on PAS using ICD and OPCS</td>
<td>Proformas Casenotes Histologies GP letter. Toes and TTEs, Echos lists provided by ward clerk from Tomcat and coded in retrospect</td>
</tr>
<tr>
<td>Antrim</td>
<td>A2 &amp; SCBU</td>
<td>Coding reminder list used to check with ward clerk. Doctors code patients on NIPPERS and do printout for coder. If necessary notes are checked. Daily visit to wards to check notes</td>
<td>Next working day</td>
<td>Nippers printout done by doctors, Notes if necessary, GP letter</td>
<td>Coded on NIPPERS by doctors printout from nippers left for coder. Coding checked. GP letter.</td>
<td>NIPPERS printout, casenotes where necessary, GP letter</td>
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<tr>
<td>Antrim</td>
<td>DSU Gynae</td>
<td>Coding Reminder list used to check with secretary. Hand written proformas and GP letters or casenote and histology. Daily visit to ward to check notes</td>
<td>Proforma lifted and casenote next working day &amp; discharge letter sent to coding</td>
<td>Case notes, histo and other systems</td>
<td>Coded on PAS using ICD &amp; OPCS</td>
<td>Proformas Copy of D/C letter &amp; casenote</td>
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<tr>
<td>Antrim</td>
<td>DSU Surgical &amp; ENT</td>
<td>As above</td>
<td>As above</td>
<td>Case notes histo and other systems</td>
<td>Coded on PAS using ICD &amp; OPCS</td>
<td>Proforma D/C letter and casenote</td>
</tr>
<tr>
<td>Antrim</td>
<td>Chemotherapy</td>
<td>Coding reminder list sent to ward clerk. Hand written proforma</td>
<td>When ward clerk puts on PAS and sends to coding</td>
<td>Proforma, COIS and cancer services system for letters.</td>
<td>Coded on PAS using ICD &amp; OPCS</td>
<td>Proforma &amp; COIS</td>
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<tr>
<td>Office</td>
<td>Area</td>
<td>Coding reminder list used to get patient number and codes. ICD10 codes for comorbidities are taken from the emed system.</td>
<td>Next day</td>
<td>Priority</td>
<td>Methodology</td>
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<tr>
<td>Antrim</td>
<td>Renal Unit</td>
<td>Coding reminder list used to check with secretary. Info from sec.</td>
<td>Next day</td>
<td>D/C letter</td>
<td>On PAS using ICD &amp; OPCS</td>
<td></td>
</tr>
<tr>
<td>Antrim</td>
<td>Proc</td>
<td>Coding reminder list used to check with ward clerk. Daily visit to ward. Checking notes.</td>
<td>Next day</td>
<td>Letter from system used in ICU, notes and systems.</td>
<td>On PAS using ICD &amp; OPCS</td>
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<tr>
<td>Antrim</td>
<td>ICU/Recovery</td>
<td>Coding reminder list used to check with ward clerk. Daily visit to ward. Checking notes.</td>
<td>Next day</td>
<td>Proforma, casenote.</td>
<td>Coded on PAS using ICD &amp; OPCS</td>
<td></td>
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<tr>
<td>Antrim</td>
<td>SSW &amp; SSA</td>
<td>Coding reminder list used to check with ward clerk. Daily visit to ward. Proforma, casenote.</td>
<td>Next day</td>
<td>Proforma Endoscribe print-out and notes.</td>
<td>Proforma, Endoscribe, casenote and histology</td>
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<td>Antrim</td>
<td>A Day</td>
<td>Coding reminder list used to check with ward clerk. Daily visit to ward to check notes.</td>
<td>Next day</td>
<td>Proforma Endoscribe print-out and notes.</td>
<td>Coded on PAS using ICD and OPCS</td>
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<td>Location</td>
<td>Area</td>
<td>Additional Information</td>
<td>Action</td>
<td>Coding Methodology</td>
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<tr>
<td>Antrim</td>
<td>TROL, AEOU, CPR, DSU</td>
<td>Coding reminder list used to check with ward clerk. Daily visit to wards review notes for co-morbidities check theatre notes add any additional information. Patients who had DCC coded to diagnosis AF. Ward clerk informs coder if patient had procedure done.</td>
<td>Next working day or when proforma completed.</td>
<td>Coded on PAS using ICD and OPCS. Proformas Casenotes Histologies GP letter. Toes are picked up by coder. Photocopying book for patients who had procedure done while in-patient and coded in retrospect.</td>
<td></td>
<td></td>
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<tr>
<td>Moyle</td>
<td>All wards</td>
<td>Coding reminder list used to check with ward clerk. Proforma and D/C letter sent to coding dept.</td>
<td>When ward clerk posts to coding dept.</td>
<td>Proforma D/C letter and casenote. Coded on PAS using ICD and OPCS. Proforma D/C letter and casenote and systems.</td>
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<tr>
<td>Whiteabbey</td>
<td>DSPU</td>
<td>Coding reminder lists and discharge lists. Daily visit to ward.</td>
<td>Next working day or when ward clerk has ready.</td>
<td>Endoscribe, Proformas and casenote. Coded on PAS using ICD and OPCS. Endoscribe, Proformas and casenotes and systems.</td>
<td></td>
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<tr>
<td>Location</td>
<td>Departments</td>
<td>Action</td>
<td>Information Documentation</td>
<td>Coding Method</td>
<td>Other Systems</td>
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<td>Whiteabbey</td>
<td>All other wards</td>
<td>As above</td>
<td>As above</td>
<td>Proformas and casenotes</td>
<td>Coded on PAS using ICD and OPCS</td>
<td>Casenotes and other systems</td>
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<tr>
<td>MUH</td>
<td>MUEU, MDPU and Ward 6</td>
<td>Proformas and letters sent to coding department Antrim for the day cases. Ward patients notes sent to coding department in Antrim</td>
<td>When information is sent</td>
<td>Proformas, histos and other systems and notes for some of the ward patients</td>
<td>ICD-10 OPCS-4</td>
<td>D/C letters, histos and NIPACS</td>
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<tr>
<td>MUH</td>
<td>Children’s ward/ Ambulatory unit</td>
<td>Coded when discharge is typed by relevant secretary and sent to coding department in Antrim</td>
<td>Following typing of discharge letters and sent to coding dept in Antrim</td>
<td>Discharge letter</td>
<td>ICD-10 OPCS-4</td>
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<tr>
<td>MUH</td>
<td>Children’s ward Dental extractions</td>
<td>Proformas sent to coding office in Antrim</td>
<td>When information arrives</td>
<td>As above</td>
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<tr>
<td>MUH</td>
<td>Children’s ward ENT patients</td>
<td>Proformas sent to coding office in Antrim</td>
<td>As above</td>
<td>Information documented on proforma for coding</td>
<td>As above</td>
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<tr>
<td>MUH</td>
<td>Children’s ward</td>
<td>Proforma sent to coding dept Antrim.</td>
<td>When information arrives</td>
<td>ICD-10</td>
<td></td>
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<tr>
<td>MUH</td>
<td>MUT Minor operation</td>
<td>Discharge letter sent to coding department Antrim</td>
<td>When information is sent to Antrim</td>
<td>Discharge letter</td>
<td>ICD-10 OPCS-4 Clinical Terms (Read Codes)</td>
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<tr>
<td>Causeway</td>
<td>DPU</td>
<td>Discharge letter, casenotes. Daily visit to ward</td>
<td>Next day</td>
<td>DPU systems, casenotes and histo system</td>
<td>ICD-10 &amp; OPCS 4.4</td>
<td></td>
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<tr>
<td>Causeway</td>
<td>Surgical</td>
<td>Proforma, casenotes. Daily visit to wards</td>
<td>Next day exception Mr Mullan’s is not coded until discharge is sent to coding</td>
<td>Proforma, casenotes and other systems except for Mr Mullans kept and coded when discharge letter sent</td>
<td>ICD-10 &amp; OPCS 4.4</td>
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<tr>
<td>Causeway</td>
<td>Urology</td>
<td>As above</td>
<td>As above</td>
<td>As above</td>
<td>ICD-10 &amp; OPCS 4.4</td>
<td></td>
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<tr>
<td>Causeway</td>
<td>Dermatology</td>
<td>As above</td>
<td>As above</td>
<td>Proforma, casenotes and systems</td>
<td>ICD-10 &amp; OPCS 4.4</td>
<td></td>
</tr>
<tr>
<td>Causeway</td>
<td>Pain</td>
<td>List forwarded by Consultant</td>
<td>Received within 5 working</td>
<td>List (consultant allocates the</td>
<td>ICD-10 &amp; OPCS 4.4</td>
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<tr>
<td>Causeway</td>
<td>Gynae</td>
<td>Daily visit to wards</td>
<td>Next day</td>
<td>Proformas, casenotes and histopathology</td>
<td>ICD-10 &amp; OPCS 4.4</td>
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<tr>
<td>Causeway</td>
<td>Obstetrics Delivery</td>
<td>NIMATS HHMN</td>
<td>6 weeks + post delivery when charts are returned from community midwife</td>
<td>Discharge summary all details in HHMN available</td>
<td>ICD-10 &amp; OPCS 4.4</td>
<td></td>
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<tr>
<td>Causeway</td>
<td>Obstetrics Antenatal</td>
<td>Proforma forwarded by ward clerk</td>
<td>Proforma forwarded daily</td>
<td>Proforma – contact ward clerks for clarification</td>
<td>ICD-10 &amp; OPCS 4.4</td>
<td></td>
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<tr>
<td>Causeway</td>
<td>Well New Born Babies</td>
<td>NIMATS HHMN</td>
<td>6 weeks + post delivery when charts are returned by community midwife</td>
<td>Discharge summary all details in HHMN available – back-log being addressed</td>
<td>ICD-10 &amp; OPCS 4.4</td>
<td></td>
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<tr>
<td>Causeway</td>
<td>New Born Babies Unwell</td>
<td>Proforma forwarded by ward clerk</td>
<td>Received soon after discharge/transfer (rely on CRL for missed ones)</td>
<td>Vague details on proforma – usually have to resort to searching chart if available</td>
<td>ICD-10 &amp; OPCS 4.4</td>
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<tr>
<td>Causeway</td>
<td>Paeds</td>
<td>NIPPERS</td>
<td>Supposed to be completed on discharge</td>
<td>* Junior doctors decided in April 07 to discontinue use of NIPPERS – huge backlog being addressed by coding off ‘normal’ discharge summary supplied by manager</td>
<td>ICD-10 &amp; OPCS 4.4</td>
<td></td>
</tr>
<tr>
<td>Causeway</td>
<td>General Medicine</td>
<td>Coding carried out on the ward using discharge note plus case note to add co-morbidities. Verification of coding carried out on receipt of</td>
<td>On discharge from hospital of patient.</td>
<td>Discharge letter NIRADS access</td>
<td>ICD-10 &amp; OPCS 4.4</td>
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<td>NIPPERS</td>
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<tr>
<td>Location</td>
<td>Ward</td>
<td>Action</td>
<td>Timing</td>
<td>Document Access</td>
<td>Coding System</td>
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<tr>
<td>Causeway</td>
<td>Coronary Care</td>
<td>Proforma and casenotes when patient discharged from hospital</td>
<td>Next day after discharge</td>
<td>Discharge letter NIRADS access</td>
<td>ICD-10 &amp; OPCS 4.4</td>
<td></td>
</tr>
<tr>
<td>Causeway</td>
<td>Rehab Ward</td>
<td>As above</td>
<td>As above</td>
<td>Discharge letter NIRADS access</td>
<td>ICD-10 &amp; OPCS 4.4</td>
<td></td>
</tr>
<tr>
<td>Community Hospitals (ROB &amp; DAL)</td>
<td>Dalriada Robinson Memorial</td>
<td>Charts</td>
<td>On discharge</td>
<td>No discharge letter available but all doctors notes/nursing notes etc &amp; Histopathology/bacteriology/X-Ray reports available</td>
<td>ICD-10 &amp; OPCS 4.4</td>
<td></td>
</tr>
</tbody>
</table>
Validation of clinical coded information

This section should include details of validation routines such as internal data quality and quality assurance measures, which are undertaken by the clinical coding department to ensure adherence to national standards and classification rules and conventions, and to facilitate the detection of errors.

1. Details of Internal and/or external audit programmes for in-patient and/or out-patient clinical coded information, for example:
   - External audits are undertaken once a year on a sample of 200 clinical records.

2. Information on the audit methodology for internal and external audits, for example:
   - Information about how the audit is undertaken
   - Audit mechanism used
   - Details of the auditors (for example staff who have qualified as registered auditors by taking the NHS Classifications Service audit course).

3. Information regarding the procedures in place to implement changes in coding practice as a result of the audit outcome, for example:
   - Information regarding who is responsible for implementing the change.
   - Mechanisms in place to ensure all staff are aware of the changes (coding and information staff).
   - Time scales for implementation of changes such as specified times of the year i.e. 1\textsuperscript{st} April/ 1\textsuperscript{st} September.

4. Internal quality assurance measures, for example:
   - Evidence of close supervision of staff undertaking the coding process i.e. Regular internal coding assessments/ quick fire tests to assess consistency and accuracy, completing and signing of forms by the coding staff to acknowledge changes/ alterations in coding practice (Form A) and regular review of coding standards by the coding manager.

5. Policies in place to ensure effective updating of documentation in line with National Standards, for example:
   Completion of form by all staff to specify they are in possession or acknowledge receipt of amendments to the Clinical Coding Instruction Manuals for ICD-10 and OPCS-4 (Form E)

6. Information regarding the primary and secondary diagnoses, and primary and secondary procedures should be documented on the proforma by the clinical staff on the patient’s discharge.
6. Details of the agreement with the medical staff to ensure they provide appropriate and relevant information for the purposes of clinical coding (Form C):

7. Details of any local policies in place for coding purposes, which have been agreed with clinical staff (Form D).

8. System validation measures in operation, for example:
   - Metadata file status – active/ inactive.
Clinical coding department structure and training

1. Departmental structure and number of clinical coding staff

Clinical Coding—April 2012

Antrim Funded Establishment

Band 5 – 1.00 WTE
Band 4 – 6.96 WTE (2.00 wte currently in training as Band3)
Band 3 – 2.43 WTE

Causeway Funded Establishment

Band 4 x 2 wte
Band 3 x 2.43

The coding staff based at Antrim Area Hospital, code AAH, Braid Valley Hospital, Mid Ulster, Whiteabbey and Moyle Hospital discharges.

2. Training Programme for Clinical Coders

At present all clinical coders established within the trust have completed the basic Clinical coding Training Programme organised and delivered by the Regional Clinical Coding Dept, DIS.

Any new Clinical Coders will be required to complete a training schedule as defined by the Trust Clinical Coding managers. This programme will involve:

- Completion of any regionally recognised/organised Clinical Coding Training Programme (within 6 months of appointment), to include coverage of
  - Clinical Coding Instruction Manual
  - ICD-10 International Statistical Classification of Diseases and Related Health Problems
  - OPCS-4.4 Office of Population Censuses and Surveys
  - Basic Anatomy and Physiology Instruction Manual
  - The Coding Clinic Collection

- “One to one” training with the Team Leader.
- “On the job” based training/experience with an experienced clinical coder but under the supervision of the Clinical Coding Team Leader. This training will last for as long as necessary and until the Clinical Coder feels confident in their work.
- All Clinical Coders are encouraged to attend any additional training or coding workshops organised regionally, especially with the release of updates/revisions to versions of the core coding manuals, i.e. ICD or OPCS.
Newly appointed staff will have their training needs in respect of IT systems and staff development assessed via line management review and will be expected to attend such IT and Personal Development courses as are identified.

In addition to specific Clinical Coding Dept training newly appointed staff will also be expected to attend Trust Induction Programme.

All existing Clinical Coding staff within the trust are expected to keep their coding skills and knowledge up to date and valid via compliance with the following training/knowledge & skills programme:

1. Satisfactory completion of the training schedule for newly appointed staff, where applicable.
2. Attendance at any regionally designed/delivered Clinical Coding Refresher Training Course every 2-3 years for experienced clinical coding staff.
3. Attendance at regular Clinical Coding Dept team meetings, where coders will be expected to participate in discussion, presentation and review of relevant clinical coding issues, delivery of service and review of data quality outputs.
4. Regular review of any coding clinic guidance issued and amendment of coding manuals/documentation where necessary (Form D), or amendments instructed by coding clinics (Form E). This to include any special instructions detailed in Form D “Details of Local Policies”, especially when a coder is commencing coding in an area unfamiliar to him/her, i.e. another hospital, ward, specialty.
5. Attendance on regular specialist training courses wherever available, as identified via line management, KSF review.
6. Attendance on relevant computer training courses to update IT skills and to reinforce Information for Health objectives, again as identified between coder and line management staff via team meetings, KSF review.
7. Attendance at other relevant training courses including health and safety, fire training, security and confidentiality etc.
8. Implementation of new OPCS-4 documentation will involve additional training of staff and implementation of any additional codes (Form B).

3. **Details of in-house career structures for all coding staff**

Clinical coding staff will be recruited at Band 3. Once their training outlined above has been successfully completed they will then receive a Band 4.

4. **Details of annual appraisals and allocation of personal objectives to encourage personal development**

As part of the KSF review process Clinical Coding staff will undertake an annual review of their job description with line management staff to ensure they are regularly updated and amended as necessary to meet the changing role of coding staff.

5. **Details of Training Records**

Clinical coding staff will be expected to maintain details of their own attendance and completion of training courses, in respect of both clinical coding and other personal and staff development programmes. However in addition to this a record of training courses attended by clinical coding staff, with dates of attendance and outcome (i.e. pass, fail etc.
for those courses with some element of testing/examination) will be kept in this Policy and Procedure Manual for each member of staff (Form A). The responsibility of keeping the document holder informed of such attendance on courses lies with the clinical coder and the Policy and Procedure document holder is responsible for ensuring Form F is maintained.

6. **Training of non-coding staff**

The NHSCT Clinical Coding Managers will be responsible for responding to any requests for training or advice made by other departments or clinicians within the trust. A programme of awareness training and publicity for clinical coding will be undertaken via:

- The development of an information leaflet for Clinical Coding Dept.
- The development of a programme of awareness sessions, participation at induction programmes by new medical staff etc.
- Participation in working groups, offering advice on areas of service delivery relevant to the work of the Clinical Coding Dept, i.e. the development of new information flows at ward level, discussions with consultants when new procedures, types of care are introduced into the trust etc.
Communications in clinical coding

This section includes details of arrangements in place for the receipt and dissemination of relevant documentation relating to clinical coding across the Trust to endorse consistency and accuracy of coded information.

1. When a clinical coder in the NHSCT encounters a problem when trying to allocate a clinical code accurately the following process should be employed as a query mechanism for internal and external queries relating to clinical coding. The steps are:

   A. Reference should be made to all current clinical coding material such as the Clinical Coding Instruction Manual ICD-10 and OPCS-4, Coding Clinic Collection and NHS Classifications Service clinical coding guidelines.

   B. The query should then be referred to senior level coding staff to determine whether the query can be resolved internally.

   C. If it is not possible to resolve the coding issue within the Clinical Coding Dept the coder and/or the Clinical Coding Manager will liaise with the appropriate clinician on applicable ICD-10 and OPCS-4 codes that can be applied. Always ensure that the advice given does not contravene the rules and conventions of the classifications or national standards.

   D. If it is still not possible to resolve coding issue then the query should be referred to the Regional Clinical Coding service by either the Clinical Coder (with the endorsement of the Clinical Coding Manager) or the Clinical Coding Manager, including the completion of any relevant query proforma to be accompanied by anonymised information if appropriate.

   E. Disseminating the resolution. Once a decision on the correct method of clinically coding the episode of care has been established the correct coding format should be disseminated by the appropriate Clinical Coder/Clinical Coding Manager (i.e. whoever submitted the query to the Regional Service) to all staff within the department and users of the information.

2. Internal meeting programmes and agenda items for the meetings

There should be an annually drawn up programme of meetings drawn up to improve communication for clinical coding staff within the trust, these should include:

- Internal meetings with coding staff once a month.
- Agenda items include query resolutions, internal assessments, quality assurance measures etc.
Security and confidentiality

The NHSCT takes the security of confidentiality of its patient and client data very seriously. To this end this Policy and Procedure Manual sets out the steps that should be taken and awareness clinical coding staff must have when carrying out their duties.

Such internal measures include:

- The importance of establishing the Trust’s commitment to data quality will be addressed at the commencement of employment and via any induction meetings new clinical coding staff may have with their line managers or corporately.

- All Clinical Coding Dept staff must be aware of and comply with any Trust Data Confidentiality Policies implemented.

- All staff should be familiar with and have access to the following confidentiality and security documentation:
  
  b). The Protection and Use of Patient Information (HSG(96)18) and HSG 2000/009

- Clinical coders as users of Clinicom PAS must attend formal training, which is organised by the Trust’s PAS System Manager. Once issued with a PAS password it becomes the Clinical Coders responsibility to ensure that such logins and passwords as issued are not shared with others, but remain under the sole use of the clinical coder.

- The environment in which users work is important in terms of data quality and security. Therefore clinical coding dept staff must adhere to good office management practice, including ensuring that PCs are not left unattended when switched on, systems such as PAS are logged out of when not being used, paper records are securely stored and paper records with patient/client identifiable information on them are confidentiality disposed of and held for no longer than necessary.

- 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 of the NHSCT unless approved by Clinical Coding Managers, who should insure that any such releases of data are anonymised and non patient identifiable.

- Any training issues identified in audit must be addressed promptly.
Clinical coding staff training programme

This form contains information regarding training courses clinical coding staff have attended and the dates of attendance.

<table>
<thead>
<tr>
<th>Name of Coder</th>
<th>Training Course Attended</th>
<th>Date of Attendance</th>
<th>Signature of Manager</th>
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</table>
Date of implementation of OPCS-4

This form contains the dates of Trust implementation of OPCS-4 updates

<table>
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<tr>
<th>OPCS-4 Version</th>
<th>Date of implementation</th>
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<tr>
<td>4.3</td>
<td>1\textsuperscript{st} April 2006</td>
</tr>
<tr>
<td>4.4</td>
<td>1\textsuperscript{st} April 2007</td>
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</table>
Clinical coding information agreements with clinical staff

I hereby agree that staff in the Directorate of …………………………… will provide clinical information on the proforma/discharge notes for coding purposes in the following areas:

a). Primary Diagnosis

b). Secondary Diagnoses (Co-morbidities)

c). Primary Procedures

d). Secondary Procedures

Signed: ……………………………………………

Job Title: ……………………………………………
Details of local policies

This section includes details of any ‘consultant specification’ coding and local clinical coding policies. For example there is no specific code in ICD-10 to reflect a non Q wave myocardial infarction”, therefore guidance should be sought from the relevant clinician regarding the coding of this diagnosis.

Example:

It is to be the local policy of this Hospital Trust to code all non Q wave myocardial infarctions to I21.4 Acute sub-endocardial myocardial infarction

Signed: …………………………………………………………………

Cardiology Consultant (Specify Clinician)

Date: …………………………………………………………………

Seen by:

<table>
<thead>
<tr>
<th>Name of Coder</th>
<th>Signature of Coder</th>
<th>Date</th>
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Amendments to Clinical Coding Instruction Manual ICD-10 and OPCS-4

This section includes details of amendments made to the Clinical Coding Instruction for Manuals for ICD-10 and OPCS-4. All coding staff should be receipt of the amendments. Anyone not in receipt of the amendments should contact the NHS Classifications Service, NHS Connecting for Health

Amendments seen by:

<table>
<thead>
<tr>
<th>Name of Coder</th>
<th>Signature of Coder</th>
<th>Documentation</th>
<th>Amendments</th>
<th>Date</th>
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<tr>
<td>A N Other</td>
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<td></td>
<td></td>
<td>28/01/2001</td>
</tr>
</tbody>
</table>
Receipt of *Coding Clinic* inserts

This section includes details of staff in receipt of the *Coding Clinic* insert. All coding staff should be in receipt of this insert and upon signature of receipt of coding clinic are obligated to update coding books.

Coding Clinic inserts received by:

<table>
<thead>
<tr>
<th>Name of Coder</th>
<th>Signature of Coder</th>
<th>Coding Clinic Ref</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. N Other</td>
<td>A N Other</td>
<td>August 2000</td>
<td>05/09/2000</td>
</tr>
</tbody>
</table>
References

These are a few suggested appendices with details of suitable reference materials that can be included within the manual.

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.connectingforhealth.nhs.uk/systemsandservices/data/clinicalcoding/data_quality/query_mech

Health Service Guideline: The Protection and Use of Patient Information

http://www.doh.gov.uk/nhsexipu/confiden/protect/index.htm

This includes information on

- HSG(96)18 / LASSL(96)5 – Health Service Guideline – The Protection and Use of Patient Information
- The Protection and Use of Patient Information – Guidance from the Department of Health
- The Data Protection Act 1998


The Data Protection Act 1998 gives every living person the right to apply for access to their health records. The exception to this is the records of the deceased person that are still governed by the Access to Health Records 1990.

Other useful links:

Patient Confidentiality and Caldicott Guardians: Frequently Asked Questions
http://www.doh.gov.uk/nhsexipu/confiden/faq.htm