This policy has been produced with the intention of promoting good practice and consistency of clinical coding within the Southern Health NHS Foundation Trust. It has been designed to ensure information produced during the coding process is accurate, timely and adheres to local and national policies and achieves national standards.

Keywords (minimum of 5): Clinical Coding, Clinical Coders, ICD-10, OPCS, Validation

Target Audience: Clinical Coding officers,Clinicians

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Approved & Ratified by: Information Governance Group

Date of meeting: 14 May 2019

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Author: Chris Turnidge, Senior Consultant, Monmouth Partners, David Marwick, Head of Information

Accountable Executive Lead: Finance Director
# Version Control

## Change Record

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<td>17/05/18</td>
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<td>V6</td>
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<td>09/05/19</td>
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<td>V7</td>
<td>1,2,5</td>
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## Reviewers/contributors

<table>
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<tr>
<th>Name</th>
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Clinical Coding Policy and Procedures

1. Introduction

This policy has been produced with the intention of promoting good practice and consistency of clinical coding within the Southern Health NHS Foundation Trust. It has been designed to ensure information produced during the coding process is accurate, timely and adheres to local and national policies and achieves national standards.

1.1 Clinical Coding Definition

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 a coded format which is nationally and internationally recognised to support both statistical and clinical uses.

1.2 Clinical Coding Description

Coded clinical data (generated from classifications OPCS-4 and ICD-10) uses rules and conventions that, when applied accurately result in the provision of high quality statistically meaningful data.

This directly affects clinicians and all healthcare professionals, financial teams, information managers and data analysts along with IT Professionals.

The NHS requires input of accurate data to reflect clinical activity and trusts now have a financial incentive to ensure that coding is accurate, comprehensive and timely.

2. Statement of purpose

To provide accurate, complete, timely coded clinical information to support commissioning, local information requirements.

2.1 Adhere to national standards and classification rules and conventions as set out in the WHO ICD-10 Volumes 1-3, National Clinical Coding Standards ICD-10, OPCS-4.8, Clinical coding instruction manual OPCS 4.8 and Connecting for Health Coding Clinic.

2.2 Ensure input into Patient Administration Systems (PAS) of complete and accurately coded information, within designated time scales, to support the information requirements and commissioning of the Southern Health NHS Foundation Trust.

2.3 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.

2.4 Ensure continual improvement of the clinical coded information within the Southern Health NHS Foundation Trust through systematic audit and quality assurance procedures.

2.5 Ensure all staff are aware of the trusts security and confidentiality policies when using patient identifiable information.
3. **Clinical Coding Procedures**

3.1 **Source Document**

The source document for coding mental health patients will be the OpenRiO system. The episode should be coded using the discharge summary or letter, if created. The medical progress notes are also available and routinely used to add information and specificity. Nursing notes can also be used should further clarification on a disorder be needed. Every effort should be made to find as much information relating to the episode as possible.

The source document for coding patients in Romsey, Fordingbridge and Lymington New Forest Hospital should primarily be Electronic Discharge Summary along with patient test results. Where the Electronic Discharge Summary has not been completed coding can be completed using any other source available at the time of coding.

The source document for Gosport and Petersfield Hospitals are discharge summaries which are emailed to the shared clinical coding mailbox from the ward clerks at the individual hospitals. Should a discharge summary not be received further information can be accessed via the OpenRiO system. Should this be unsuccessful the ward clerk can be contacted for any further information.

The source documentation for Alton Community Hospital is electronic discharge summary received into the shared clinical coding mail box. Coding is completed onto the OpenRiO system.

3.2 **Coding**


ICD 10 codes are also available for reference on the World Health Organisation web site: [http://apps.who.int/classifications/icd10/browse/2016/en](http://apps.who.int/classifications/icd10/browse/2016/en)

High cost drugs lists and Chemotherapy Regimens lists are available from [www.connectingforhealth.nhs.uk](http://www.connectingforhealth.nhs.uk)

3.3 **Point of Coding**

The coding process will be completed as close to patient discharge as possible. This is undertaken remotely from Monmouth Partner's secure central office based in London by fully qualified clinical coders.

Mental Health coding is carried out via the OpenRiO system accessed via the remote desktop icon. Lymington Hospital and Romsey Hospital coding is carried out via the eCaMIS Live system accessed via the remote desktop icon. Portsmouth Hospitals Trust coding is carried out via the PAS system accessed via the iDesktop.

3.4 **Time Scales**

The team will aim to code all episodes within four working days of the discharge month's end date. This will be monitored by the Lead Clinical Coder. Should problems arise relating to missed deadlines these will be addressed accordingly by the Lead Clinical Coder.
4. **Validation of Clinical Coded Information**

4.1 **Quality assurance checks**

The Lead Clinical Coder will aim to undertake an internal quality assurance check every three months using a random sample of at least 30 clinical records.

4.2 **DSPT Audits**

Data standards and protection toolkit clinical coding audits are undertaken once a year on a sample of at least 100 clinical records.

4.3 **Correction of Errors**

All errors identified as a result of an audit are to be corrected within one month.

4.4 **Local Policies**

When local policies are created the Lead Clinical Coder will inform all members of the team and ensure books are updated accordingly. Each member of staff will responsible for creating local policies. All members of the team will sign each local policy to prove they have seen the policy.

Local policies will be divided into Mental Health and Integrated Community Services.

5. **Communications in Clinical Coding**

To endorse consistency and accuracy of coded information the following steps are in place:

- Clinical Coding Instruction manuals ICD-10 and OPCS – 4.8, Coding Clinic and NHS Connecting for Health’s Clinical Coding Guidelines are used.
- Liaison with appropriate clinician on applicable ICD-10 and OPCS 4.8 codes. Clinical Coders ensure that the advice given does not contravene the rules and conventions of the classifications or national standards. Standards agreed with clinicians are documented appropriately.
- Reference to senior level coding staff to determine whether the query can be resolved internally.
- Referring any query to the National Clinical Coding Query Mechanism including completion of the relevant query proforma information if appropriate.
- Distribute the resolution to the team.

6. **Internal Meetings and Agenda Items**

Internal meetings with coding staff will be held as and when required and the agenda items will include query resolutions, internal assessments, audit feedback etc. All coding staff are required to attend the internal meetings and appropriate times will be made available when all can attend.
7. Clinical Coding Team Structure and Training

7.1 Structure

Monmouth Partners will ensure that all work is covered during periods of leave (e.g. annual, sick, carer’s, special, etc.)

7.2 Leave

Monmouth Partners will ensure that their coders attend all training as necessary. The training requirements are as follows:

- Attendance of the Clinical Coding Foundation workshop within six months of appointment for all untrained coders.
- Attendance on the Clinical Coding Refresher Training Course every 3 years for experienced clinical coding staff.
- Attendance on regular specialist training courses wherever available.
- Attendance on relevant computer training courses to keep their IT skills up-to-date.
- Attendance to other relevant training courses in line with trust policies (e.g. health and safety, fire training, security and confidentiality etc.).

7.3 Training

7.4 Induction Programmes for New Staff

An induction and training programme for all new clinical coding staff will be implemented and will include attendance on training courses, on-going in-house training and monitoring, and attendance on other relevant trust courses (e.g. health and safety, fire training, security and confidentiality etc.).

7.5 Annual Appraisals

Individual performance appraisals and personal development plans will be undertaken yearly in line with Monmouth’s internal company policy.
8. **Implementation and Compliance**

8.1 **Responsibilities of all staff and Non-Executive Directors**

All staff (whether permanent, temporary or contracted), non-executive directors and contractors are responsible for ensuring that they are aware of the requirements incumbent upon them and for ensuring that they comply with these on a day-to-day basis.

Trust clinicians and administrative staff must forward the provider spell summaries/discharge summary forms to the clinical coding team within two days of patient discharge.

Managers at all levels are responsible for ensuring that the staff for whom they are responsible are aware of and adhere to this policy. They should ensure that the policy and its supporting standards and guidelines are built into local processes. They are also responsible for ensuring staff are updated in regard to any changes in this policy.

8.2 **Training of Non-Coding Staff**

Training programmes for users of coded information and those who produce the information for coding purposes (e.g. awareness sessions, participation at induction programmes by new medical staff, etc.) will be made available on request.

9. **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
- Primary procedures (with dates)
- Secondary procedures (with dates)
- Co-Morbidities (Appendix 1)
- Complications of treatment
- Other factors that may have delayed the patient discharge from hospital

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.

10. **Review**

This policy will be reviewed annually.

11. **Distribution**

This policy will be available at the Trust’s designated locations.
## 12. Useful Contacts

<table>
<thead>
<tr>
<th>Name</th>
<th>Job Title</th>
<th>Telephone Number</th>
<th>Email Address</th>
</tr>
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<tbody>
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</tr>
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<td>David Marwick</td>
<td>Head of Information, Southern Health NHS Trust</td>
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### Appendix 1 List of mandatory comorbidities

<table>
<thead>
<tr>
<th>Condition</th>
<th></th>
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<tbody>
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<td>Abnormal liver function test (in the absence of any underlying cause)</td>
<td>Emphysema</td>
</tr>
<tr>
<td>Alcohol abuse</td>
<td>Epilepsy</td>
</tr>
<tr>
<td>Alzheimer’s disease including dementia in Alzheimer’s disease</td>
<td>Elderly / Geriatric falls</td>
</tr>
<tr>
<td>Anxiety disorders including anxiety</td>
<td>Heart Failure</td>
</tr>
<tr>
<td>Asthma</td>
<td>Hemiplegia</td>
</tr>
<tr>
<td>Autism</td>
<td>Hypertension</td>
</tr>
<tr>
<td>Cerebrovascular diseases</td>
<td>Ischaemic heart disease</td>
</tr>
<tr>
<td>Chronic bronchitis</td>
<td>Left Ventricular Failure</td>
</tr>
<tr>
<td>Chronic kidney diseases including chronic tubulo-interstitial nephritis, small kidney(s) and polycystic kidney(s)</td>
<td>Living Alone</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease / Chronic obstructive airways disease</td>
<td>Mitral Valve disease</td>
</tr>
<tr>
<td>Congestive cardiac failure</td>
<td>Multiple Sclerosis</td>
</tr>
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<td>Current anti-coagulant therapy</td>
<td>Personal history of anti-coagulant therapy</td>
</tr>
<tr>
<td>Current smoker</td>
<td>Personal history of self-harm</td>
</tr>
<tr>
<td>Dementia including dementia in Alzheimer’s disease</td>
<td>Presence of cardiac pacemaker</td>
</tr>
<tr>
<td>Depressive disorders including depression and bipolar disorder</td>
<td>Psychosis and psychotic disorders including schizophrenia, schizotypal and delusional disorders</td>
</tr>
<tr>
<td>Developmental delay including learning difficulties and learning disability</td>
<td>Registered Blind</td>
</tr>
<tr>
<td>Diabetes Mellitus</td>
<td>Renal failure</td>
</tr>
<tr>
<td>Drug abuse</td>
<td>Respiratory failure</td>
</tr>
<tr>
<td>Dysphagia (difficulty in swallowing)</td>
<td>Rheumatoid arthritis</td>
</tr>
<tr>
<td>Dysphasia</td>
<td>Severe or profound hearing loss</td>
</tr>
<tr>
<td>Eating disorders</td>
<td>Urinary retention</td>
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