TRUST-WIDE SERVICE BASED POLICY

CLINICAL CODING

Policy Number:	IT15
Scope of this Document:	All Staff
Recommending Committee:	Joint SIRO and Information Governance Committee
Approving Committee:	Executive Committee
Date Ratified:	October 2014
Next Review Date (by):	October 2017
Version Number:	Version 3.2
Lead Executive Director:	Executive Director of Finance
Lead Author(s):	Director of Informatics and Performance Improvement

TRUST-WIDE SERVICE BASED POLICY

Version 3.2

Quality, recovery and wellbeing at the heart of everything we do

SUPPORTING STATEMENTS – this document should be read in conjunction with the following statements:

SAFEGUARDING IS EVERYBODY'S BUSINESS

All Mersey Care NHS Foundation Trust employees have a statutory duty to safeguard and promote the welfare of children and adults, including:

- being alert to the possibility of child/ adult abuse and neglect through their observation of abuse, or by professional judgement made as a result of information gathered about the child / adult;
- knowing how to deal with a disclosure or allegation of child / adult abuse;
- undertaking training as appropriate for their role and keeping themselves updated;
- being aware of and following the local policies and procedures they need to follow if they have a child / adult concern;
- ensuring appropriate advice and support is accessed either from managers, *Safeguarding Ambassadors* or the trust's safeguarding team;
- participating in multi-agency working to safeguard the child or adult (if appropriate to your role);
- ensuring contemporaneous records are kept at all times and record keeping is in strict adherence to Mersey Care NHS Foundation Trust policy and procedures and professional guidelines. Roles, responsibilities and accountabilities, will differ depending on the post you hold within the organisation;
- ensuring that all staff and their managers discuss and record any safeguarding issues that arise at each supervision session.

EQUALITY AND HUMAN RIGHTS

Mersey Care NHS Foundation Trust recognises that some sections of society experience prejudice and discrimination. The Equality Act 2010 specifically recognises the *protected characteristics* of age, disability, gender, race, religion or belief, sexual orientation and transgender. The Equality Act also requires regard to socio-economic factors including pregnancy /maternity and marriage/civil partnership.

The trust is committed to equality of opportunity and anti-discriminatory practice both in the provision of services and in our role as a major employer. The trust believes that all people have the right to be treated with dignity and respect and is committed to the elimination of unfair and unlawful discriminatory practices.

Mersey Care NHS Foundation Trust also is aware of its legal duties under the Human Rights Act 1998. Section 6 of the Human Rights Act requires all public authorities to uphold and promote Human Rights in everything they do. It is unlawful for a public authority to perform any act which contravenes the Human Rights Act.

Mersey Care NHS Foundation Trust is committed to carrying out its functions and service delivery in line the with a Human Rights based approach and the FREDA principles of **F**airness, **R**espect, **E**quality **D**ignity, and **A**utonomy

CONTENTS

		Page
1.	Introduction	5
	Rationale	5
	Scope	5
2.	Statement	6
4.	Coding Procedure	6
5.	The Role of Junior Doctors in the Coding Process	8
6.	Validation of Clinical Coded Information	9
7.	Clinical Coding Department Structure and Training	10
8.	Communication in Clinical Coding	11
9.	Security and Confidentiality	12
10.	Reference Documents	12
11.	Equality and Human Rights statement	12
12.	Bibliography	13
13.	Glossary	13
14.	Appendices	14-36

1. INTRODUCTION

1.1 Rationale

Accurate clinical coding is a driver for national change in the treatment of diagnosed conditions and associated co-morbidities. It is important for the Trust to understand the caseload case mix and reasons for admission within the Trust. It helps to inform:

a) Health and Social Care Professionals
b) Managers, Commissioners and Planners
c) Patients and Public
d) Payment by Results
e) Information Governance Toolkit Requirements
f) National Standards set by the DoH
g) Audit Commission

1.2 Scope

All staff involved in the diagnosis of conditions are responsible for the collection and collation of the clinical coding. It is required to accurately report the complexity and make up of the case mix and to satisfy national requirements. The standards associated with clinical coding change regularly and clinical coders ensure that our information is of the highest standard and accuracy. This policy is intended to ensure that all staff involved in the process understands their responsibilities and that required training is kept up to date.

In this context the term Clinical Coding refers to the coding of diagnostic; Mental Health, physical; medical and social conditions present in individuals receiving care from Mersey Care NHS Foundation Trust.

The classification used is International Statistical Classification of Diseases and Related Health Problems Version 10 (ICD10), including the fifth digit Mental Health codes (ICD 10 Classification of Mental and Behavioural Disorders) and fifth digit Neurological codes. OPCS Classification of Interventions and Procedures version 4.7 (OPCS) is used for coding procedures/interventions.

2. STATEMENT

2.1 All procedures involved in the capture of information for clinical coding purposes are clearly defined in this document for all services.

2.2 All quality assurance procedures for the clinical coding department are detailed in this document to ensure continual improvements in the standard and quality of coded data in the trust.

2.3 All changes to the clinical coding policy and/or procedures are detailed in this policy and procedure document in the appropriate manner to ensure all contributors are in agreement with the current practice. Any alterations to clinical coding practice should have change and implementation dates provided within this document, and comply with national coding rules and conventions.

2.4 All future clinical coding policy and procedure decisions made between the clinical coding department and individual clinicians will be fully described, agreed and signed by the relevant personnel within this document. All policies or procedures agreed within this document do not contravene national standards or clinical coding rules and conventions.

2.5 Training plans for members of the department and those involved in the clinical coding process are clearly defined and documented within this document.

2.6 Details of communication arrangements are detailed in this document to ensure effective dissemination of information regarding coding, resolution of queries and changes in coding practice to all coding staff and users of information.

2.7 All confidentiality and security issues incurred during the coding process are detailed in this document to ensure adherence to local and national policies.

3. CODING PROCEDURE

3.1 Current clinical coding practices:

3.1.1 Information is documented by clinical staff regarding the service user's diagnosis and treatment within the Health Records.

3.1.3 Inpatient Discharges and Ward Transfers

3.1.3 Each week a specific discharge list is printed by the coding staff who use it to obtain diagnoses using various methods. The methods to collect diagnosis are from the discharge letter recorded within the Patient Clinical Information System and all patient notes on the Patient Clinical Information System and Windip if further verification is needed they obtain it verbally from the Medical Staff. (see Appendix 1).

When completing for the Learning Disabilities Respite Ward the following process should be followed:-

- Verification of the diagnosis can be found on ePEX or Windip. The Clinical Coders then record the primary diagnosis and co-morbidities on a proforma.
- Clinical Coders liaise with the Senior Ward Manager on a weekly basis for primary diagnosis or co-morbidities or any other diagnoses during the stay i.e. fall, chest or urinary tract infection etc. (See Appendix 2)
- Local coding policies must be signed off as per the form. (Appendix 4). The Clinical Coders also visit the ward to update all diagnoses and proformers. All

proformas are signed and dated by the Ward Manager and kept in file for validation.

3.1.4 For all available diagnoses on the Patient Clinical Information System (ePEX) the coder translates the diagnosis into ICD10 and OPCS codes and then enters the diagnosis against the appropriate ward stay on ePEX. If the diagnosis is not clarified the coders must write the unconfirmed diagnosis against the service user on the list, and then contact the relevant clinician i.e. Junior Doctor or Consultant. Once the diagnosis has been confirmed the coder must write 'Confirmed by (Dr Name)', date and confirmed diagnosis against the service user's name, the diagnosis is then converted into ICD10 codes etc.

3.1.5 If there are problems obtaining the diagnosis the coders will notify the Information Governance Officer/Trust Health Records Manager, who will contact the consultant team.

3.1.6 When a discharge letter is not available and patient notes are unclear the coder must try to obtain the diagnosis verbally from the named doctor.

3.1.7 Once all coded diagnoses are entered onto the Patient Clinical Information System all documentation is retained within the Clinical Coding Office and scanned on to Windip following which they are confidentially destroyed by shredding.

3.1.8 Procedure for validation is followed (see Appendix 3).

3.1.9 Episode/Caseload Diagnosis

3.1.10 Consultants download their current caseload list on a monthly basis from the Business Intelligence Today portal (BiT). This enables them to manage their caseload and to see which open episodes are without diagnoses recorded and to review and update the diagnoses they have already provided.

3.1.11 The consultant reviews their caseload and, for any service users who do not have any diagnoses, they write them against the record in the list. The list will automatically indicate where any present diagnoses have been amended.

3.1.12 The caseload lists are sent to the generic Data Quality email account. The Clinical Coders print out the list for translating into ICD10 and enter the new diagnoses or amend them in the appropriate consultant episode. The date each diagnosis starts from is held within the Clinical Information System.

3.1.13 Paper copies are not accepted by the clinical coding department.

3.1.14 If there are any discrepancies then the coder will discuss with the consultant. When the discrepancies have been resolved, the coder will translate to ICD 10 and enter onto the system.

3.1.15 The caseload printouts are then saved on to the epex system.

3.1.16 Procedure for validation is followed (see Appendix 3)

3.2 Source Document:

3.2.1 Diagnoses are mainly obtained from patient notes that are recorded on ePEX, Windip and discharge letters recorded on the Clinical Information System

3.2.2 Diagnoses are also obtained by the Clinical Coders by contacting the relevant medical team member.

3.2.3 Clinical Coders access the service user's Health Record as and when they feel it is required or necessary.

3.3 Coding System:

The Trust uses the coding classifications ICD10 and OPCS 4.

3.4 **Timescales:**

3.4.1 For discharge diagnoses the coding process is instigated at the beginning of each week. The aim is to have all diagnoses coded weekly and entered onto ePEX. Checklists are prepared and worked upon daily to reduce any outstanding diagnosis.

3.4.2 Episode and caseload diagnoses are done when received from Data Quality team.

3.4.3 Diagnoses must be submitted by Payments by Results (PbR) Flex Date after the end of each month to Secondary User Service (SUS) for Hospital Episode Statistics (HES). Flex Dates can be obtained from the Hospital Episodes website.

3.4.4 100% completion of coding for discharged or finished consultant episodes has to be achieved by the end of the second week of the current month.

3.4.5 There is monitoring in place to ensure weekly outstanding missing data is captured to ensure 100% completion is achieved.

4. THE ROLE OF JUNIOR DOCTORS IN THE CODING PROCESS

4.1.1 Junior Doctors are instrumental in the provision of high quality coding and the importance of their role and relationship with the Information Department is recognised.

4.1.2 All Junior Doctors are encouraged to give diagnostic information and are provided with various types of documentation relating to ICD 10 and its uses (Appendix 2).

4.2 Induction

4.2.1 Clinical coding is part of the online e-learning section of the Junior Doctors Induction. The induction programme occurs at the time of rotation.

5. VALIDATION OF CLINICAL CODED INFORMATION

5.1 To ensure adherence to National Standards and National clinical coding rules and conventions, validation routines such as internal data quality measures are followed to facilitate the detection and correction of errors within Mersey Care NHS Foundation Trust which are:

- Document any new protocols established or changes to existing coding policy.
- Ensure that coding staff are aware of changes to policy.
- To undertake internal sampling of coded data.
- Disseminate any problems highlighted in audits and address any local training issues.
- To maintain the Clinical Coding Validation Procedure document.
- Develop the role of clinical coding within the Trust.
- Maintain the good working relationship with Service Clinicians.
- Promote the role of clinical coders with clinicians and raise awareness of the importance of clinical coding and level of detail required for accurate coding.
- To review the online induction presentation to doctors
- Clinical Coders to attend the Cheshire & Merseyside Quarterly Coding Advisory Group Meetings hosted by the Clinical Coding Academy, MIAA.

5.2 Details of Internal and External audit programmes for coding:

5.2.1 Internal audits are conducted by the Clinical Coding team within the Trust.

5.2.2 External audits are undertaken by an accredited Clinical Coding auditor from MIAA.

5.3 Procedures to implement changes as a result of Internal/External Audit Recommendations

5.3.1 Following receipt of the audit report an Audit Action plan is produced. The actions are discussed with clinical coders to ascertain if the changes can be implemented within the coding team. The actions are taken to the Data Quality Steering Group and noted there once completed.

5.4 Details of processes for clinical staff to provide appropriate and relevant information for clinical coding purposes

- Within Mersey Care NHS Foundation Trust, the process of obtaining diagnosis varies between services. Please see below for coding process by service:

- Adult Mental Health – from Letter, patient notes that are recorded on epex/windip or direct verbal contact with Junior Doctor.

- Older Peoples – Letter, patient notes that are recorded on epex/windip or direct verbal contact with Junior Doctor.

- Rehab wards – Letter, patient notes that are recorded on epex/windip or direct verbal contact with Junior Doctor.

- Brain Injuries –Letter, patient notes that are recorded on epex/windip or direct verbal contact with Junior Doctor.

- Learning Disabilities (Local Division) – from patient notes that are recorded on epex/windip and direct verbal contact with Senior Ward Manager

- Drug Service – Letters, electronic notes.

- Alcohol Service – by letters, electronic notes.

5.4.1 For full details of coding procedure by service please see Appendices.

6. CLINICAL CODING DEPARTMENT STRUCTURE AND TRAINING

6.1.1 The Clinical Coding Department has three members of staff two full time qualified Clinical Coders and one full time Novice Clinical Coder.

6.1.2 The Clinical Coders report to the Information Governance Officer/Trust Health Records Manager. Trust responsibility for clinical coding sits with the Director of Informatics and Performance Improvement.

6.2 Training Programme Novice Coder Level:

6.2.1 All clinical coders on appointment to post, are required to attend a novice coding course.

6.2.2 When a novice coder has completed their novice training course they will be given assistance for the next two years by an experienced coder. Their coded data will be analysed and corrected by the experienced coder before it is entered onto the Trust's Clinical Information System.

6.2.3 Following this two year supervision, the novice will now be classed as an experienced Clinical Coder.

6.2.4 During the two years the novice coder will attend both a six and twelve month follow up course provided by the Clinical Coding Academy within MIAA who provide a written assessment and feedback on progress to the Trust.

6.3 Training Programme Trained Coder Level:

6.3.1 Upon completion of the three years, the Clinical Coders are then required to attend a Clinical Coding Refresher Course every year.

6.3.2 Coders are required to attend specialty workshops whenever possible.

6.3.3 All Clinical Coders are encouraged to train towards achieving the National Clinical Coding Qualification (ACC) and the Trust will support the coder in attaining this qualification. Please see (Appendix 5) for policy 'Career Pathway for Clinical Coding Staff to Attain Accredited Clinical Coding Qualification'

7. COMMUNICATION IN CLINICAL CODING

7.1.1 It is vital that there are clear procedures documented to deal with the queries arising during the coding process. Everyone involved in the supply and use of clinical information should be aware of the process of collecting data.

7.2.1 Query Mechanism

7.2.2 All queries relating to clinical coding should attempt to be resolved internally and only after escalating through the coding management structure should they be submitted in writing to NHS Digital (previously referred to as Health & Social Care Information Centre), following the protocol below:

7.3 Query Protocol

- Reference to all coding materials such as the NHSME Clinical Coding Standards Manual, Coding Clinic Collection and NHS Information Authority clinical coding guidelines. (See Appendix 6 for useful information.)
- Queries to be raised and discussed with other coders in the team to see if the query can be resolved at this level.
- Secondly contact colleagues at other Trusts for help and advice.
- Thirdly referred to the Information Governance Officer/Trust Health Records Manager, to see if the issue can be resolved internally.
- Finally coding queries unresolved at all levels within the department should then be forwarded onto NHS Digital. This can be done as follows:

  - By email giving as much information as possible, copy of discharge letter sent if necessary ensuring all confidential information is removed.
  - All responses to the Trust's queries are circulated to every coder within the department.
  - Changes to the coding policy are disseminated to coding staff via the Coding Group email;
  - Coders are allocated time on receipt of coding clinics and other relevant documents to update their classifications.

7.4 Regional Coding Communication

- Coding Clinics are accessible on line.
- Amendments to the NHS Executive Clinical Coding Standards along with the Data Quality Review are accessible on line. Each coder has their own Standards, which they are required to keep up to date, they sign a form acknowledging they have read and understood each change in the standards
- Feedback from the Clinical Coding Advisory Group meetings is disseminated to all coders, along with minutes.
- The Regional Clinical Coding Team have regular meetings, agenda includes issues that have arisen, feedback from courses the coders have attended etc.
- The Mental Health Unification Group meet quarterly at Derby.

8. SECURITY AND CONFIDENTIALITY

8.1 All staff within the Team dealing with identifiable service user information are made aware of the importance of ensuring service user confidentiality and the security of sensitive information.

8.2 All staff within the department are made aware of the policies and procedures governing the disclosure and sharing of data both internally and with external organisations operated by the Trust.

8.3 All staff are made aware of the departmental policy that any information being forwarded to external sources for coding queries should be completely anonymous.

8.4 All staff within the department are made aware of who the Trust's Caldicott Guardian is, should any issues in security and confidentiality arise.

8.5 All staff have access to the following confidentiality and security documentation:

- The Data Protection Acts (1984 and 1998),
- Confidentiality: NHS Code of Practice,
- The Code of Practice for Record Management,
- Caldicott Principles,
- Access to Health Records (1990),
- Information Security Management: NHS Code of Practice.

9. REFERENCE DOCUMENTS

- Executive Clinical Coding Standards and publications of the coding clinic,
- International Statistical Classification of Disease and Related Health Problems, 10th Revision (ICD-10),
- ICD 10 Classification of Mental and Behavioural Disorders,
- Classification of Surgical Operations and Procedures 4th Revision (OPCS 4),
- The Data Protection Acts (1984 and 1998),

- Confidentiality: NHS Code of Practice,
- The Code of Practice for Record Management,
- Access to Health Records (1990),
- Information Security Management: NHS Code of Practice.

10. DEVELOPMENT & CONSULTATION PROCESS

This policy has been developed by the Trust's Clinical Coding team. The policy has also been reviewed by the Director of Informatics & Performance Improvement and the Information Governance Committee.

11. DUTIES & RESPONSIBILITIES

Chief Executive
The Chief Executive as the accountable office is responsible for the management of the organisation and for ensuring appropriate mechanisms are in place to support service delivery and continuity.

Clinical Coders
Their role is to ensure diagnoses are obtained, coded to national standards using ICD-10 standards and OPCS then recorded accurately against the service users health and social care record.

Consultants
Consultant staff are responsible for providing full, accurate and comprehensive diagnoses including non-mental health diagnoses. .

Junior Doctors
There is a requirement for junior medical staff to record accurate detailed clinical information to enable effective coding of diagnoses.

Data Quality Team
The DQ team have the responsibility for submitting monthly datasets as per national requirements.

Executive Director of Finance
Formal responsibility for Clinical Coding lies with the Executive Director of Finance.

Director of Informatics and Performance Improvement
The Director of Informatics and Performance Improvement is responsible for the Clinical Coding Team and their annual programme of work, clinical information systems and the reporting of management information.

12. MONITORING

Monitoring of this policy will be by an annual external audit and an annual internal audit. Both audit findings will be reviewed and monitored at the Information Governance Committee.

13. BIBLIOGRAPHY

No Bibliography.

14. GLOSSARY

There is no glossary.

Appendix 1

LOCAL CODING POLICIES BY SERVICE

12. APPENDICES

12.1 LOCAL CODING POLICIES BY SERVICE

There are 10 diagnoses spaces on ePEX so current diagnoses must come first.

12.1.1 Service Specific

12.1.1.1 Brain Injury Unit

a. Main resulting mental illness classification

b. Any other mental illness diagnosis

c. Pre/Post/Current physical diagnosis

d. Sequalae of Brain Injury code usually **T90.5 BUT each record is to be CHECKED**

e. Social codes plus Smoker

External cause codes

Allergies

12.1.1.2 Mersey Care NHS Trust use **OPCS** rehabilitation code for every service user in Brain Injury Unit, as they are all being re-trained in activities of daily life.

12.1.1.3 Each diagnosis is either discussed by direct verbal contact with the Consultant or by electronic records or letters.

12.1.1.4 Acute, Older Peoples and Forensic

a. Main reason for admission,

b. Any other current or underlying psychiatric condition,

c. Relevant on-going/current physical condition,

d. Social codes,

e. External cause codes,

f. Allergies,

g. Smoking/Non Smokers.

12.1.1.5 These diagnoses are obtained by electronic records or verbally from clinician for clarification, coders do have access to health records as required.

12.1.1.6 Kevin White Drug Dependency Unit / Windsor Clinic Alcohol Dependency Unit.

Diagnoses are established initially from Discharge Letters and the Electronic Patient Record. Any queries are resolved by direct contact with Junior Doctor or Consultant.

Diagnosis consists of:

a. Main dependent drug/alcohol
b. Any other dependent drug(s)
c. Other non-dependent drug(s)
d. Any psychiatric diagnosis
e. Any physical diagnosis
f. Any social diagnosis

Any external cause codes

Allergies

Smoking/Non Smoking

Drug rehabilitation code OPCS or Alcohol rehab OPCS – **must always be included**

From 01.06.2003 - D.T.T.O (Drug testing and treatment order) code is coded as Z65.3

From 07.07.2004 – Breath Test is coded to R84.2

12.1.1.7 Learning Disabilities (Local Division)

a. Main reason for admission, i.e. Respite on Wavertree Bungalow.
b. Any other psychiatric diagnosis,
c. Physical diagnosis,
d. Social codes,
e. Previous psychiatric admission.

12.1.1.8 Service User diagnoses are established initially from the health records via a visit to the Ward. These diagnoses are recorded on a proforma and regularly reviewed and used for every subsequent admission, as in some cases up to 9

diagnoses are relevant to each admission i.e. Downs Syndrome, Autism, Mild Mental Retardation, Incontinent (Urine and Faeces), Poor Vision, Diabetic (I.D.D.M.) and Epileptic (Grand Mal).

12.1.1.9 For each Service Users' subsequent admission the coder contacts the Unit Manager to check the reason for admission, any changes to the established diagnosis and any acute conditions i.e. chest infection, urinary tract infection, which automatically becomes primary diagnosis, followed by established diagnoses.

12.1.1.10 For all Services in order to code any diagnosis sequence correctly, a check will be made as to where the Service User has been admitted from and discharged to. This is important and will have significant impact when "Payments by Results" is implemented in Mental Health Trusts.

12.1.1.11 The Clinical Coder is responsible for translating medical terminology (diagnosis) to ICD10 codes for all Service Users and subsequently entering it on Clinical Information System.

12.1.2 Condition Specific

12.1.2.1 Overdoses

12.1.2.2 Care needs to be taken when coding all overdoses/self harm.

12.1.2.3 As Mersey Care NHS Foundation Trust does not have an A&E Department check to see if the Service User was treated i.e. admitted to an Acute Hospital (RLUH/Aintree/Whiston etc) is under taken. The initial provider will code acute condition and Mersey Care NHS Foundation Trust will only show Personal History of self harm (**Z915**).

12.1.2.4 Mersey Care NHS Foundation Trust has an arrangement with above 3 hospitals for checking this. However, in the case of overdoses that are admitted to Mersey Care NHS Foundation Trust wards National Standards state that all drugs should be coded separately.

12.1.2.5 Because nationally Hospital Episode Statistics (HES) only accepts the first 7 diagnosis and the Clinical Information System can record up to 10 to allow us to code the Service Users resulting mental state, after initial coding of overdose or self-harm, coders will record as many drugs involved as possible when other conditions are present (or main ingredient of that drug).

12.1.2.6 Dementia

Senile Dementia Alzheimer Type will need to be further clarified to 4th digit
Early Onset (before 65) G300-D + F000-A
Or

Late Onset (after 65) G301-D + F001-A

If service user's age is on the borderline then this needs to be clarified with the doctor.

12.1.2.7 Unspecified diagnosis is always returned for further clarification and 4th/5th digit codes will be used wherever possible.

12.1.2.8 Neurological extracts are available for Doctors and Consultants on request to the Clinical Coder.

12.1.2.9 Supervised Methadone Replacement Programme and Still Using Heroin

12.1.2.10 If service user is taking heroin as well as methadone replacement then code as follows:

F112
F1122 (fifth character denotes replacement therapy) as per local policy

12.1.2.11 PICU- Psychiatric Intensive Care Unit

Diagnoses are established by looking through all electronic records if none are available then direct contact is made with Senior Doctor or Consultant. This process has been at the request of the consultant.

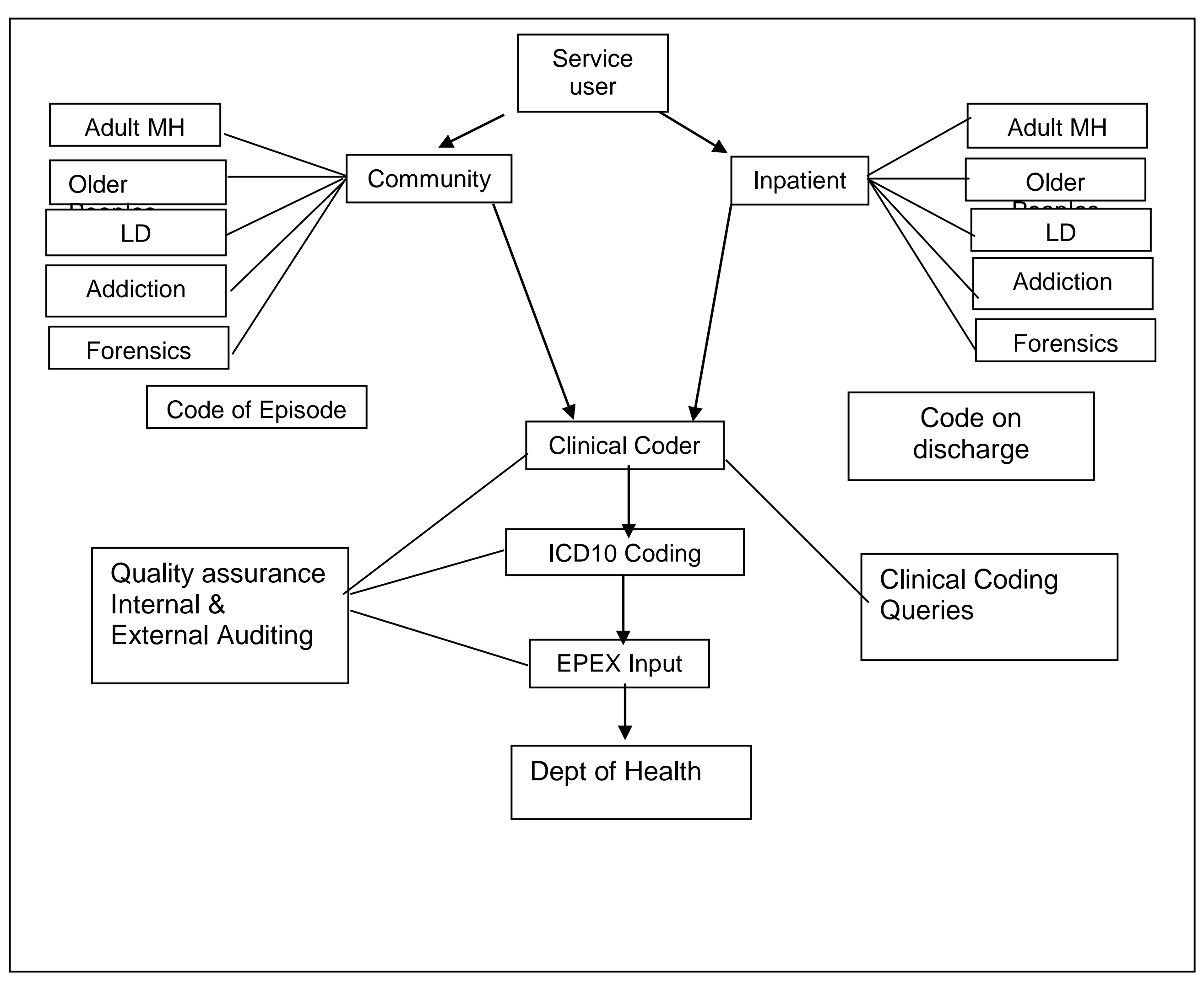
12.1.3 The Clinical Coding Process

12.1.3.1 Process for service users registered on Mental Health Information System

Diagnosis list prepared once per week, consisting of:

- Health record number
- Name
- Age
- Consultant
- Ward admitted to
- Date of admission
- Date of discharge
- Discharge Destination
- Discharge method

12.1.4 Process Chart



Appendix 2

ICD 10 DIAGNOSIS PROMP SHEET:

Primary Diagnosis (Main condition treated or investigated)
If no definite diagnosis main symptoms **must** be recorded here.

Overdoses please clarify if occurred on Trust premises or prior to admission.

Any other ongoing/current psychiatric condition, or any additional drugs/alcohol related problems.

Any relevant on-going/current/chronic/physical condition/medication e.g. taking anti-coagulants. Arthritis, asthma, heart/circulatory problems, diabetes, wheelchair dependence

Social and external cause conditions affecting patient's diagnosis, care and treatment (include any falls whilst in our care and any injury incurred)

Living Alone – Is this affecting the length of stay?
Tobacco – Is it dependent or use of?

Previous Admission Status – Has the service user ever had any psychiatric treatment **anywhere** at all.

If so, where and when.

Allergies – Please state if the service user has any allergies (Penicillin must always be recorded)

N.B. Any diagnosis not sufficiently clarified will be returned for amendment.

Clinical Coding, Mersey Care NHS Trust.
V7 Building. Kings Business Park. Prescot. L34 1PJ
Tel. No. 471 2484/2758/2614

ICD 10 DIAGNOSIS PROMPT SHEET: 1

KEVIN WHITE UNIT ONLY

ONE **MAIN DEPENDENT DRUG** **Please note Cannabis cannot be coded to dependent drug**

TWO **OTHER DEPENDENT DRUGS**

THREE **NONE DEPENDENT DRUGS**

FOUR **PSYCHIATRIC CONDITIONS**

FIVE **PHYSICAL CONDITIONS SOCIAL AND EXTERNAL CAUSES**

SIX **PREVIOUS ADMISSION ANYTIME/ANYWHERE**

SEVEN **ALLERGIES e.g. PENICILLIN MUST ALWAYS BE RECORDED**

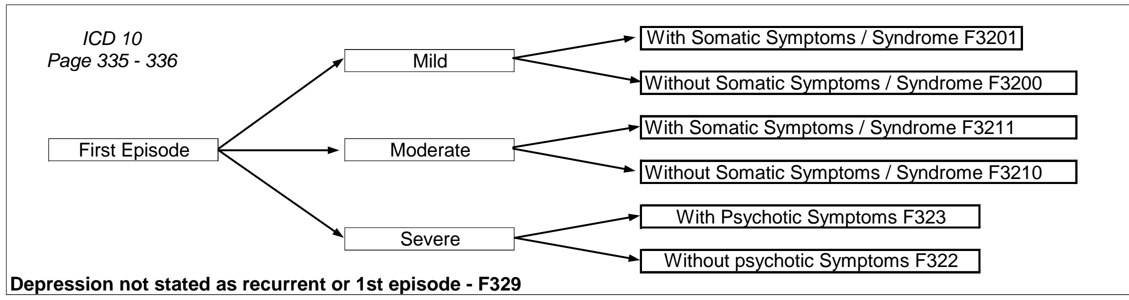
Clinical Coding, Mersey Care NHS Trust.
V7 Building. Kings Business Park. Prescot. L34 1PJ
Tel. No. 471 2484/2758/2614

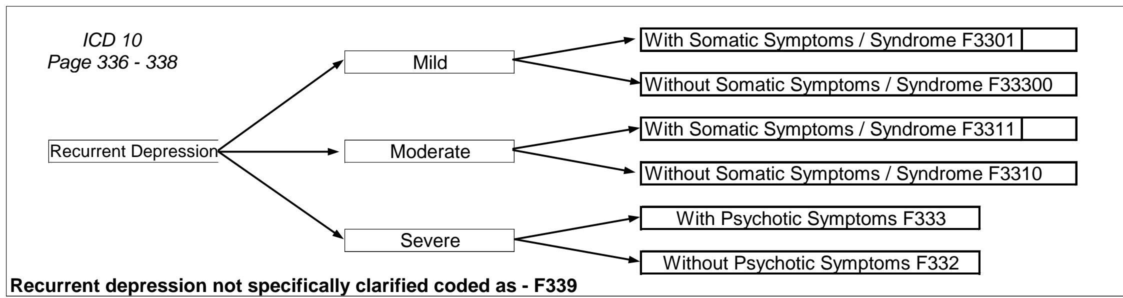
ICD 10 DIAGNOSIS PROMPT SHEET: 2

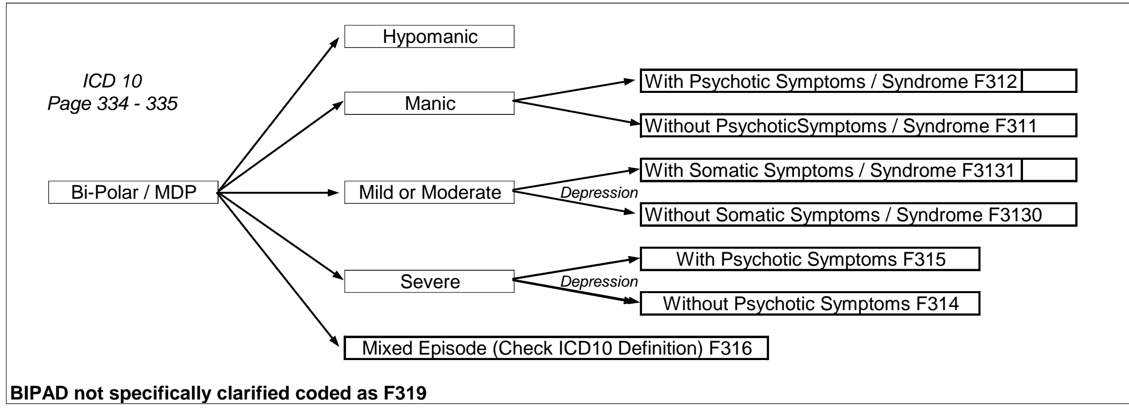
DEPRESSION

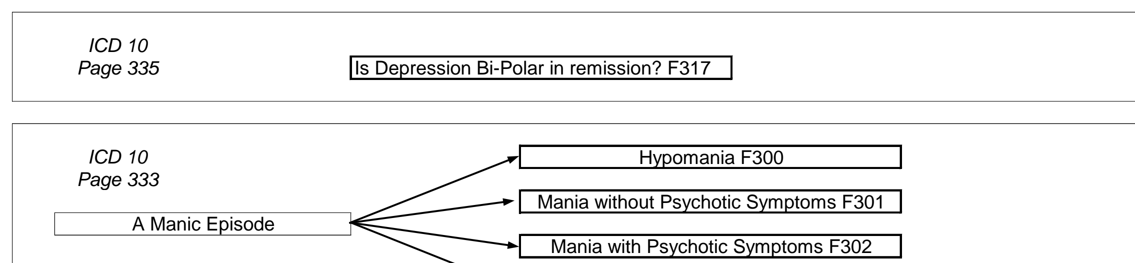
Depression not stated will always be coded to unspecified.

Depression needs to be more specific. Is it:





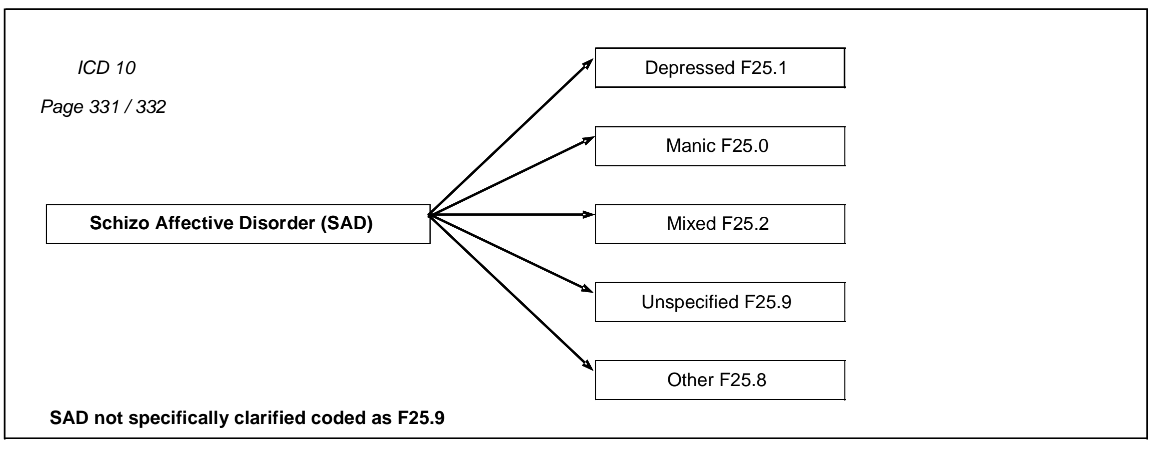


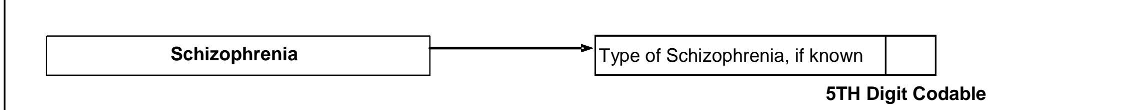


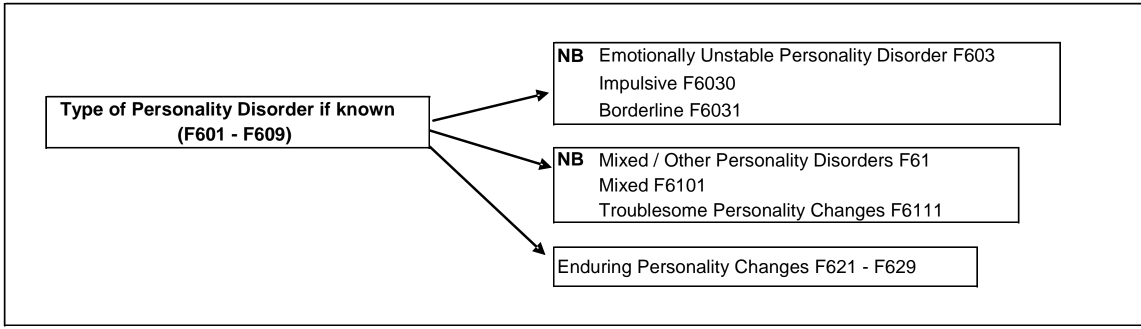
Manic Episode Unspecified coded as F309

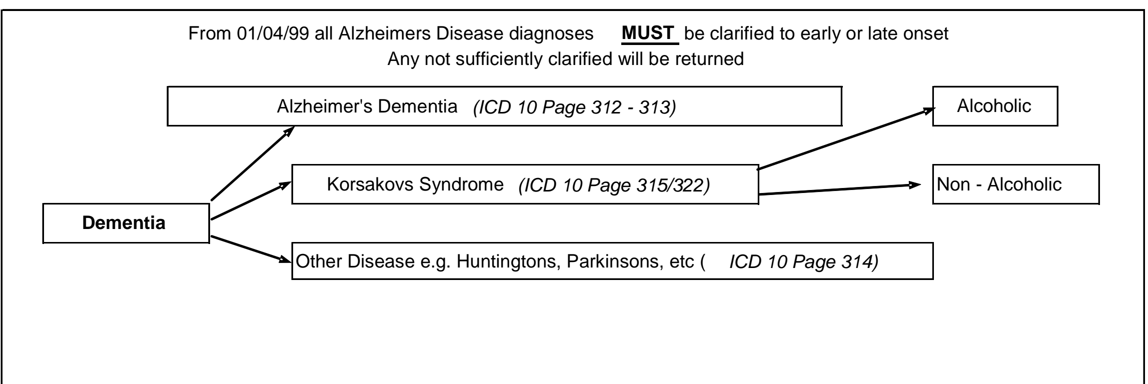
F53 Mental / Behavioural disorders in the Pueperium - Important you read notes F53 / Check your ICD10

ICD 10 DIAGNOSIS PROMPT SHEET: 3





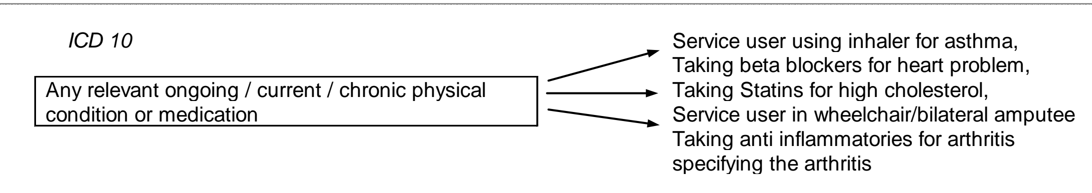


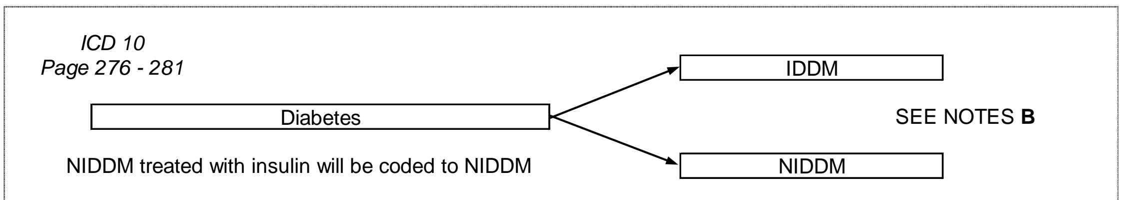


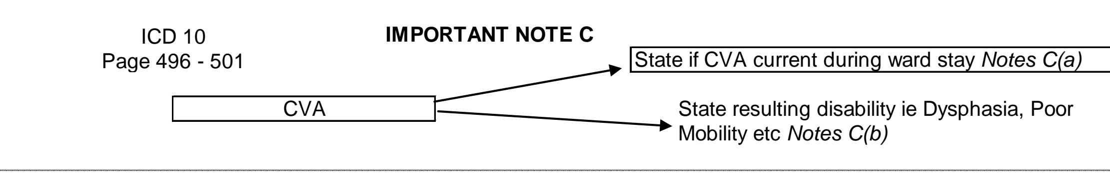
ICD 10 DIAGNOSIS PROMPT SHEET: 4

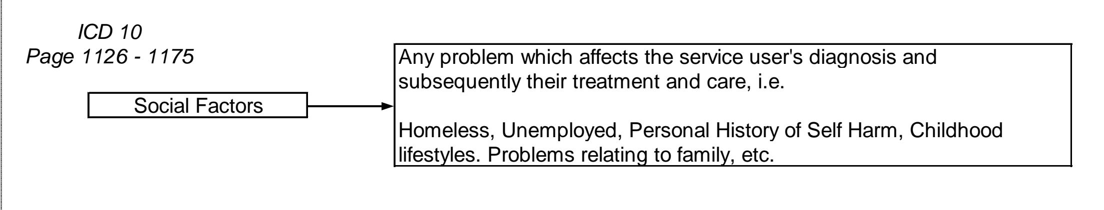
OTHER DIAGNOSIS

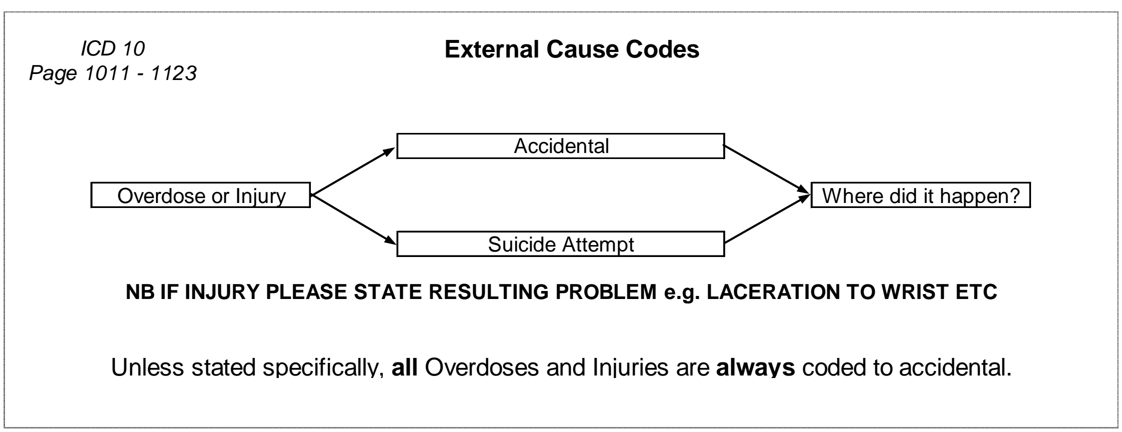
Angina - Please state service user's other heart problems eg I.H.D. (See notes A)











Appendix 3

INFORMATICS & PERFORMANCE IMPROVEMENT DEPARTMENT
PROCEDURE FOR THE VALIDATION OF CLINICAL CODING

In order to perform validation, a scan (report) of discharged service users must be generated via ePEX Clinical Information System by the Clinical Coding Staff and printed out each Monday for the previous weeks accumulative discharges.

A member of the Clinical Coding staff either views the discharge letter and/or clinical data entered within e-Health Record comprising of ePEX and the Electronic Document Management System Windip in order to obtain and establish the diagnoses in respect of the Service users In-Patient stay.

Upon the clinician being contacted regarding the diagnoses information they must ensure this information is provided for the Clinical Coding staff who in turn will record that the diagnosis has been confirmed against the service user named on the discharge scan (report), the diagnoses and initials of the clinician who provided the information must be recorded. The diagnostic information is then keyed onto ePEX by the Clinical Coding team.

Episode/Caseload Diagnosis

Consultants download a list of their current caseload from the Business Intelligence Today system (BiT) - a procedure document is available within the portal on how to download). This enables the consultant to view which patients do not have a diagnosis but also allows them to review and update the diagnoses they have already provided.

The caseload lists are then sent to the generic Data Quality email account, and forwarded onto the Clinical Coders by the Data Quality Officers, who in turn print out the list for translating into ICD10 and enter the new diagnoses or amends them in the appropriate consultant episode on ePEX. The Clinical Information system, to ensure a current and comprehensive suite of co-morbidities. If there are any discrepancies, the Clinical Coder will contact the consultant direct. When discrepancies have been resolved, the Clinical Coder will translate to ICD 10 and enter onto the system.

The Episodes/Caseloads are then saved electronically in appropriate files.

The Clinical Coding staff are responsible for ensuring that the Junior Doctors e-learning training module is up to date.

Implemented: August 2007
Review Date: June 2015
Next Review Date: April 2017
Author: Clinical Coders

FORM C

Appendix 4

Details of Local Policies

Please complete this form detailing 'consultant specification' coding and local clinical coding policies, which are not routinely recorded in the health records.

Details of Consultant Specification coding:

Sign: ………………………………………………………………

Date: ………………………………………………………………

Seen by

Name of Coder	Signature of Coder	Date

Appendix 5

CAREER PATHWAY FOR CLINICAL CODING STAFF TO ATTAIN ACCREDITED CLINICAL CODING QUALIFICATION

In order to ensure that Clinical Coders are trained to a high standard in Clinical Coding Mersey Care NHS Foundation Trust supports and promotes continuing professional development.

Year 1

Upon taking up post within Mersey Care NHS Foundation Trust the new member of staff will be required to attend the Trust Induction Programme. Leading on from this the member of staff will receive departmental Induction and be shown the Mersey Care NHS Foundation Trust home website where all Trust policies can be located together with a directory of services provided within Mersey Care NHS Foundation Trust.

During the first month they will have access rights set-up with an NHS email account. Following this training will be given on the Trusts Clinical Information System which includes reference to current legislation that the Trust must work within. Specific departmental procedures will be outlined to the newcomer to assist understanding the functionality of Clinical Coding and how it fits into the organisation – this may also involve the member of staff spending time in "other" relevant sections to understand data flows e.g. national reporting deadlines.

As part of the departmental induction process the clinical coder will be expected to familiarise themselves with general medical terminology as well as specific terms used within Mental Health Services. Additional guidance will be provided on the usage of the International Classification of Diseases (ICD v10) and Office for Population Censuses and Surveys (OPCS v4) Classification of Interventions and Procedures.

Staff who have not had any previous experience of Clinical Coding or staff that have not actively coded for the last 2 years will be required to attend a Novice Clinical Coders' Course. This must be a recognised course which may be organised by the MIAA (Mersey Internal Audit Agency).

Following attendance at the Novice Clinical Coders' Course the Coder will be given assistance for approximately the next 2 years by experienced coders. Their coded data will be monitored regularly with spot checks to allow data to be analysed and corrected by the experienced coder before it is entered onto the Trust's Clinical Information System ePEX.

If at any point the novice coder or experienced coder are unsure of the information given, it is advised that they seek to further clarify the issue with the Clinician and if need be raise the issue with the Information Governance Officer.

In addition the novice coder will have a 6 month review followed by a 12 month review which may be provided by the MIAA who provide a written assessment and feedback on progress to the Trust.

Clinical Coding Staff are encouraged to become a member of a professional organisation e.g. Institute of Health Records & Information Managers (IHRIM) or Association for Informatics Professionals in Health and Social Care (ASSIST).

During the first year the Clinical Coder will have a Personal Development Review (PACE) performed by the immediate line manager for the clinical coding team who is the Information Governance Officer/Trust Health Records Manager, any requests for training should be raised and identified during the Personal Development Review meeting.

Each Clinical Coder has their own instruction manuals, which they are required to keep up to date. The Clinical Coding Team have regular meetings, agenda includes issues that have arisen, feedback from courses the coders have attended etc. Feedback from the Clinical Coding Advisory Group meetings and the Mental Health Clinical Coding Unification Group are disseminated to all coders, along with minutes. Amendments to the NHS Executive Clinical Coding Standards along with Data Quality Review Newsletter are distributed within the department.

Year Two

Throughout their employment with Mersey Care NHS Foundation Trust the Clinical Coder will be required to attend specialty workshops and an anatomy & physiology workshop that may be organised locally by the MIAA or National events relevant to the knowledge and skills required for Clinical Coding staff. The Information Governance Officer, who is the immediate line manager for the Clinical Coding Department, will also ensure that annual Performance Development Reviews are performed to identify any further training requests and to support the Clinical Coder in gaining knowledge and experience. Mersey Care NHS Foundation Trust will endeavour to facilitate and support its Clinical Coding staff with placements at other "Acute Trust" sites in order to let the Clinical Coding staff gain more experience of coding other specialties.

As the Clinical Coder gains experience they will be expected to participate in departmental audits. They will also be expected to assist with the review of departmental procedures or the development and production of written procedures.

Following the 2 year supervision period, the novice coder would then be considered to be classed as an experienced Clinical Coder.

Year Three

During year 3 all Clinical Coding staff at Mersey Care NHS Foundation Trust will be required to attend a Clinical Coding Refresher Courses and any relevant Clinical Coding Qualification Workshops organised by the Clinical Coding Academy of MIAA or National Training Team.

Mersey Care NHS Foundation Trust will endeavour to facilitate and support its Clinical Coding staff with placements at other "Acute Trust" sites in order to let the Clinical Coding staff gain more experience of coding other specialties. The Clinical Coder will also be involved in the review of the e-learning presentation in respect of Clinical Coding as part of the Junior Doctors Induction Programme. As the Clinical Coder at year 3 should have gained a substantial knowledge base then they will be expected to commence undertaking internal clinical coding audits.

Within the third year the Clinical Coder will also be required to complete/update all Mersey Care NHS Foundation Trust Corporate Mandatory e-learning Training modules.

National Accredited Clinical Coding Qualification

All Clinical Coders are encouraged to train towards achieving the National Accredited Clinical Coding Qualification (ACC). Clinical Coding staff should discuss with their Line Manager at their Personal Development Plan whether they wish to undertake the National Accredited Clinical Coding Qualification which is the recognised professional certificate available for Clinical Coding staff. Examinations are held in March and November annually. If the Clinical Coder wishes to pursue taking the qualification then Clinical Coding Academy of MIAA should be contacted to discuss the best options for supporting and preparing the Clinical Coder for the qualification.

Implemented:	November 2008
Review Date:	August 2016
Next Review Date:	August 2017
Author:	Clinical Coders

Appendix 6

USEFUL INFORMATION

Websites and contact numbers that are of use to coders:

Appendix 1:

NHS Classification Service

http://systems.hscic.gov.uk/data/clinicalcoding/codingstandards

NHS Classification Service Helpdesk website

http://systems.hscic.gov.uk/data/clinicalcoding/contact

Or information.standards@hscic.gov.uk or fax 01392 206945 or telephone 08451 300114

Appendix 2: Health Service Guideline: Service user Confidentiality and Access to Health Records

http://systems.hscic.gov.uk/infogov/confidentiality/index_html

http://systems.hscic.gov.uk/scr/patients

The Health & Social Care Information Centre's website includes further links to:

Patient confidentiality

Access to Health Records

Publications and legislation

Patient Confidentiality and Caldicott Guardians: Frequently Asked Questions

Appendix 7

Equality and Human Rights Analysis

Title: Policy and Procedure Manual for Clinical Coding
Area covered: Clinical Coding within Mersey Care

What are the intended outcomes of this work? To ensure that this document does not have any adverse equality or human rights implications.
Who will be affected?

Evidence
What evidence have you considered? *The document in question was read, and where necessary discussed between the assessors, in order to consider whether the policy (and its impact) will have on human rights or equality.*
Disability inc. learning disability Document states it is available in different formats upon request to the document author.
Sex Not applicable.
Race Not applicable.
Age Not applicable.
Gender reassignment (including transgender) Not applicable.
Sexual orientation Not applicable.
Religion or belief Not applicable.
Pregnancy and maternity Not applicable.

Carers Not applicable.
Other identified groups Not applicable.
Cross cutting Not applicable.

Sexual orientation Not applicable.
Religion or belief Not applicable.
Pregnancy and maternity Not applicable.
Carers Not applicable.
Other identified groups Not applicable.
Cross cutting Not applicable.

Human Rights	**Is there an impact? How this right could be protected?**
This section must not be left blank. If the Article is not engaged then this must be stated.	
Right to life (Article 2)	Not applicable.
Right of freedom from inhuman and degrading treatment (Article 3)	Not applicable.
Right to liberty (Article 5)	Not applicable.
Right to a fair trial (Article 6)	Not applicable.
Right to private and family life (Article 8)	Not applicable.
Right of freedom of religion or belief (Article 9)	Not applicable.
Right to freedom of expression Note: this does not include insulting language such as racism (Article 10)	Not applicable.

Right freedom from discrimination (Article 14)	Not applicable.

Engagement and involvement

Removed after consultation with George Sullivan (email 14/11/2013).

Summary of Analysis Not applicable.

Eliminate discrimination, harassment and victimisation
Not applicable.

Advance equality of opportunity
Not applicable.

Promote good relations between groups
Not applicable.

What is the overall impact?
The assessment panel view is there are no equality and human rights issues with the document.

Addressing the impact on equalities Not required.

Action planning for improvement Not required.

Please give an outline of your next steps based on the challenges and opportunities you have identified. *Include here any or all of the following, based on your assessment*

- *Plans already under way or in development to address the **challenges** and **priorities** identified.*
- *Arrangements for continued engagement of stakeholders.*
- *Arrangements for continued monitoring and evaluating the policy for its impact on different groups as the policy is implemented (or pilot activity progresses)*
- *Arrangements for embedding findings of the assessment within the wider system, OGDs, other agencies, local service providers and regulatory bodies*
- *Arrangements for publishing the assessment and ensuring relevant colleagues are informed of the results*

- *Arrangements for making information accessible to staff, patients, service users and the public*
- *Arrangements to make sure the assessment contributes to reviews of DH strategic equality objectives.*

For the record **Name of persons who carried out this assessment (Min of 3):** Lee Ellison, Clare Scott, & Mike Jones (Finance). **Reviewed by Gina Kelly**
Date assessment completed: 14/11/2013 **Review 10/10/2016**
Name of responsible Director: Jim Hughes
Date assessment was signed: 14/11/2013 **10/10/2016**

CLINICAL CODING

Policy and Procedures

REVIEW AND SIGNATURE OF CODERS

NAME	DATE
A. Emmerson Kelly	14.4.2014
P Riley	14.4.2014
D A Bradon	14.4.2014

FORM C

Appendix 4

Details of Local Policies

Please complete this form detailing 'consultant specification' coding and local clinical coding policies, which are not routinely recorded in the health records.

Details of Consultant Specification coding:

F11.22 Methadone replacement regime
F11.2 Opioid (Heroin)

Both codes should be coded if patient is using both substances.

Sign: B.V. [signature] [BAPU RAVINDRANATH - Consultant Psychiatrist]

Date: 16-4-14

Seen by

Name of Coder	Signature of Coder	Date
Pat Riley	P Riley	16. 4. 14
D A BRADDON	[signature]	16/4/14
A EMMERSON-KELLY	A Emmerson-Kelly	16/4/14

FORM C

Appendix 4

Details of Local Policies

Please complete this form detailing 'consultant specification' coding and local clinical coding policies, which are not routinely recorded in the health records.

Details of Consultant Specification coding:

Any illness related to alcohol can be coded for patient at Windsor Clinic. Alcohol induced physical health problems are very common at Windsor Clinic and that would not be within the F-Section of ICD 10, hence other codes will be used.

Sign: ……………………………………………… DR ABBASI

Date: 10/09/15

Seen by

Name of Coder	Signature of Coder	Date
PAT RILEY	T Riley	10/9/15
DEBBIE BRIDSON	[signature]	10/9/15