AUDITOR NAME REDACTED

Information Governance Clinical Coding Audit Report

Homerton University Hospital NHS Foundation Trust

January 2015

Auditor: - REDACTED
(HSCIC Approved Auditor)

Contents

Executive summary	2
Introduction	7
Background	7
Terms of reference	7
Aim of audit	8
Objectives of audit	8
Audit methodology	8
Site background	10
Summary of audit findings	11
General findings	11
Summary of errors	12
Conclusions	13
Recommendations	14

Appendices

A	Analysis of Errors	15
B	Error Key Definitions	18
C	Information Governance Requirement 505	21
D	Information Governance Requirement 510	23
E	References	25

Executive Summary

Introduction

A clinical coding audit was commissioned by the Head of Clinical Coding in partial completion of Information Governance toolkit requirement 505 & 510 for the Homerton University Hospital NHS Foundation Trust. It was carried out during January 2015

The aim of this audit was to assess the quality and consistency of clinical coding at the Trust and make any necessary recommendations for improvement of quality and processes.

Background

Homerton University Hospital NHS Foundation Trust was opened in April 2004 and was one of the first ten foundation trusts in England. It is a generalised trust treating all specialities within a challenging diverse cultural and racial demographic.

Methodology

A selection of notes for inpatient and day case spells discharged during October 2014 were audited. The selection methodology was random but also ensured a fair and representative sample of the Trust's casemix. All episodes in individual spells were audited.

The electronic discharge summary was used as the source documentation and comparisons were made between the codes assigned by the auditor and the coder using the latest NHS Classification Service Clinical Coding Audit Methodology (V8)

Any differences found were discussed and agreed with the Head of Clinical Coding..

Although the Trust has purchased the 'EasyAudit' software package, Information dept were unable to provide a data extract to load onto this with the timeframe, as such, this was a manual paper audit. All errors found by the Auditor (and agreed by the Head of Clinical Coding) were also manually checked using the Healthcare Resource Group (HRG) software to assess if the HRG had changed. Where this had occurred this was noted on the error sheet together with the rationale for the change.

Results

Summary of results (**previous year's results in brackets for comparison**). Full details can be found in Appendix A at the end of the report.

It should be noted that different specialities were submitted for audit on this occasion and that several smaller audits had been carried out previously which totalled the required 200 cases

Number of FCEs	Primary Diagnosis Accuracy	Secondary Diagnosis Accuracy	Primary Procedure Accuracy	Secondary Procedure Accuracy	Episodes Changing HRG
200 (202)	**94.0%** (95.05%)	**86.0%** (93.91%)	**95.0%** (99.17%)	**96.0%** (99.53%)	**12%** (1.48%)

50 FCEs (Finished Consultant Episodes) were audited at the request of the Trust A further 3 audits had previously been carried out totalling 150+ episodes. The cost of the HRG (Healthcare Resource Group) changes was a net undercharge by the Trust of £4437.00. There were no 'Unsafe to Audit'

Information Governance Toolkit Level

The error percentages above correspond overall to Level 2 of the IG toolkit requirement 505, however the Trust has not met the full requirement for this level and has also failed to meet that of level 1,. The Trust is therefore at **Level 0**. The percentage coding requirements for this attainment level are shown below, together with those required for Level 3

Level of Attainment 2014/2015		
	Level 2	**Level 3**
Primary Diagnosis	>=90%	>=95%
Secondary Diagnosis	>=80%	>=90%
Primary Procedure	>=90%	>=95%
Secondary Procedure	>=80%	>=90%

General Conclusions

Information Governance Requirement 505 – The Trust has achieved attainment **level 0** (See appendix C for full breakdown).

Information Governance Requirement 510 - The Trust has achieved attainment **level 1** (See appendix D for full breakdown).

The quality and consistency of the coding in this sample was found to be good; however suffered due to coders not being released for training courses in order to maintain their skills and problems with the clinical discharge summary.

There is no audit policy nor Policy and Procedure document

The HRGs are not visible to the coder at time of coding.

The discharge summaries are inconsistent and incorrectly completed by clinical staff.

The discharge summaries to be examined were ready and available to the auditor at time of audit and the process was well managed by both the recently appointed Head of Clinical Coding and the Coding Team.

Progress has been made on one of the previous recommendations; however there has been no Manager for three years which, until the recent appointment of a Head of Clinical Coding, has stalled progress.

The staff compliment stands at 6 full-time permanent members of staff. There is one vacancy currently being covered by contract staff. There is also a dedicated recently appointed Head of Coding (1 WTE) Due to the small compliment of staff the Trust is at significant risk in the case of any type of diminished capacity, such as long-term absence for sickness or annual leave or any resignations.

Key Recommendations

Information Governance Requirement 505 –

Requirements for Level 1

The procedures for the annual audit of clinical coding have been documented

A clinical coding audit programme has been undertaken by a Clinical Classifications Service (CCS) approved clinical coding auditor within the last twelve months prior to the final submission of the Information Governance Toolkit. The CCS approved auditor must have complied with all requirements of the Clinical Coding Auditor Programme and adhered to thee CCS Clinical Coding Audit Methodology and the Approved Clinical Coding Auditor Code of Conduct.

Information Governance Requirement 510 –

Requirements for Level 2

All clinical coding staff who assign ICD-10 and OPCS-4 codes must attend a clinical coding refresher course of no less than four days duration every 3 years

Clinical coding refresher courses are delivered by approved clinical coding trainer(s) using only materials developed by the Clinical Classifications Service

The organisation supports all clinical coders in gaining Accredited Clinical Coder (ACC) status. National Clinical Coding Qualification training is based on national standards for ICD-10 and OPCS-4 and is delivered by a Clinical Classifications Service approved clinical coding trainer.

The following recommendations are to assist the Trust in maintaining a high level of data quality and ensuring a robust financial cycle:-

In order for coders to update and maintain their skills it is recommended that they attend appropriate specialty workshops and where applicable a Refresher course as soon as places are available.

An achievable audit policy is put in place and a HSCIC auditor appointed (vacancy has been approved) or alternative arrangements put in place to ensure that a robust audit cycle is initiated within two months.

Further investigation to confirm if a Policy & Procedure is available and that has been updated to reflect current coding standards and conventions. To ensure that if there are any local policies they do not contravene coding rules and conventions within one month.

To contact the person responsible in the Trust for updating the HRG (Healthcare Resource Group) software to the correct version. This would then show both the Coders and Management the HRG at completion of episode and assist in providing information for Management analysis, Oversees Visitor billing and Stroke cost analysis. This should take place as soon as possible, within one month

It is recommended that Clinical staff are engaged in order to demonstrate that correct completion of the discharge summary improves both quality of coding and potentially finance at any appropriate forum within the next 3months

It is recommended that further analysis is undertaken to assess if the relatively few chronic co-morbidities documented on the discharge summary found in this sample are a genuine reflection of the Trust's demographic. Initially this could take the form of a review of previous episodes on screen to provide an indication if further investigation, i.e. interrogation of patient's case notes, is warranted within a 3 month timeframe

Further clarification should be sought from clinicians regarding when adhesions are found at operation and whether these are divided or not. This is a data quality and potential finance issue and should be resolved as speedily as possible, within one month

Consideration should be given within one month to one coder extracting all the information where an episode is split between more than one consultant..

It is recommended that the risk due to diminished capacity and experience in staffing levels within the department to Trust finances and impact on any long term strategic developments be assessed more fully, as a matter of urgency within two months.

Introduction

There is wide recognition in the National Health Service (NHS) of the importance of good quality Coded Clinical Data and the fundamental role it plays in the management of hospitals and services. The government's introduction of a National Performance Framework has created a mechanism whereby NHS Trusts will be judged on accurate results. This approach is designed to focus on the results achieved by the NHS in a way that is meaningful to the public, healthcare professionals and to NHS Managers. Healthcare information at local and national level is crucial to support management, planning and monitoring of health services.

Clinical data must be accurately and consistently recorded to well define national standards to enable it to be used for statistical analysis. Information drawn from accurate Clinical Coding better reflects the pattern of practice of Clinicians and provides a sound basis for the decision making process. The use of tools such as Clinical Indictors pushes forward the need for accurately and consistently recorded clinical information. Such information should be produced as part of the regular activity within a hospital provider unit. Steps to ensure that this is the case should include audit of clinical coded data.

In 1998 the Information for Health Strategy reported that the use of data accreditation processes would be mandatory. Data Accreditation is now known as Information Governance and part of the process demands that the quality of the coded clinical data be audited by an external body. This audit can be used as evidence to support the Trust in demonstrating that it has satisfied the requirements necessary to achieve Information Governance.

In 2003 the NHS introduced Payment by Results, which mean that PCT's will commission most acute care on the basis of cost-and-volume agreements using Healthcare Resource Groups that are derived from the coded clinical data. Incomplete or inaccurate information, either in the medical record or in the clinical coded data, may result in an episode being allocated to an inappropriate HRG and may impact on the financial standing of the hospital.

Background

The NHS Health and Social Information Care Centre developed good practice guidelines for data collection, and a Data Accreditation scheme to help raise the quality of data collected within the NHS. This is underpinned by the Information Strategy, which uses Coded Clinical Information for Information Governance.

This Audit has been commissioned by Maurnie Foley, Head of Clinical Coding at Homerton University Hospital NHS Foundation Trust to comply with Information Governance.

Terms of Reference

The audit was based on the current methodology (Version8) of the Clinical Coding Audit Methodology set out by the Health & Social Care Information Centre. This document provides guidance on conducting a Clinical Coding audit.

The audit was carried out by a HSCIC Registered Auditor, Jane Wonnacott ACC (Dis)

The Auditor used the discharge summary as this is the source documentation at the Trust '

The sample size of the audit was 50 finished consultant episodes (FCE's) and representative of the Trust's case mix. The episodes to be audited were randomly selected from those discharged in October 2014.

Aim of the Audit

The purpose of the audit is to assess the quality of Coded Clinical Data within the Trust as it pertains to the minimum data set (MDS).

Objectives of the Audit

- to review the information for accuracy and adherence to national standards;
- to measure the Trust against IG attainment level requirements 505 and 510;
- to review and analyse any coding errors found and endeavour to trace the source of the errors;
- to identify areas of coding practice requiring improvement;
- to promote interchange between Clinicians and Clinical Coders;
- to make recommendations, if appropriate, to improve the quality of the Coded Clinical Data;
- to compare the information provided to the Clinical Coders at the time of coding with the information contained in the clinical case notes at the time of audit; and
- to review the quality, accuracy and completeness of the information source provided to the Clinical Coders for the purpose of Clinical Coding.

Audit Methodology

The audit was based on the current version of the Clinical Coding Audit Methodology (Version 8) set out by the Health & Social Care Information Centre. This document provides guidance on conducting a Clinical Coding audit.

The Trust supplied approximately 50 (200 overall) discharge summaries for the audit, representative of the activity of the Trust and the necessary information to support the audit process.

The Trust were unable to provide the Auditor with an electronic data file consisting of defined data values in a fixed .csv format which conformed to Data Dictionary Definitions to load onto the Easy Audit package as such the audit was a manual paper audit.

The audit was carried out in January 2015, whereby 50 finished consultant episodes were audited relating to discharged episodes from October 2014. A feedback session was provided to the Head of Clinical Coding and any errors found were discussed and agreed.

The Auditor extracted diagnostic and procedural information from the discharge summaries and assigned appropriate codes. The Auditor applied relevant rules and conventions pertaining to the ICD-10 and OPCS-4.7 classifications. The Auditor also applied the national Clinical Coding standards published in the Clinical Coding Instruction Manual ICD-10 and OPCS-4.7(including amendments to the manual) and changes to standards reported in the Coding Clinic section of the Data Quality Review.

Comparisons were then made between the information extracted from the case notes by the Auditor and the information drawn from the discharge summaries and the information provided by the Trust on the data extract. The Auditor reviewed the following areas:

- **Accuracy**: Codes on ICS were considered accurate if they describe the actual condition of the patient (and any procedures performed) as completely as possible within the constraints of the classifications used and as completely as necessary for the intended use of the data. The three dimensions to coding accuracy are:

- **Individual codes** – are these an accurate reflection of the Clinical statement?

- **Totality of codes** – do they represent all the relevant Clinical details?

- **Sequencing of codes** – are the codes in the correct sequence as defined by the rules and conventions of the classification and the mandated definition of a main diagnosis?

- **Errors Found:** The Auditors analysed the type of coding errors (a full list of discrepancy errors can be found in Appendix B).

The errors were then categorised as follows:

- incorrect main diagnosis selected;
- incorrect three-character category;
- incorrect four-character category;
- omission of diagnosis / procedure codes;
- irrelevant codes;
- incorrect sequencing of diagnostic codes; and
- episode unsafe to audit

The audit did not concentrate solely on the accuracy of the Clinical Coding but also other factors influencing the Coding process.

Other areas included:

- documentation issues;
- documentation incomplete; and
- documentation inconsistent

There was a post audit interview between the Head of Clinical Coding and the Auditor.

A first draft report that included the findings, conclusions and recommendations of the audit was submitted to the hospital for review.

One error was found in the procedural (OPCS 4.7) ‘Z’ codes but has not been included in the percentages.

Site Background

The Homerton University Hospital NHS Foundation Trust has a centralised Clinical Coding Department which sits within the Corporate Directorate. Coders access the electronic discharge summaries, the source document at the Trust and extract the information from these. The Clinical Coders also have access to the radiology, histopathology, Endoscopy and K2 (Obstetric) screens. The Clinical Coders are responsible for the inputting of their own information and do not have responsibility for any other duties other than Clinical Coding.

The Department does not appear to have a policy and procedure document, although this has been mentioned as being available in a previous report it could not be located for this audit.

The Clinical Coders are allocated discharge days as a means of distributing the workload, however this policy is under review by the recently appointed Head of Clinical Coding to ensure that the Trust is maximising its clinical coding resource.

The Clinical Coding Department has regular clinical coding meetings with clinicians for the following specialties: - General Medicine, Diabetic Medicine, Respiratory Medicine and Obstetrics. For all other specialties there is limited ad-hoc liaison with clinical staff.

The staff compliment stands at 6 full-time permanent members of staff. There is one additional vacancy currently being covered by contract staff. There is also a dedicated recently appointed Head of Coding (1 WTE) Due to the small compliment of staff the Trust is at significant risk in the case of any type of diminished capacity, such as long-term absence for sickness or annual leave or any resignations.

The Trust has approximately 73,000 FCEs per year covering both inpatient and day case stays.

The coders input the data via an encoder (Medicode) onto the Trust's Cerner system. This system allows for the recording of 5th digits for ICD 10 coding and does not include optimisation software. The Head of Coding and Clinical Coders have access within the system to alter the coded data once an episode has been completed. The HRG (Healthcare Resource Group) codes are not visible to the coders on completion of the episode

The Clinical Coding Department does not have a NHS HSCIC (Health & Social Care Information Centre) Registered Auditor on site and no formal internal audit policy

The coding department does not have an NHS HSCIC approved licensed trainer on site, training is provided by the London Clinical Coding Academy. Some of the staff have attended a mandatory refresher training of no less than 4 days duration within the last three years but two are overdue and none have attended specialty workshops for several years All Clinical Coders who assign ICD-10 and OPCS-4 codes within the Trust have attended a formal clinical coding foundation course within 6 months of commencing their employment. The clinical coding courses attended were delivered using only materials developed or endorsed by the Clinical Classifications Service (CCS) and by a CCS approved or licensed clinical coding trainer.

Summary of the Audit Findings

General Findings

Noted was the effort taken by the staff to provide the printed discharge summaries and the level of co-operation received from all staff during the audit was excellent.

The Trust's Information Department were unable to provide the requested data files, as such this was a manual paper audit.

Currently 4 members of the Clinical Coding Department have attained ACC status. A further 2 members of staff are due to sit the examination in March 2015 and are being supported by the Team. The Head of Coding has also attained ACC status.

Clinical Coders who assign ICD-10 and OPCS-4 codes within the Trust has attended a formal clinical coding foundation course within 6 months of commencing their employment. Some, but not all, clinical coding staff who assign ICD-10 and OPCS-4 codes have attended clinical coding refresher courses, of no less than four days duration, every 3 years. The clinical coding courses attended were delivered using only materials developed or endorsed by the Clinical Classifications Service (CCS) and by an HSCIC approved or licensed clinical coding trainer. The coders have not attended any specialty workshops for several years.

The source documentation is the electronic discharge summary, with the exception of Bariatric Medicine where the case notes are used due to inadequate discharge summaries and the relative small numbers involved. The use of the full case notes is recommended for the purposes of clinical coding to ensure that the correct HRG group is assigned and for the purposes of data quality, however the logistics of the Trust using the full case notes as recommended by the Clinical Classification Service (CCS) may prove insurmountable and efforts should be concentrated on ensuring that the electronic discharge summary is fit for purpose.

The Clinical Coding Department does not appear to have a Policy and Procedure Document, although this was documented as being available in the previous Information Governance report it could not be traced for this audit. It should be noted that there has been a recent change of personnel at the Trust in clinical coding with an appointment of a Head of Clinical Coding and she will be investigating this further.

Of the 200 episodes audited (50 presented at this audit), none were unsafe to audit. There were 6 HRG changes. The table below shows the overall percentage of correct coding. (A full summary can be found in Appendix A).

Coding accuracy: Previous year's figures in brackets are shown for comparison.

It should be noted that different specialities were submitted for audit on this occasion and that several smaller audits had been carried out previously which totalled the required 200 cases

Number of FCEs	Primary Diagnosis Accuracy	Secondary Diagnosis Accuracy	Primary Procedure Accuracy	Secondary Procedure Accuracy	Episodes Changing HRG
200 (202)	**94.0%** (95.05%)	**86.0%** (93.91%)	**95.0%** (99.17%)	**96.0%** (99.53%)	**12%** (1.48%)

Summary of Errors

A separate file detailing all errors and their circumstances is available though not detailed within the report at the request of the Trust.

There were 3 errors in the <u>primary diagnosis</u>:-

All three errors would be classed as 'coder error'

The patient had had a laparoscopic cholecysectomy performed. This type of procedure would not have been performed for nausea and vomiting (the coders choice) which is a symptom of cholecysititis, the auditor's extracted code. The histopathology report would have confirmed this. There was no change to the HRG.

The discharge summary clearly documented the specific diagnoses of non-toxic multinodular goitre which the coder had failed to extract. This change did not alter the HRG.

The coder for this part of a split episode had failed to apply the rules of the primary diagnosis and realise that the primary reason for the patient's care at this point in the stay was the persisting bile leak. The HRG was changed for this part of the episode only.

There were a total of 10 errors in the <u>secondary diagnosis</u>.

All errors would be classed as 'coder error'

There were 10 errors due to the coder failing to add relevant existing or acute secondary conditions. All conditions were clearly documented on the discharge summary. The Auditor therefore added any that had been missed to ensure consistency in the data and this was agreed by the Head of Clinical Coding who was responsible for signing off any errors found.

There were 2 errors in the primary procedure

All errors would be classed as 'coder error'

The discharge summary only stated that the hernia had been repaired not what type of repair had been used. The coder had used a specific code which in this case was not appropriate. The HRG remained unchanged.

A further episode was part of a split episode with each part appearing to have been coded by different coders. The procedure was missed although clearly documented in several places on the discharge summary. The HRG was changed as a result.

There was 1 error in the secondary procedure,

This would be classed as 'coder error'

The coder had correctly place the colonscopy the patient had in the primary position. The missed gastroscopy was cleared documented on the discharge summary although its addition did not change the HRG.

Conclusions

The quality and consistency of the coding in this sample was found to be good; however suffered due to coders not being released for training courses in order to maintain their skills and problems with the clinical discharge summary.

There is no audit policy nor Policy and Procedure document

The discharge summaries are inconsistent and incorrectly completed by clinical staff.

The discharge summaries to be examined were ready and available to the auditor at time of audit and the process was well managed by both the recently appointed Head of Clinical Coding and the Coding Team.

The HRGs are not visible to the coders at time of coding.

Progress has been made on one of the previous recommendations; however there has been no Manager for three years which, until the recent appointment of a Head of Clinical Coding, has stalled progress.

The staff compliment stands at 6 full-time permanent members of staff. There is one vacancy currently being covered by contract staff. There is also a dedicated recently appointed Head of Coding (1 WTE) Due to the small compliment of staff the Trust is at significant risk in the case of any type of diminished capacity, such as long-term absence for sickness or annual leave or any resignations.

Information Governance Requirement 505 –

Level 1 - There are documented procedures for the annual audit of clinical coding. A clinical coding audit programme has been initiated. – neither of these requirements have been attained

The Trust is therefore at level 0 (See appendix C for full breakdown).

Information Governance Requirement 510 –

There is a programme of clinical coding foundation course training conforming to national standards for all clinical coding staff entering coded clinical information.

The Trust has therefore achieved Level 1 (see appendix D for full breakdown)

Recommendations

In order to attain the next levels of Information Governance requirements the following is recommended.

Information Governance Requirement 505 –

Requirements for Level 1

The procedures for the annual audit of clinical coding have been documented.

A clinical coding audit programme has been undertaken by a Clinical Classifications Service (CCS) approved clinical coding auditor within the last twelve months prior to the final submission of the Information Governance Toolkit. The CCS approved auditor must have complied with all requirements of the Clinical Coding Auditor Programme and adhered to thee CCS Clinical Coding Audit Methodology and the Approved Clinical Coding Auditor Code of Conduct.

Information Governance Requirement 510 –

Requirements for Level 2

All clinical coding staff who assign ICD-10 and OPCS-4 codes must attend a clinical coding refresher course of no less than four days duration every 3 years.

Clinical coding refresher courses are delivered by approved clinical coding trainer(s) using only materials developed by the Clinical Classifications Service

The organisation supports all clinical coders in gaining Accredited Clinical Coder (ACC) status. National Clinical Coding Qualification training is based on national standards for ICD-10 and OPCS-4 and is delivered by a Clinical Classifications Service approved clinical coding trainer.

Complete, accurate and timely coded clinical data has always been essential in providing information for statistics, epidemiology, managers, clinical audit and now increasingly for financial purposes with the introduction of payment by results. There is evidence that Homerton University Hospital NHS Foundation Trust is aware of the need for accurate complete and timely coding The degree of success in achieving this is dependent on all of those involved in the process having an understanding of what is required by all parties. The following recommendations are intended to assist in that objective.

In order for coders to update and maintain their skills it is recommended that they attend appropriate specialty workshops and where applicable a Refresher course as soon as places are available.

An achievable audit policy is put in place and a HSCIC auditor appointed (vacancy has been approved) or alternative arrangements put in place to ensure that a robust audit cycle is initiated within two months.

Further investigation to confirm if a Policy & Procedure is available and that has been updated to reflect current coding standards and conventions. To ensure that if there are any local policies they do not contravene coding rules and conventions within one month.

To contact the person responsible in the Trust for updating the HRG (Healthcare Resource Group) software to the correct version. This would then show both the Coders and Management the HRG at completion of episode and assist in providing information for Management analysis, Oversees Visitor billing and Stroke cost analysis. This should take place as soon as possible, within one month

It is recommended that Clinical staff are engaged in order to demonstrate that correct completion of the discharge summary improves both quality of coding and potentially finance at any appropriate forum within the next 3months

It is recommended that further analysis is undertaken to assess if the relatively few chronic co-morbidities documented on the discharge summary found in this sample are a genuine reflection of the Trust's demographic. Initially this could take the form of a review of previous episodes on screen to provide an indication if further investigation, i.e. interrogation of patient's case notes, is warranted within a 3 month timeframe

Further clarification should be sought from clinicians regarding when adhesions are found at operation and whether these are divided or not. This is a data quality and potential finance issue and should be resolved as speedily as possible, within one month

Consideration should be given within one month to one coder extracting all the information where an episode is split between more than one consultant..

It is recommended that the risk due to diminished capacity and experience in staffing levels within the department to Trust finances and impact on any long term strategic developments be assessed more fully, as a matter of urgency within two months.

Appendix A - Summary of Errors

		Number		**%**
	Total number of episodes examined	50		
UTA	Unsafe to Audit			
	Actual number of episodes examined			
	Number or episodes where HRG would change as a result of the Auditor’s Coding	6		12
Primary Diagnosis				
	Number of primary diagnoses correct	47		94
Non Coder Error				
PDI	Information not available at the time of Coding			
PDD	Primary Diagnosis Documentation issue			
PDM	Primary Diagnosis Coded to Management Specification			
PDC	Primary Diagnosis Coded to Clinician Specification			
PDSC	Primary Diagnosis Coded due to System Constraint			
Coder Error				
PD3	Primary Diagnosis Incorrect – 3-character level	2		4
PD4	Primary Diagnosis Incorrect – 4-character level			
PD5	Primary Diagnosis Incorrect – 5-character level			
PDIS	Primary Diagnosis Incorrectly Sequenced	1		2
PDO	Primary Diagnosis Omitted			

Secondary Diagnosis			%
	Number of secondary diagnoses	72	
	Number of secondary diagnoses correct	62	86
Non Coder Error			
SDI	Information not available at the time of Coding		
SDD	Secondary Diagnosis Documentation issue		
SDM	Secondary Diagnosis Coded to Management Specification		
SDC	Secondary Diagnosis Coded to Clinician Specification		
SDSC	Secondary Diagnosis Coded due to System Constraint		
Coder Error			
SD3	Secondary Diagnosis Incorrect – 3-character level		
SD4	Secondary Diagnosis Incorrect – 4-character level		
SD5	Secondary Diagnosis Incorrect – 5-character level		
SDIS	Secondary Diagnosis Sequencing		
SDO	Secondary Diagnosis Omitted	10	14
SDNR	Secondary Diagnosis Not Relevant		
ECI	External Cause Code Incorrect		
ECO	External Cause Code Omitted		
ECNR	External Cause Code Not Relevant (not included in totals)		

		Number		%
Primary Procedures				
	Number of primary procedures	40		
	Number of primary procedures correct	38		95
Non Coder Error				
PPI	Information not available at the time of Coding			
PPD	Primary Procedure Documentation issue			
PPM	Primary Procedure Coded to Management Specification			
PPC	Primary Procedure Coded to Clinician Specification			
PPSC	Primary Procedure Coded due to System Constraint			
Coder Error				
PP3	Primary Procedure Incorrect – 3-character level			
PP4	Primary Procedure Incorrect – 4-character level	1		2
PPIS	Primary Procedure Incorrectly Sequenced			
PPO	Primary Procedure Omitted	1		2
PPNR	Primary Procedure Not Relevant (not included in totals)			

Secondary Procedures				
	Number of secondary procedures	24		
	Number of secondary procedures correct	23		96
Non Coder Error				
SPI	Information not available at the time of Coding			
SPD	Secondary Procedure Documentation issue			
SPM	Secondary Procedure Coded to Management Specification			
SPC	Secondary Procedure Coded to Clinician Specification			
SPSC	Secondary Procedure Coded due to System Constraint			
Coder Error				
SP3	Secondary Procedure Incorrect - 3-character level			
SP4	Secondary Procedure Incorrect - 4-character level			
SPIS	Secondary Procedure Incorrectly Sequenced			
SPO	Secondary Procedure Omitted	1		4
SPNR	Secondary Procedure Not Relevant (not included in errors)			

N.B.

The OPCS-4 codes from the Chapter Z Subsidiary Classification of Sites of Operation have not been included for calculation of discrepancies

Percentages may not add up to 100% due to rounding

Appendix B – Error key descriptions

<table>
<tr><td>UTA</td><td>UNSAFE TO AUDIT</td></tr>
<tr><td colspan="2">The Auditor is unable to audit the coded clinical data against the source documentation.
For example:
There is insufficient or no information regarding the episode in the Auditor’s source documentation.</td></tr>
<tr><td colspan="2">Primary Diagnosis error keys</td></tr>
<tr><td colspan="2">Coder error</td></tr>
<tr><td>PD3</td><td>PRIMARY DIAGNOSIS INCORRECT AT THREE CHARACTER LEVEL</td></tr>
<tr><td colspan="2">The primary diagnosis code has been allocated to an incorrect three character code.</td></tr>
<tr><td>PD4</td><td>PRIMARY DIAGNOSIS INCORRECT AT FOUR CHARACTER LEVEL</td></tr>
<tr><td colspan="2">The primary diagnosis code has been allocated to an incorrect fourth character.</td></tr>
<tr><td>PD5</td><td>PRIMARY DIAGNOSIS INCORRECT AT FIVE CHARACTER LEVEL</td></tr>
<tr><td colspan="2">The primary diagnosis code has been allocated to an incorrect fifth character.</td></tr>
<tr><td>PDIS</td><td>PRIMARY DIAGNOSIS INCORRECTLY SEQUENCED</td></tr>
<tr><td colspan="2">The primary diagnosis code recorded by the Auditor has not been sequenced by the Coder as the primary diagnosis.</td></tr>
<tr><td>PDO</td><td>PRIMARY DIAGNOSIS OMITTED</td></tr>
<tr><td colspan="2">The primary diagnosis recorded by the Auditor has not been recorded by the Coder in any diagnosis field.</td></tr>
<tr><td colspan="2">Non-Coder Error</td></tr>
<tr><td>PDI</td><td>INFORMATION AVAILABLE AT THE TIME OF AUDIT NOT AVAILABLE AT THE TIME OF CODING</td></tr>
<tr><td colspan="2">Information available to the Auditors was not available at the time of coding. This is where information regarding the episode became available after the episode was coded. This error key is not to be used if the information was not accessed by the Clinical Coder at the point of coding, for example, with histopathology reports.
This error key would also be assigned by the Auditor when the source documentation used at the time of coding did not contain all pertinent information required for accurate and complete coding and the Coder did not have access to this information, for example, coding from proforma with no access to the case notes.</td></tr>
<tr><td>PDD</td><td>PRIMARY DIAGNOSIS DOCUMENTATION ISSUE</td></tr>
<tr><td colspan="2">The auditor’s code allocated from the source documentation differs from that of the Trusts due to unclear or inconsistent information.
For example:
Inconsistency between information recorded by clinical staff contained on source documentation and it is not clear which is correct
The source documentation is illegible.</td></tr>
<tr><td>PDM</td><td>PRIMARY DIAGNOSIS CODED TO MANAGEMENT SPECIFICATION</td></tr>
<tr><td colspan="2">There is a clear and documented directive from management to contravene coding to national standards.
For example:
by unbundling diagnoses or procedures into component parts
by adding or optimising the coded clinical data to alter the derived HRG.</td></tr>
<tr><td>PDC</td><td>PRIMARY DIAGNOSIS CODED TO CLINICIAN SPECIFICATION</td></tr>
<tr><td colspan="2">There is a clear and documented directive from Clinicians to contravene coding to national standards or capture those instances where a Clinician has requested that coding be done in a particular way as it more accurately captures the diagnosis.
For example:
by unbundling diagnoses or procedures into component parts.</td></tr>
<tr><td>PDSC</td><td>PRIMARY DIAGNOSIS CODED DUE TO SYSTEM CONSTRAINT</td></tr>
<tr><td colspan="2">Due to the system that the Organisation uses the primary diagnosis codes is technically incorrect at some level, omitted or sequenced incorrectly.</td></tr>
</table>

<table>
<tr><td colspan="2">Secondary diagnosis error key descriptions</td></tr>
<tr><td colspan="2">Coder Error</td></tr>
<tr><td>SD3</td><td>SECONDARY DIAGNOSIS INCORRECT AT THREE CHARACTER LEVEL</td></tr>
<tr><td colspan="2">The secondary diagnosis code has been allocated to an incorrect three character code.</td></tr>
<tr><td>SD4</td><td>SECONDARY DIAGNOSIS INCORRECT AT FOUR CHARACTER LEVEL</td></tr>
<tr><td colspan="2">The secondary diagnosis code has been allocated to an incorrect four character code.</td></tr>
<tr><td>SD5</td><td>SECONDARY DIAGNOSIS INCORRECT AT FIVE CHARACTER LEVEL</td></tr>
<tr><td colspan="2">The secondary diagnosis code has been allocated to an incorrect five character code.</td></tr>
<tr><td>SDNR</td><td>SECONDARY DIAGNOSIS NOT RELEVANT</td></tr>
<tr><td colspan="2">The secondary diagnosis code recorded by the Coder is not relevant to the episode of care.</td></tr>
<tr><td>SDO</td><td>SECONDARY DIAGNOSIS OMITTED</td></tr>
<tr><td colspan="2">Diagnosis that has been recorded by the Auditor as relevant but is missing from the Organisation’s recorded episode.</td></tr>
<tr><td>SDIS</td><td>SECONDARY DIAGNOSIS INCORRECT SEQUENCING</td></tr>
<tr><td colspan="2">The sequencing of the secondary codes contravenes national standards. This error key can only be assigned for error in the following national standards:
Outcome of delivery (Z37 and Z38 if not well baby)
Asterisk codes must be preceded by a dagger code
Specific coding conventions in ICD-10 i.e. use additional code
Extent of body surface in burns (T31, T32).</td></tr>
<tr><td>ECI</td><td>EXTERNAL CAUSE CODE INCORRECT</td></tr>
<tr><td colspan="2">The external cause code recorded by the Organisation is incorrect at any character level.</td></tr>
<tr><td>ECO</td><td>EXTERNAL CAUSE CODE OMITTED</td></tr>
<tr><td colspan="2">The external cause code has been omitted from the Organisation’s recorded episode.</td></tr>
<tr><td colspan="2">Non-Coder Error</td></tr>
<tr><td>SDI</td><td>INFORMATION AVAILABLE AT THE TIME OF AUDIT NOT AVAILABLE AT THE TIME OF CODING</td></tr>
<tr><td colspan="2">See PDI.</td></tr>
<tr><td>SDD</td><td>SECONDARY DIAGNOSIS DOCUMENTATION ISSUE</td></tr>
<tr><td></td><td>See PDD</td></tr>
<tr><td>SDM</td><td>SECONDARY DIAGNOSIS CODED TO MANAGEMENT SPECIFICATION</td></tr>
<tr><td></td><td>See PDM</td></tr>
<tr><td>SDC</td><td>SECONDARY DIAGNOSIS CODED TO CLINICIAN SPECIFICATION</td></tr>
<tr><td></td><td>See PDC</td></tr>
<tr><td>SDSC</td><td>SECONDARY DIAGNOSIS CODED DUE TO SYSTEM CONSTRAINT</td></tr>
<tr><td colspan="2">See PDSC</td></tr>
</table>

Primary procedure error key descriptions	
Coder Error	
PP3	PRIMARY PROCEDURE INCORRECT AT THREE CHARACTER LEVEL
The primary procedure code has been allocated to an incorrect three character code.	
PP4	PRIMARY PROCEDURE INCORRECT AT FOUR CHARACTER LEVEL
The primary procedure code has been allocated to an incorrect four character code.	
PPIS	PRIMARY PROCEDURE INCORRECTLY SEQUENCED
The primary procedure code recorded by the Auditor has not been sequenced by the Coder as the primary procedure.	
PPO	PRIMARY PROCEDURE OMITTED
The primary procedure recorded by the Auditor has not been recorded by the Coder in any procedure field.	
PPNR	PRIMARY PROCEDURE NOT RELEVANT
The primary procedure recorded by the Coder is not relevant to the episode of care.	
Non-Coder Error	
PPI	INFORMATION AVAILABLE AT THE TIME OF AUDIT NOT AVAILABLE AT THE TIME OF CODING
See PDI.	
PPD	PRIMARY PROCEDURE DOCUMENTATION ISSUE
	See PDD
PPM	PRIMARY PROCEDURE CODED TO MANAGEMENT SPECIFICATION
	See PDM
PPC	PRIMARY PROCEDURE CODED TO CLINICIAN SPECIFICATION
	See PDC
PPSC	PRIMARY PROCEDURE CODED DUE TO SYSTEM CONSTRAINT
See PDSC	
Secondary Procedure error key descriptions	
Coder Error	
SP3	SECONDARY PROCEDURE INCORRECT AT THREE CHARACTER LEVEL
The secondary procedure code has been allocated to an incorrect three character code.	
SP4	SECONDARY PROCEDURE INCORRECT AT FOUR CHARACTER LEVEL
The secondary procedure code has been allocated to an incorrect four character code.	
SPIS	SECONDARY PROCEDURE INCORRECTLY SEQUENCED
The Organisation has not sequenced the procedure coding according to the rules and conventions of the classification. For example: See use as secondary code when associated with…	
SPO	SECONDARY PROCEDURE OMITTED
Secondary procedure that has been recorded by the Auditor as relevant but is missing from the Organisation’s recorded episode.	
SPNR	SECONDARY PROCEDURE NOT RELEVANT
The secondary procedure code recorded by the Coder is not relevant to the episode	
Non-Coder Error	
SPI	INFORMATION AVAILABLE AT THE TIME OF AUDIT NOT AVAILABLE AT THE TIME OF CODING
See PDI.	
SPD	SECONDARY PROCEDURE DOCUMENTATION ISSUE
	See PDD
SPM	SECONDARY PROCEDURE CODED TO MANAGEMENT SPECIFICATION
	See PDM
SPC	SECONDARY PROCEDURE CODED TO CLINICIAN SPECIFICATION
	See PDC
SPSC	SECONDARY PROCEDURE CODED DUE TO SYSTEM CONSTRAINT
See PDSC	

Appendix C

Information Governance Requirement 505 - There are established procedures in place for the regular quality inspections of the coded clinical data using the Clinical Classifications Service Clinical Coding Audit Methodology to demonstrate compliance with the clinical classifications OPCS-4 and ICD-10 and national clinical coding standards.. The results of any clinical coding audits conducted within the last twelve months are noted and actioned

Attainment Levels - These are cumulative e.g. to attain Level 3 you must complete all Level 1, 2 and 3 criteria.

0	**There is insufficient evidence to attain Level 1.**
1	**There are documented procedures for the annual audit of clinical coding. A clinical coding audit programme has been initiated.** **a**: The procedures for the annual audit of clinical coding have been documented. **<u>Evidence Required:</u>** • Data Quality and Clinical Coding Audit schedule or Departmental/organisational policy and procedure document. **b:** A clinical coding audit programme has been undertaken by a Clinical Classifications Service (CCS) approved clinical coding auditor within the last twelve months prior to the final submission of the Information Governance Toolkit. The CCS approved auditor must have complied with all requirements of the Clinical Coding Auditor Programme and adhered to thee CCS Clinical Coding Audit Methodology and the Approved Clinical Coding Auditor Code of Conduct. **<u>Evidence Required:</u>** • A full copy of the Clinical Coding Audit Report which bears the auditor credentials has ideally been uploaded to the Information Governance Toolkit. The CCS may request reports for review from time to time to inform any changes to national standards and training.
2	**Any recommendations made in previous clinical coding audits have been noted and actioned. An overall % accuracy score in a clinical coding audit of greater than or equal to level 2 scores in the guidance has been achieved.** **a:** Any recommendations made in the previous clinical coding audits have been noted and actioned. **<u>Evidence Required:</u>** • An improvement plan, e.g. recommendations for training included in a departmental organisation training plan, a recommendation to improve clinician input may result in minutes/meeting notes or e-mail confirmation of meeting attendance. **b:** The internal clinical coding audit percentage accuracy scores found by the clinical coding auditors should reach level 2 scores: **<u>Evidence Required:</u>** • A full copy of the Clinical Coding Audit Report which bears the auditor credentials has ideally been uploaded to the Information Governance Toolkit. The CCS may request reports for review from time to time to inform any changes to national standards and training.

<table>
<tr>
<td>3</td>
<td>Any recommendations made in previous clinical coding audits have been noted and actioned. An overall % accuracy score in a clinical coding audit of greater than or equal to level 3 scores in the guidance has been achieved.

a: The internal clinical coding audit percentage accuracy scores found by the clinical coding auditors should reach level 3 scores:
• Primary Diagnosis >=95%
• Secondary Diagnosis >=90%
• Primary Procedure >=95%
• Secondary Procedure >=90%

<u>Evidence Required:</u>
• A full copy of the Clinical Coding Audit Report which bears the auditor credentials has ideally been uploaded to the Information Governance Toolkit. The CCS may request reports for review from time to time to inform any changes to national standards and training.
b: [Level 3 Maintenance - only required if Level 3 achieved in previous year]
Clinical coding audit methodologies and requirements for undertaking the audits may change over time. It is therefore important that the documented procedures to support the clinical coding audit programme are regularly reviewed and kept up-to-date to ensure a cycle of continuous improvement.

<u>Evidence Required:</u>
• Minutes/meeting notes where the processes have been reviewed during the year including any decisions made at the meeting, any updates and/or changes to the policy and procedures document or changes to the Data Quality Programme Outline should be acknowledged/noted in the document.</td>
</tr>
</table>

Appendix D

Information Governance Requirement 510 - There is a comprehensive programme of clinical coding training for clinical coding staff involved in entering coded clinical information conforming to national clinical coding standards..

Attainment Levels - These are cumulative e.g. to attain Level 3 you must complete all Level 1, 2 and 3 criteria.

0	**There is insufficient evidence to attain Level 1.**
1	**There is a programme of clinical coding foundation course training conforming to national standards for all clinical coding staff entering coded clinical information.** **a:** All clinical coding staff who assign ICD-10 and OPCS-4 codes must complete the e-learning packages 'A Basic Introduction to Clinical Coding' and 'Anatomy and physiology' prior to attendance on formal clinical coding standards training, of no less than 21 days duration, within 6 months of commencing employment. **Evidence Required:** • A departmental training plan document or a copy of the attendee's training certificate of attendance and proof of the employee's start date of employment as a clinical coder. **b:** The clinical coding standards course of no less than 21 days duration delivered by an Clinical Classifications Service approved clinical coding trainer. delivered using only materials developed by the Clinical Classifications Service **Evidence Required:** • A copy of the attendee's training certificate of attendance. Confirmation of trainer status can be obtained by emailing datastandards@hscic.gov.uk.
2	**A programme of clinical coding refresher course training every three years for all clinical coding staff entering coded clinical information is in place that conforms to national standards. All clinical coders are supported in gaining Accredited Clinical Coder (ACC) status by passing the National Clinical Coding Qualification (UK).** **a:** All clinical coding staff who assign ICD-10 and OPCS-4 codes must attend a clinical coding refresher course of no less than four days duration every 3 years. **Evidence Required:** • A departmental training plan document or a copy of the attendee's refresher course certificate of attendance and proof of attendance on any previous refresher training courses. **b:** Clinical coding refresher courses are delivered by approved clinical coding trainer(s) using only materials developed by the Clinical Classifications Service **Evidence Required:** • A copy of the attendee's refresher course certificate of attendance. Confirmation of trainer status can be obtained by emailing datastandards@hscic.gov.uk. **c:** The organisation supports all clinical coders in gaining Accredited Clinical Coder (ACC) status. National Clinical Coding Qualification training is based on national standards for ICD-10 and OPCS-4 and is delivered by a Clinical Classifications Service approved clinical coding trainer.

	Evidence Required: • A departmental training plan document which contains details of the support given to coders in helping them achieve ACC status, copies of ACC pass certificates of any coders who have attained ACC status in the last year.
3	**Clinical coders have attended clinical coding specialty and update training workshops when classification revisions require.** **a:** Clinical coding staff who assign ICD-10 and OPCS-4 codes within the organisation have attended all specialty workshops relevant to their work, and update training workshops when classifications require. **Evidence Required:** • A departmental training plan document or a copy of the attendee's specialty workshop certificate of attendance and proof of attendance on any previous update training courses. **b:** The clinical coding specialty and update workshops are delivered by an Clinical Classifications Service approved clinical coding trainer. using only materials developed or endorsed by the Clinical Classifications Service or developed in accordance with national clinical coding standards. **Evidence Required:** • A copy of the attendee's specialty or update course certificate of attendance. Confirmation of trainer status can be obtained by emailing **c:** [Level 3 Maintenance - only required if Level 3 achieved in previous year] There is documented training and assessment framework which actively promotes and supports all clinical coding staff who assign ICD-10 and OPCS-4 codes within the organisation to gain Accredited Clinical Coder (ACC) status by passing the National Clinical Coding Qualification (UK). In addition where an organisation has identified achieving Approved Clinical Coding their training and ongoing Approved status. **Evidence Required:** • A departmental training plan document and proof of Accredited Clinical Coders who have achieved Approved Clinical Coding Trainer and / or Auditor status in the past year. The Trainer or Auditors name will also have been added to the NCS register of approved trainers and auditors.

`## Appendix E

Reference Documentation

Primary Diagnosis definition
HSG (96)23, 20 September 1996

Classifications
International Statistical Classification of Diseases and Health Related Problems, Tenth Revision - Volume 1, 2010 Edition, World Health Organisation.
International Statistical Classification of Diseases and Health Related Problems, Tenth Revision - Volume 2, 2010 Edition, World Health Organisation.
International Statistical Classification of Diseases and Health Related Problems, Tenth Revision - Volume 3, 2010 Edition, World Health Organisation.

Tabular list – Volume I of the Classification of Interventions and Procedures, Version 4.6.
Index - Volume II of the Classifications of Interventions and Procedures, Version 4.6.

Coding Clinic Collection
www.connectingforhealth.nhs.uk/ClinicalCoding/publications

Clinical Coding Instruction Manual
Clinical Coding Instruction Manual ICD-10 & OPCS-4, Accurate data for quality information, NHS Classifications Service, NHS Connecting for Health