NAME OF CHILD: Claire Roberts

Name: Danny McWilliams

Title: Mr.

Present position and institution: Performance Improvement Manager. Belfast Health and Social Care Trust.

Previous position and institution:
[As at the time of the child's death]
Clinical Coding Manager. Belfast Health and Social Care Trust.

Membership of Advisory Panels and Committees:
[Identify by date and title all of those between January 1995 - September 2012]

Previous Statements, Depositions and Reports:
[Identify by date and title all those made in relation to the child's death]
Clinical Coding Policy
Responses to queries involving coding processes

OFFICIAL USE:
List of previous statements, depositions and reports:

Ref:	Date:	

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(1) **Please state your qualifications as at 1996 (and kindly provide a copy of your Curriculum Vitae).**

GCE O & A Level Education.

BSC Social Administration and Policy. 2:1.

Clinical Coding Certificate. Issued by Department of Health-Directorate of information Systems

(2) **Please provide any and all information regarding your work commitments at the RGH from the date of your appointment to 2006.**

In November 1994, I was appointed as Clinical Coder. In 1996, I achieved the post of Clinical Coding Manager which is a Permanent full time position. I am responsible for Clinical Coding processes including timeliness, quality and management of coding staff and provision of casemix information related to clinical coding.

(3) **Please describe the role, function and accountability of your post as at 1996 and 2006, including those individuals to whom you reported, and who reported to you.**

1996-Clinical Coding Manager for RVH. Responsible for Clinical Coding function, management of coding staff, quality assurance and provision of casemix information related to clinical coding. Reported to Information Manager John Stewart. Those reporting to me included: Margaret Newell, Darren Browne, Maureen McChesney, Eleanor Causby, Margaret Leith, Mary Burke, Geraldine Toner,Anne Mc Kenna.

2006-Clinical Coding Manager for Belfast Trust-all sites. Responsible for Clinical Coding function and management of coding staff and provision of casemix information related to clinical coding. Responsible for Benchmarking services for Trust and reported to Noel Williams who was the Service Planning and Contracts manager. Those reporting to me included: Darren Browne, Rosemary Hutton, Brendan Cassidy. Coding Staff reported to these staff members but I had responsibility for overall function.

(4) **Was there a written job description for your post in 1996 and/or 2006? If so, please provide copy of the same. Yes. This is not available as yet Trust HR Department are searching for these.**

(5) **Please identify your predecessor and successor in post.**

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Predecessor; Eunan Carr

Successor: Darren Browne

(6) Please describe and explain as fully as possible the meaning attributed to 'clinical coding' both in 1996 and 2006, including what exactly is coded. Please provide the references to any texts that you consider appropriate and where possible actual copies.

Clinical coding is the extraction, interpretation and translation of diagnostic and procedural information into alphanumeric code according to national guidelines using national classifications after transfer or discharge. This facilitates a wide range of purposes including epidemiology, planning and many other business and patient safety analyses.

Classifications used include: ICD10(International Classification of diseases and health Related Problems) and OPCS 4 (Office of population Census and Surveys Classification of interventions and procedures).

ICD10 and OPCS Instruction Manuals and reviews of definitions through updates known as Coding Clinic'

(7) Please describe the role, function and accountability of the Clinical Coding Department as at 1996 and 2006, including job responsibilities and descriptions of how the Department conducted its work.

1996 (RVH Only)-Role and function was to ensure diagnostic and procedural information was extracted and recorded to the correct specificity and in a timely manner to facilitate analysis at a diagnostic and procedural level. Individual coding staff were managed by the coding manager and supported by the coding supervisor in terms of processes and duties. Coders would normally have specific areas of work however at times would be expected to support other areas in times of absence or high workload. Processes were in place to manage day to day operational issues, query resolution, quality control and interaction with directorate staff.

Performance measured through coding timeliness, audit and Coding quality indicators

Accountability rested with the coding manager and information manager. Twice yearly accountability review would be held to examine performance of coding as part of the overall Information Departments performance.

2006(BHSCT) As above. Clinical coding basic functionality remains the same. Trust merger means this has changed in scope rather than nature. Classifications have improved but remain largely the same in terms of function and methodology.

(8) With respect to Clinical Coding at the RBHSC/RGH in both 1996 and 2006 please address the following:

(a) How, when, from whom and in what format did the Clinical Coding Department receive medical information for coding?

1996-Information for clinical coding was gathered from several sources depending on the speciality or area involved. This ranged from full casenotes, discharge/transfer proformas (usually produced by Junior doctors), discharge letters (usually produced by consultants), Electronic systems and some bespoke documentation. The precise source used was usually based on available resource i.e. casenote coding takes considerably more time. Clinicians

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were also contacted on a regular basis to clarify medical terminology or disease processes. Assignment of codes was however was carried out by coding staff according to the rules of the ICD and OPCS classification.

In some areas completed Discharge/transfer proformas (completed by junior doctors) would have been sent to consultant staff to verify the information.

With specific regard to RBHSC medical information, this was carried out generally but not exclusively through the use of discharge proforma. In a significant number of cases this may also have been carried out using the full casenote or occasionally a consultant discharge letter if a discharge proforma was not available or unclear (quality of coding copy was often difficult to read). Completed proformas would have been gathered by the coder from the ward on the day or day after discharge where sometimes the casenote would also be available to clarify proform information. Charts could also be accessed by coders through visiting medical records or secretaries offices in the case of backlogs etc.

Due to the fact that PICU did not normally discharge patients a discharge/transfer proforma was not always completed. Therefore an additional bespoke form was usually but not always completed for patients in PICU. This would have included any diagnostic or procedural information. The coder would have accessed this after discharge/transfer to extract medical information. This means information for PICU patients could often be a merge of the casenote, any completed discharge/transfer proforma and the bespoke form. The coder would have attended PICU to photocopy or extract the information from the bespoke form.

Discharge/transfer proformas (completed by junior doctors) would have been sent to some consultant staff to verify the information for wards in RBHSC however it was unusual to have any changes made. This process did not apply to PICU as there was already additional information available from the bespoke form.

2006- the process was largely the same as in 1996.

(b)   **The process involved in coding from treatment/death through to completion;**

In RBHSC in 1996 and 2006 the coder would have retrieved proformas or searched for charts/Consultant letters after a patient's discharge. Translation into ICD 10/OPCS code was completed using classification guidelines. Codes would then be entered onto PAS. This process was applied whether the patient was discharged normally or died.

(c)   **How is the cause of death determined to permit a coding?**

According to the rules of the ICD 10 Classification coding is not carried out on basis of cause of death but rather the main condition treated or investigated during the patients stay. This may or may not have been the cause of death.

(d)   **What classifications were in use during these periods, including versions and editions of the same, and the distinction between such classifications?**

Diagnostic information was classified using the classification:ICD10(International Classification of diseases and Health Related Problems). This classification was mandated for use across all

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NHS hospitals the United Kingdom. This is an international classification produced by the World Health organisation but with some UK amendments.

Procedural information was classified using the classification OPCS 4.2 (Office of population Census and Surveys Classification of Procedures). This classification was mandated for use across all NHS hospitals the United Kingdom. This is a United Kingdom classification only and produced by the NHS.

(e) **Were there any shortcomings or deficiencies in respect of these classifications? If so what were they and how (if at all) were they brought to the attention of the Trust?**

These classifications were, and still are, designed to gather statistical information and are not used in any patient clinical decision making. The classifications in some areas therefore may have generalised codes for diagnoses and procedures which would be improved with more specificity. They may also lag in terms of new treatments i.e. specific codes may not yet exist for new types of procedures. These issues would be raised by the coding manager with the Regional coding bodies and they and their counterparts across the United Kingdom. These comments or recommendations may be incorporated into new revisions of the classification. However the OPCS classification is the only United Kingdom classification that can be changed nationally. ICD 10 is an International classification and thus changes less frequently.

(f) **Were there any shortcomings or deficiencies in respect of clinical coding generally and if so what were they and how (if at all) were they brought to the attention of the Trust?**

The main shortcoming in clinical coding would centre on the resources required to code as accurately and as timely as possible and to carry out sufficient audit and training. There were also issues in terms of awareness of coding throughout the Trust. These would be brought to the attention of the Trust via business cases for new coding staff or liaison meetings with directorates to resolve local problems e.g. availability of documents to code from etc.

(g) **What were the number of permitted primary diagnoses and the number of permitted co-morbities? Explain whether it was common for more than one primary diagnosis to be inputted and, if so, upon what basis?**

The number of permitted diagnoses and co-morbidities was 17. There was only one primary diagnoses inputted. Other diagnoses or co-morbidities were entered after this.

(h) **What system was in use for the input of classifications, e.g. Patient Administrative System;**

Patient Administration System was used for the input of data. Coded data was entered for specific episodes of care against specific consultants for the relevant dates. Demographic information relating to the patients details and speciality etc. are also on this record and are checked to ensure the correct information is logged against the correct patient and consultant. Other bespoke systems within the Trust would occasionally use shortlists derived from ICD10 or OPCS codes but these were not under the management of the coding department or resourced by its staff.

(i) **How and by whom was the system accessed in respect of coding? Was it possible to change codes retrospectively and if so in what circumstances, how and with whose**

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approval could it be done?

PAS can be accessed through Trust systems by password only, level of access is dependent on the needs of a staff members post. This access is granted through line managers and processed by medical records PAS team. The function used on PAS for clinical coding would have been mainly available to coding staff. However other staff may have required access to view clinical coding for their own needs e.g Audit departments etc. but these staff should not have access to change codes.

(j) **What was the role, function, accountability and responsibilities of the Hospital Information Branch?**

HIB were responsible for the regional management of the coding function liaising with individual Trusts. This would have included: issuing national guidance or any regional variations, training of new coding staff, continuing training for existing coding staff, issue of classifications, query resolution and representation on national coding bodies and audit function.

(k) **What was the role, function, accountability and responsibilities of the Coding Clerk? Please identify the person who held that position.**

The coding clerk was responsible for ensuring the capture of diagnostic and procedural information. Specifically its extraction, interpretation and translation into ICD10 and OPCS 4 codes and entry on the PAS system to the correct specificity and in a timely manner to facilitate analysis at a diagnostic and procedural level. The coder was responsible to the coding manager.

The coder was Margaret Newell.

(l) **What was the role, function, accountability and responsibilities of the Regional Coding Co-ordinator and Coding Auditor? Please identify the person who held that position.**

The regional coding co-ordinator was responsible for the regional management of the coding function liaising with individual Trusts. This would have included: issuing national guidance or any regional variations, training of new coding staff, continuing training for existing coding staff, issue of classifications, query resolution and representation on national coding bodies and limited audit function.

This person was Joy Trouton.

(m) **What was the process that would need to have been followed for information to be obtained from the clinical coding system, e.g. if information was being sought in relation to hyponatraemia-related deaths? Would such a search provide results for both primary and secondary diagnoses?**

If a request for information was requested this would have been extracted from the database which holds PAS data. Generally a phone call or request via e-mail or letter would be the initial step in a request and this may have required some clarification. This clarification would sometimes include whether the requestor required primary and/or secondary conditions. It would require very little extra process to extract primary and secondary conditions. With specific regard to hyponatraemia there is a specific code for this

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condition which requires no cross referencing or interpretation for coding onto PAS.

(n) **Is information stored in the system concerning patients who had developed hyponatraemia as a condition, whether or they subsequently died? If so, how could a search be carried out to identify the incidence of hyponatraemia?**

Hyponatraemia is a codable condition and can be cross referenced against deaths. The search would be based on the diagnosis code presence and method of discharge showing that the patient died.

(o) **What would constitute 'evidence' that a coding has taken place, e.g. patient x has been coded with a primary/secondary diagnosis classification of hyponatraemia?**

Coding on PAS would show the diagnoses recorded in the appropriate field, its presence depends on whether the information has been provided in the discharge proforma or in any other documentation. The physical casenote would not usually show evidence that a record was coded in most areas in RVH or RBHSC.

(p) **Was the Clinical Coding Department acted under any targets in respect of both the accuracy and efficiency of coding? If so what were they and who set them? What (if any) difficulties did the Clinical Coding Department experience in seeking to fulfil its functions?**

Targets for timeliness were set by each Trust and a loose target was set at that time of completed coding within approximately 30 days. It would have been very common for this target not to be met for substantial numbers of patients but monitoring of this target was carried out on a monthly basis. Audits were periodically carried out by the coding manager or supervisor to quantify the quality of coded data but no specific number of these was set, resources to do this were very limited and thus not regular or comprehensive. Regular reports were produced showing coding quality indicators against other hospitals to provide some form of target proxy or approximate quality level expected.

(9) **Please identify whether the clinical coding information held for Claire Roberts was ever changed and, if so, when, by whom, for what purpose and with whose approval.**

It is not possible to say if the records were changed, either when or by whom. Records could be changed either though findings of an audit or receipt of additional information. The only staff permitted to change codes would be the relevant coding staff.

Audit logs showing who has accessed particular records on PAS only go back as far as 2 years as the system purges audit logs for space issues. The level of detail would also not be available to see what exactly was done in a transaction i.e. if the coding was specifically changed to different codes.

(10) **Please describe the system of audit that was in place in the RBHSC/RGH with respect to clinical coding, including who conducted it, under what auspice, how often, at whose direction. Please also explain the purpose of such audits e.g. to report on trends.**

Audit of coding quality was carried out by the coding manager or supervisor but this was very infrequent. This was to ascertain whether coding guidelines were applied and that all diagnoses

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and/or procedures were included if available. Audit was infrequent due to resource issues.

Requests for information on disease trends e.g. certain diagnoses/procedures was very common and would have been carried out by the coding manager. This would have usually been at the request of clinicians involved in clinical audit or research within the Trust or regionally. No records would exist as to what was requested and by whom.

(11)   **Please state whether there was any system or procedure (other than by audit) for identifying such trends, e.g. trigger lists, reporting requirements (for coders or clinicians).**

At that time there were no standing system but if concerns were raised in any area clinicians could organise a clinical audit which would have been facilitated through clinical coding. This would be in addition to any other safety processes at a directorate level.

(12)   **Please describe how clinical coding is conducted in respect of cases that are referred to the Coroner.**

Cases referred to the coroner were treated in the same way as any other coded record. This method as previously mentioned could vary on whether coding took place from proformas or casenotes etc.

(13)   **In respect of the PICU Coding Form (Ref:090-055-203) and the actual codes applied in the case of Claire Roberts (Ref: 313-001-002) please state:**

(a)   **Why there are discrepancies between the diagnoses contained on the Coding Form and the diagnoses actually coded e.g. myelitis, encephalomyelitis, cerebral oedema, status epilepticus;**

Coding for this episode would have been taken from several sources. From examining the coding and source documents it appears that the bespoke PICU coding form was used together with the normal Discharge/Transfer proforma and casenote. The PICU form concentrates on the diagnoses being treated in PICU while the discharge/transfer proforma or casenote provides information for the stay in general.

(b)   **Whether there were any other forms involved in the clinical coding of the death of Claire Roberts. If so please provide copy of them.**

It appears that the Discharge/Transfer Proforma and casenote were used in conjunction with the PICU coding form. We do not have any means (electronic or paper) of identifying in absolute terms what documentation was used.

(c)   **The identity of the second signatory beneath Dr. McKaigue and explain the likely reason for such a signature.**

The second signatory belongs to the clinical coder Margaret Newell. This was signed to confirm she had sight of the information for coding purposes.

(d)   **Whether the codes applied to Claire in (Ref: 313-001-002) relate solely to the treatment of Claire between 21st and 23rd October 1994 or whether they include her earlier admission on 4th September 1987;**

The codes are related to the admission for 21st to 23rd October 1996.

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(14) Please state any and all guidance, protocols, standards or guidelines that governed clinical coding during these periods and provide a copy of them.

Technical issues relating to coding were governed by the National Rules of the Classifications ICD 10 and OPCS 4. These rules were adhered to as far as available source medical documents would allow. In terms of diagnostic coding these rules are set by the World Health Organisation with local amendment by the NHS Information Centre/Connecting for Health. In relation to procedural coding these guidelines are set purely by the NHS Information Centre/Connecting for Health.

The Trust had a target of 100% coding timeliness within a one month period, this was not usually attained due to resource issues. Quality targets were not specifically set but audit was carried out when possible and reports were produced showing coding quality indicators.

(15) Was there any Clinical Coding Policy during this time? If so, please identify it and provide a copy of the relevant document(s). If not, describe the guidance under which you operated and identify its source.

There was no formal clinical coding policy in 1996 but standards of practice were governed by national classification rules and known best practice. Local practice was based around timeliness and quality of coding and the role of coding staff was clearly outlined in job descriptions

(16) Please state whether there was any interface between the Clinical Coding Department, the Trust Board, the Hospital Information Branch of the Department of Health, the Government Records Office, and/or the Northern Ireland Statistical Research Agency, and if so explain as fully as possible what it was.

The coding department was managed under information management department. All departments in the Trust were responsible to the directors in Executive Team who were responsible to Trust Board.

A Regional forum-Hospital Liaison Group was in existence to provide liaison and guidance surrounding information definitions etc. HIB, Board and Trust representatives would have been present. These meetings did not focus on clinical coding as such but issues could be brought to the group in this regard. At that time there was no regional coding forum to specifically interface on clinical coding.

(17) Please provide any further comments you may wish to make.

Clinical coding and the resultant casemix information was not and is not used in any clinical decision making processes at an individual level. It can facilitate aggregate study of disease and procedural information which may inform audits or outcomes assurance. It also has a prominent role in business processes such as planning of services and financial management.

(18) Please identify any further relevant documents or materials.

None.

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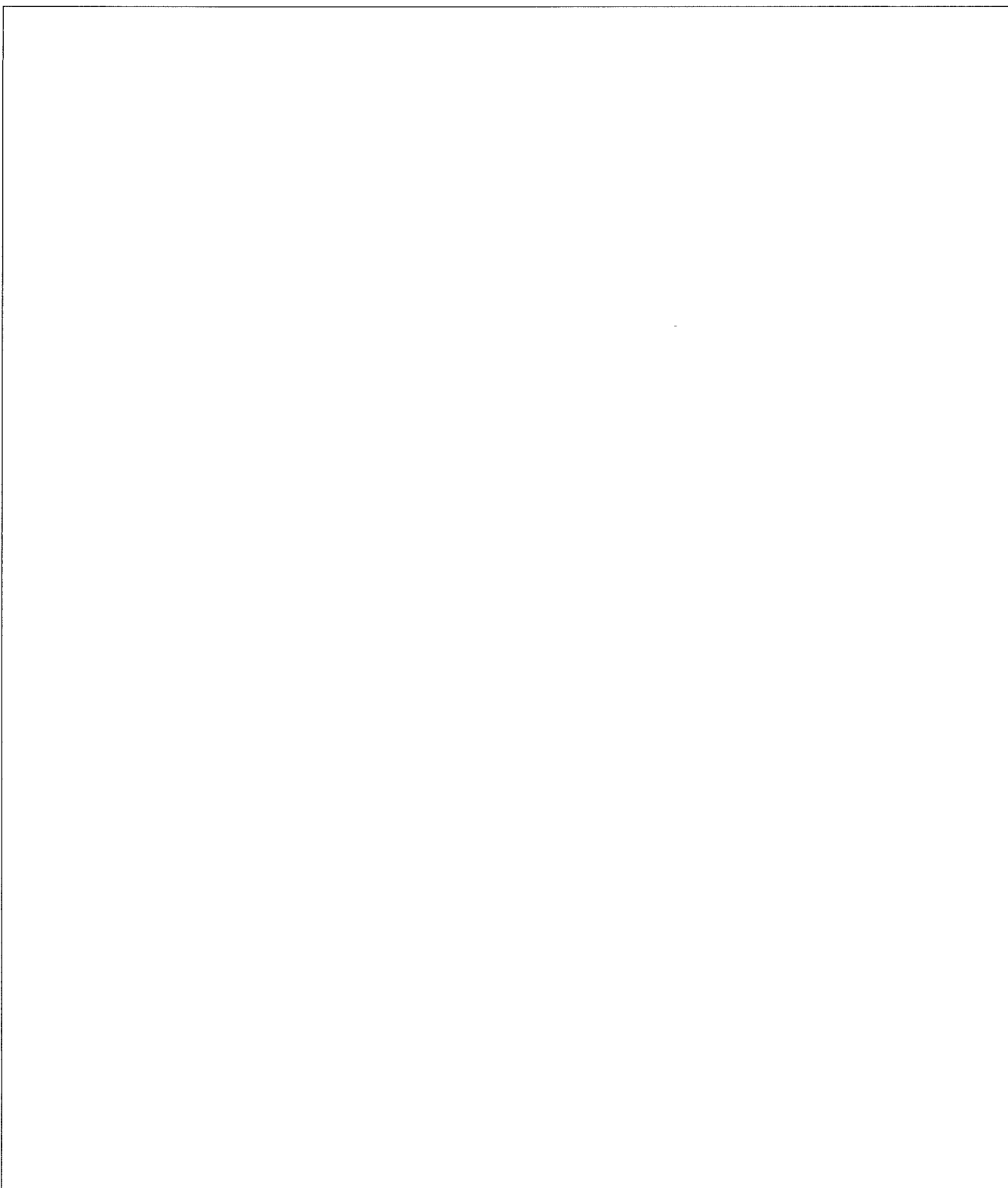
THIS STATEMENT IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF

Signed: *Danny mcwilliams*   Dated: *5th October 2012*

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THE ROYAL GROUP OF HOSPITALS AND DENTAL HOSPITAL
HEALTH AND SOCIAL SERVICES TRUST

JOB DESCRIPTION

TITLE OF POST:-   Clinical Coding Manager- Grade 5

LOCATION:-   Information Management Department, Directorate of Planning, Contracting & Information

RESPONSIBLE TO:-   Director of Planning, Contracting & Information

REPORTS TO:-   Clinical Activity Information Manager

MAIN PURPOSE:-

The post holder will play a key role in the abstraction of coded and captured clinical data and in supporting the analysis and interpretation of information derived from the coded clinical data.

MAIN DUTIES:-

1. Co-ordinate the capture of all diagnostic and procedural coding throughout the Royal Hospitals.

2. Prepare, develop and update clinical coding plans for the Trust.

3. Communicate effectively with clinicians, nurses and managers on matters concerning clinical coding.

4. Work with clinicians and senior managers to develop appropriate data collection systems for each specialty and to implement appropriate coding systems (ICD10/OPCS4/READ).

5. Participate in the recruitment, induction and training of all staff involved in clinical coding in accordance with procedures laid down and approved by the DHSS.

6. Audit the completeness, timeliness and accuracy of clinical coding throughout the Trust.

7. Establish and implement awareness programmes for medical and other staff groups in the need for accurate and timely completion of patient records.

8. Co-ordinate the Trust's work with the CHKS National Comparative Database and provide information on Trust and Peer Group activity to clinicians and clinical/non-clinical managers.

9. Act as a source of technical expertise on diagnostic and procedural grouping for analytical purposes.

10. Respect the confidentiality of all patient data in accordance with regional and in-house codes of practice.

11. Review individually at least annually the performance of immediately sub-ordinate staff, provide guidance on personal development requirements and advise and initiate further training where appropriate.

12. Maintain staff relationships and morale among the staff reporting to him/her.

13. Delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making, while retaining overall responsibility and accountability for results.

14. Take such action as may be necessary in disciplinary and grievance matters, in accordance with procedures laid down and approved by the Trust.

THIS JOB DESCRIPTION IS NOT MEANT TO BE DEFINITIVE AND MAY BE AMENDED TO MEET THE CHANGING NEEDS OF THE TRUST.

FEBRUARY 1996

THE ROYAL GROUP OF HOSPITALS AND DENTAL HOSPITAL
HEALTH AND SOCIAL SERVICES TRUST

Employees of the Trust are required to support its Mission which states:-

"It is our fundamental purpose in the Royal Hospitals to provide the highest quality cost effective health care, as an outstanding acute general hospital and tertiary referral centre, through exceptional service to our patients, staff and community in an environment of education, teaching and research."

GENERAL RESPONSIBILITIES:

Members of staff are expected at all times to provide a caring service and to treat those with whom they come into contact in a courteous and respectful manner.

Staff are expected to demonstrate their commitment to the Trust by their regular attendance and the efficient completion of all tasks allocated to them.

All staff must comply with the Royal Group of Hospitals and Dental Hospital Health and Social Services Trust's No Smoking Policy.

All duties must be carried out in compliance with the Royal Group of Hospitals Trust's Health and Safety Policy and statutory regulations.

The Trust is an Equal Opportunities Employer. You are required to adhere to the Trust's Equal Opportunities Policy throughout the course of your employment.

To ensure the ongoing confidence of the public in officers of the Trust and to maintain high standards of personal accountability, staff must abide by the Code of Business Conduct.

THE ROYAL GROUP OF HOSPITALS AND DENTAL HOSPITAL
HEALTH AND SOCIAL SERVICES TRUST

JOB SPECIFICATION

TITLE OF POST:-   Clinical Coding Manager- Grade 5

LOCATION:-   Information Management Department, Directorate of Planning, Contracting & Information

ESSENTIAL CRITERIA

1.   A university degree **or** a recognised professional qualification

and

demonstrate a knowledge of human physiology/life science gained **either** through 'A' level or above **or** through having at least one years experience clinical coding experience in a multi-specialty environment and having attended a Nationally recognised training course in clinical coding.

2.   Have the ability to communicate effectively.

DESIRABLE CRITERIA

1.   Have experience with NHS clinical coding systems.

2.   Familiarity with SMS PAS.

3.   An awareness of the current reforms in the NHS.

4.   Data manipulation and presentational skills.

NOTE:

Where Educational/Professional qualifications form part of the criteria you will be required, if shortlisted for interview, to produce original certificates issued by the appropriate authority. If educational certificates are not available an original letter detailing examination results from your School or College will be accepted as an alternative.

Failure to produce evidence of your qualifications will result in the interview not proceeding.

Clinical Coding Manager – Revised Proposal for Job Description

1. Co-ordinate capture of all diagnostic and procedural coding throughout the Royal Hospitals. ✓

2. Prepare, develop and update clinical coding plans for the trust. ✓

3. Communicate effectively with clinicians, and managers on matters concerning clinical coding. ✓

4. Work with clinicians and senior managers to develop appropriate data collection systems for each specialty and to implement appropriate coding coding systems(ICD10/OPCS4/READ) ✓

4.5 Analyse and present casemix information for senior Clinical and Managerial staff in relation to service planning within the trust. ✓

5. Participate in the recruitment, induction and training of all staff involved in clinical coding in accordance with procedures laid down and approved by the DHSS. ✓

6. Audit the completeness, timeliness and accuracy of clinical coding throughout the trust. ✓

7. Establish and implement awareness programmes for medical and other staff groups in the need for accurate and timely completion of patient records. ✓

8. Co-ordinate the trusts work with the CHKS National Comparative Database and provide information on Trust and Peer group activity to clinicians and clinical/non-clinical managers. ✓

8.1 Initiate comparative analyses on efficieny and quality issues both internally and through the use of CHKS and any other body. Provide technical expertise for such analyses. ✓

8.2 Participate in contractual negotiations with the Trust and CHKS and critically assess quality of services provided. ✓

8.5 Participate in the Implementation of clinical governance from an information perspective in liaison with Medical Directors and senior managerial staff etc. including membership of steering and technical groups.

8.6 Analyse and present casemix information relating to mortality and morbidity to senior clinical and managerial staff. Develop and maintain protocols for performance measurement on such issues with information manager and senior clinicians.

8.8 Represent the trusts Information Department in Regional groups especially in relation to casemix information.

9. Act as a source of technical expertise on diagnostic and procedural groupings for analytical purposes. ✓

9.2 Analyse and present casemix grouping information for clinical and managerial purposes and act as a source of technical expertise for use of such groupings and promote use throughout the trust.

9.5 Organise liason and integration of other trust casemix information systems with PAS and provide technical expertise for the introduction of such systems in the trust.

10. Respect the confidentiality of all patient data in accordance with regional and in-house codes of practice. ✓

11. Review individually at least annually the performance of immediately sub-ordinate staff, provide guidance on personal development requirements and advise and initiate further training where appropriate.

12. Maintain staff relationships and morale among the staff reporting to him/her.

13. Delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making, while retaining overall responsibility and accountability for results.

14. Take such action as may be necessary in disciplinary and grievance matters, in accordance with procedures laid down and approved by the trust.

September 2000

Clinical Coding Manager – Revised Proposal for Job Description

1. Manage and develop the co-ordination and capture of all diagnostic and procedural coding throughout the Royal Hospitals.

2. Prepare, develop and update clinical coding plans for the trust.

3. Communicate effectively with clinicians, and managers on matters concerning clinical coding.

4. Work with clinicians and senior managers to develop appropriate data collection systems for each specialty and to implement appropriate coding coding systems (ICD10/OPCS4/READ/SNOMED)

5. Analyse and present casemix information for senior clinical and managerial staff in relation to service planning within the trust.

6. Participate in the recruitment, induction and training of all staff involved in clinical coding in accordance with procedures laid down and approved by the DHSS.

7. Audit the completeness, timeliness and accuracy of clinical coding throughout the trust.

8. Establish and implement awareness programmes for medical and other staff groups in the need for accurate and timely completion of patient records.

9. Manage and develop comparative analyses on matters of efficiency and quality with various organisations including DHSS other trusts and through the use of CHKS and any other body. Provide technical expertise for such analyses and take action on emerging issues with clinicians, management and any other relevant internal or external organisation.

10. Manage and develop the trusts CHKS clinical governance information system. Analyse and present emerging clinical quality issues with divisional clinical directors. Organise regular meetings with divisions in order to investigate possible variances in clinical performance. Represent the trust in meetings with CHKS and partner trusts.

11. Inform the medical director and senior executives of potential clinical issues arising from clinical information analyses including all aspects of mortality and morbidity.

12. Inform and prepare divisons and the medical director/executive management for discussion of clinical issues at accountability meetings including all aspects of mortality and morbidity.

13. Increase awareness on the use of clinical information and the clinical governace agenda to all levels of clinical and managerial staff.

14. Participate in contractual negotiations with the trust and CHKS and critically assess quality of services provided.

15. Introduce innovative methods and indicators for clinical assessment and performance measurement in all clinical areas including the consultant appraisal process and performance management generally. Liase with the medical director , senior clinicians and Department of Health in the development of such indicators. Promote and assess the use of clinical information in the performance management agenda within the trust and in relation trust and DHSS requirements.

16. Participate in clinical governance and information forums at a senior level within the trust including excellence and clinical governance steering groups and divisional clinical governance steering groups.

17. Assist the information manager in representing the the trust in regional groups especially in relation to clinical information and performance

18. Establish liason and communication with other NHS trusts and organisations throughout the UK for the purpose of sharing information and procesess in relation to performance,clinical information and clinical coding.

19. Analyse and present HRG and casemix grouping information for clinical and managerial purposes and act as a source of technical expertise for use of such groupings and promote use throughout the trust. Provide support for addressing HRG costing issues in conjunction with the finance department and divisions.

20. Participate in the organisation and liason for the integration of other trust casemix information systems with PAS and provide technical expertise for the introduction of such systems in the trust.

21. Contribute to the performance management process generally with a view to expansion of clinical performance management.

22. Respect the confidentiality of all patient data in accordance with regional and in-house codes of practice.

23. Review individually at least annually the performance of immediately sub-ordinate staff, provide guidance on personal development requirements and advise and initiate further training where appropriate.

24. Maintain staff relationships and morale among the staff reporting to him/her.

25. Delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making, while retaining overall responsibility and accountability for results.

26. Take such action as may be necessary in disciplinary and grievance matters, in accordance with procedures laid down and approved by the trust.

April 2003