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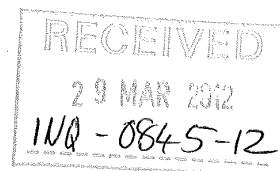
— PRACTITIONERS IN LAW TO THE
HEALTH & SOCIAL CARE SECTOR —

2 Franklin Street, Belfast, BT2 8DQ
DX 2842 NR Belfast 3

Your Ref:
BPC-0072-11

Our Ref:
HYP B04/01

Date:
26.03.12



Mr B Cullen
Solicitor to the Inquiry
Arthur House
41 Arthur Street
Belfast
BT1 4GB

Dear Sir,

RE: INQUIRY INTO HYPONATRAEMIA RELATED DEATHS

I refer to the above and your letter of 8th December 2012 (BPC-0072-11). I am instructed as follows: -

- 1) The Belfast Health and Social Care Trust "Clinical Coding Policy" is enclosed.
- 2) Codes are applied to cases from examination of the medical records by coding clerks without reference to clinical staff. I enclose the codes which were applied to the cases of Claire Roberts and Lucy Crawford. The IT Department believes these codes were not changed subsequently however there is a field in the background of the Patient Administration System which states when the episode was coded and although it will take some time to extract this information it is being accessed.

I am instructed that in the case of Claire Robert's it will be seen that if the coding was entered around the time of death only the addition of "excess ADH production" would have occurred as a result of the Inquest as the other elements of the cause of death were already coded.

Yours faithfully,

Joanna Bolton
Solicitor Consultant

Email: [REDACTED]

Tel: [REDACTED]

Providing Support to Health and Social Care



INVESTOR IN PEOPLE

LUCY CRAWFORD - [REDACTED]

Admitted on 13/04/00 08:40 To PMC ICU CH ICU

Disposal 14/04/00 DIED - POST MORTEM

Primary :G93.6 Cerebral oedema

Subsid. :A08.4 Viral intestinal infection, unspecified

Diag G93.6 Cerebral oedema

Belfast Health and Social Care Trust

Clinical Coding Policy

Last updated on 22nd June 2011

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1.0 Introduction

As each year goes by the demands for information at a casemix level are steadily increasing. Essentially, the bulk of diagnostic and procedural information is provided through the clinical coding function. Demands and uses of coding include epidemiology, service planning, research and commissioning to name but a few. New demands relating to patient safety and HRG based commissioning have further stressed the vital nature of clinical coding. In this environment it is vital that clinical coding is of only the best quality if analysis and comparisons are to be meaningful.

Coding Uses

- | | |
|-----------------------------|---|
| <i>Epidemiology</i> | - Incidence and cause of disease nationally and internationally e.g. NI cancer statistics, asthma rates. |
| <i>Commissioning</i> | - Coding soon to become basis of commissioning at a casemix level using HRGs. Also informs boards of the levels and type of activity in hospital. |
| <i>Modernisation</i> | -Service improvement initiatives e.g.changing treatment processes and re-organising services. |
| <i>Planning</i> | - Provides casemix information for planning new services in hospital and at lower directorates levels. |
| <i>Patient Safety</i> | -Risk Adjusted mortality and mortality & complication rates for specific diseases & procedures are facilitated through coding e.g. MI & NoF mortality, adverse drug reactions, complications of surgery and mortality & readmissions etc. |
| <i>Comparative Analysis</i> | - Comparative analysis of quantitative and qualitative issues e.g. daycase ratios and LoS etc for certain conditions and procedures. Qualitative issues as in clinical governance. |

The Belfast health and social care Trust has four main sites and produces a total of over 225,000 FCEs per year plus a further 20,000 outpatients with procedure requiring coding. The Trust is a University Teaching organisation and provides the vast majority of regional services for Northern Ireland.

BHSCT FCEs 2010/11

	FY2010/2011 1			FY2010/2011 Total
Hospital Description	Inpatient	Day Case	Reg Attenders	
Belfast City/Cancer Centre	33537	29469	33036	96042
Royal Group	52777	28686		81463
Greenpark	8400	12818		21218
Mater Hospital	18523	8504		27029
Grand Total	113237	79477	33036	225750

Purpose

Clinical coding staff in the Belfast Health and Social Care Trust will ensure that all necessary patient diagnostic and procedural information is captured and translated into ICD10 and OPCS 4 classifications and entered onto the Trust Patient Administration System in an accurate, timely and comprehensive manner. This applies to all In-patient, Daycase and selected Outpatients with procedures.

Clinical coding in BHSCT will be carried out with stringent adherence to national coding rules and guidance issued by the DHSS Information Authority and its designated regional bodies.

2.0 Structures

Clinical coding takes place on all four hospital sites and is managed centrally within the Trust. The coding department sits under Information Services which is in turn under the directorate of Performance and Service Delivery. Coding is largely carried out on a site basis, however cross site working is constantly increasing and is the ideal. Recruitment and resource allocation are based around this principle as far as possible.

Management Team

The team comprises a Senior manager with responsibility for clinical coding (Performance Improvement & Information Manager), Clinical Coding Manager who manages the operational service, Team Leader and an Auditor and Trainer to assist the manager. The two senior managers are responsible for the deliberation and setting of strategy and policy.

Manager: responsible for processes which capture and develop all diagnostic and procedural information for the Trust PAS system ensuring all aspects of quality are robust and coders are adequately trained supported and audited. The manager is also responsible for liaison with clinicians and directorate management for issues related to accuracy and timeliness of data capture.

Team Leader: assists in all data capture processes and coder management, and operational management of coding staff.

Auditor/Trainer: to perform audit throughout the trust under the direction of the manager and to provide training for new coders and workshops as a result of clinical coding audits. Duties also involve answering queries with the coding manager.

Coding Staff

There are a total of 17.4 WTE coding staff in the Trust. Coders are expected to code in all areas requested and to apply all national and local technical instruction stringently and consistently. Liaise regularly with clinicians to clarify and validate clinical information and coding issues and liaise with administrative staff to ensure chart flow and other administrative processes function effectively.

At this time all coding staff are Band 4 under Agenda for Change terms, however regular assessment of the potential to recruit at different bands or for assistant posts will be on the recruitment agenda.

Coding staff practice a mixture of specialty specific coding and mixed specialty coding but are trained to code in all specialties. There are certain specialties which exist only on some sites.

Belfast City Hospital-All coders code in all specialties on a rotational basis

Mater Hospital- All coders code in all specialties on a rotational basis

Greenpark- All coders code in all specialties on a rotational basis

RGH-Coding is carried out on a largely specialty specific basis with coders having responsibility for specific specialties. However coders are trained in all specialties and in recent periods rotation has increased.

3.0 Coding Methodology and Source Documentation

Coding strategy and policy will be directed by the senior team in line with national guidance and in response to the current demands and needs of the Trust.

All in-patient, daycase and regular attenders are coded while only outpatients with procedures are coded on PAS. The majority of In-patient episodes will be coded using casenotes with access to electronic systems to enhance or validate coded records. However the Trust must constantly work towards a process of total casenote coding rather than proforma coding.

Diagnostic and procedural information for in-patients is captured mainly through the examination of patients casenotes, diagnoses and procedures are then translated into ICD10 and OPCS4 codes which are entered onto the Trust PAS system. Proformas and/or discharge notes and letters are used in some specialties as the source documentation.

When electronic sources are at an optimum level these can incrementally replace chart coding.

3.1 Coding Process for Casenote Coding

Coders visit wards on a daily basis where casenotes for discharged patients are left in designated areas. Coders are instructed to take a copy of the completed discharge proforma from the chart and to add to it any relevant clinical information i.e diagnoses, procedures etc. which are gathered from close examination of the full casenote. The coder then returns to their workstation to code this information and enter it onto PAS. At this stage all additional electronic information sources are used where relevant to add additional specificity etc. Greenpark is the only exception to this rule whereby charts are sent on a daily basis to the coding office, this process will change to the ward visit approach when resources allow this.

A discharge list or daily bed state for the relevant day will be examined in order to ensure a chart is present for all discharges and transfers. Ward clerks should be contacted in the event of missing casenotes and the destination of the casenotes noted for tracking. Coders should not remove the casenotes from the ward at any time. In the event that a chart is not available a proforma should be left for coding staff.

Recording of diagnoses and procedures can only be made if they are clearly written in the documentation by a Doctor. Phone calls to ward staff are not to be used as a source for diagnostic or procedural information. Nursing and PAMs notation will only be used to clarify information and not as the primary source of diagnoses and procedures.

Errors or non-specific notation on a proforma within a chart can also be amended using definitive medical documentation. Any uncertainty or ambiguity must be addressed by the coder and medical staff. Uncoded episode reports must be run on a weekly basis by each coder or supervisor/manager.

Liaison with ward clerks/ secretaries to ensure the availability of documentation is an integral part of a coders duties. Good working relationships should be fostered with all directorate administrative and clerical staff. Problems with documentation and process such as chart flow should be addressed at the time with relevant parties. Persisting problems should be notified to the coding manager.

List of Standard Acceptable Chart Documentation for Coding

Proforma	Clinical Notes
Operative Notes	Nursing Notes
Care Pathways	Discharge Letters
Pathology Results	Histology Results
GP Letters	Radiology Results

The above list is indicative and subject to change.

3.2 Coding Process for Proforma Coding

Coders retrieve proformas from designated areas or are sent copies of discharge proformas on a daily basis for the previous days discharges. The full content of the proforma must be used. This entails scrutinising the 'comments' section as well as diagnosis and procedure sections. In some areas validation will take place using documentation from other sources

Proformas

In-patient and daycase proformas (Hard copy or electronic) are typically comprised of blank diagnostic and procedural boxes. It has been possible to introduce some 'tick box' type proformas which with intelligent design can provide useful prompts to clinicians. This is the preferred future direction for proformas and hopefully can be automated via the discharge letter system or improved hard copy proformas.

Tick box type proformas are generally discouraged for in-patients and daycases as they lead to the supply of non-specific diagnostic and procedural information lacking in comprehensiveness. However in some areas this is acceptable i.e. Outpatients and some daycases.

Recording of diagnoses and procedures can only be made if they are clearly written in the documentation by a Doctor. Phone calls to ward staff are not to be used as a source for diagnostic or procedural information. Nursing and PAMs notation will only be used to clarify information and not as the primary source of diagnoses and procedures.

3.3 Electronic systems

Coding staff have access to radiology, pathology, Theatre, Mgt System and Patient centre(some areas only). Coders also have access to bespoke clinical systems such as DPU & Cardiology or A&E systems. Coders are not permitted to use these systems as the sole source of clinical information without specific request to the coding manager and this should be in minimal circumstances. These systems are used mainly to clarify and complement information from charts.

Liaison with ward clerks/ secretaries to ensure the availability of documentation is an integral part of a coders duties. Good working relationships should be fostered with all directorate administrative and clerical staff. Problems with documentation and process such as chart/proforma flow should be addressed at the time with relevant parties. Persisting problems should be notified to the coding manager.

3.4 Data Entry by Non-Coders

Clinical coding is a complex task requiring skill and experience however there are some instances where non-coding staff can carry out data entry type duties. This will only occur where the coding management team has designed proformas which adhere to all coding guidance. These basically require a doctor to tick a box which identifies a diagnosis or

procedure which is then only cross referenced with a pre-defined code. In essence this is data entry and not to be confused with clinical coding

4.0 Queries

All queries regarding clinical issues should be addressed to the ward medical staff or consultants for initial clarification and further information. Where this is not possible the manager or trainer/auditor are contacted, especially when the query involves a coding issues as much as a clinical issue.

All queries involving technical coding issues should be addressed to the coding manager and auditor/trainer.

Medical staff are not required to resolve coding issues as such, queries addressed to them will usually involve clinical not coding issues. It is intended that all medical input into the coding process will involve clarifying and improving the quality of diagnostic and procedural information in partnership with coding staff.

Communication between coders and clinicians is stressed and encouraged in order to resolve queries and to instill confidence in the coding process.

Areas of concern regarding documentation etc. at ward level should be addressed to the manager immediately for instance if patterns of uncompleted proformas are noticed.

5.0 Validation

Procedures and diagnoses in some specialties are also coded onto separate systems e.g. Theatre Management System and Thoracic Surgery, these will include data items that PAS does not record. Such systems can be used with instruction from the coding manager to further validate casenote information.

In surgical areas procedures recorded on TMS can be cross referenced with PAS coding. Consultant validation of clinical coding is a main objective of trust coding policy and various methods of facilitating this will be pursued. Currently a system is in place on one site(BCH)which allows consultants in some specialties to validate every coded episode via the discharge letter system. Errors are addressed via the coding staff on site or are defined as correct electronically.

5.1 Local Coding Policy

All coding practice which has been agreed at a local level in those instances where specific conditions or procedures are coded in a manner that does not necessarily follow exact coding guidance will be agreed, dated and signed by clinical staff. These practices will be circulated to all staff and must be adhered to unless other arrangements have been made as they add accuracy to the coded record. The coding

manager and trainer/auditor will manage this process and records will be kept centrally by the coding manager.

6.0 Clinical Coding Process- High Level Requirements

- Coders will code all primary and secondary diagnoses. The primary diagnosis is the *main condition treated or investigated during a patients episode*. This should be coded to the *most specific* code available.
- Secondary Diagnosis: other conditions arising or treated within the episode, or any other conditions that the patient has that may or may not affect the management of the patient. All relevant external cause codes and health status codes should be included as should all aetiology and manifestation codes(dagger and asterisk)
- All operative procedures must be coded as specifically as possible with dates. Procedures may involve treatment for the prevention, diagnosis, care or relief of disease, correction of deformity or treatment associated with pregnancy and childbirth.
- Primary procedure: The main procedure for which the patient was admitted or was carried out during the episode.
- Secondary Procedure: procedures carried out simultaneously with the primary or that arise in the same episode.
- All necessary approach, site and laterality codes must be included.
- Sequencing of procedures must never be based on price lists or any other criteria than that of Clinical Coding Guidance.
- The four step Coding Process must be followed at all times:
Analyse the medical terminology
Locate the term in the Alpha Index
Assign a tentative code
Verify/amend the code by checking the tabular list
- Coders must make use of all the source documentation at their disposal in a patients casenotes and elsewhere to ensure an accurate and comprehensive record of a patients episode is captured. These will include proformas, clinical notes, procedure notes,radiology and pathology systems etc. care pathway and nursing notes. Where possible other databases/sources can be used for validation with approval/direction from coding manager.(see appendix)

- Coders should have 95% of discharged episodes coded within 3 working days to facilitate timely analysis and information uses. Monthly performance measures on this issue will be observed and reported to directorates and management..
- It is each coders personal responsibility to code all finished consultant episodes within the three day target. Coders must run at least weekly coding reminder lists to assess and plan their workload. Likely pressures which could impinge upon timeliness must be reported immediately to the manager and central team
- Coders will rigorously pursue any documentation or medical personnel which could be of assistance in coding a patients episode. This will at times include contacting other hospitals usually within Northern Ireland. Coders will never in any case be permitted to contact patients or their relatives within or outside the hospital at any time.

7.0 Clinical Coding Staff

- All clinical coding staff involved in the translation of medical terminology into alphanumeric format and entry to PAS will be designated as AFC Band 4.
- Only coders with Clinical Coding Certificates are permitted to code within the trust. Exceptions will be made for those who must wait for an approved regional training course, however interim training will be provided within the Trust in these cases to allow limited coding.
- Coding staff should be recruited for the purpose of clinical coding and not to perform other duties which may impinge on this. The only exception to this is where a post is recruited on the basis of part time coding with other duties which should be allocated with specific timeframes.
- All coders must attend any internal or external training courses and workshops deemed necessary for the completion of their duties. Coders will also be encouraged to pursue National Accreditation. Literature and circulars commensurate with duties must be studied and filed appropriately. Meetings with the coding manager must also be attended.
- Coders will give appropriate notice of any leave intentions and this will be approved by the coding manager on the basis of the needs of the service. Cover will be provided on the basis of priority.
- Coders will rotate between sites/directorates for the purpose of gaining wider experience and alleviating pressures elsewhere in the trust.

- Coders are expected to interact with all levels of staff on a regular basis, especially clinicians in order to resolve queries or to gain a better understanding of clinical issues.

8.0 The Clinicians Role

Clinicians are not expected to code. Clinician input is required in the provision of legible, accurate and comprehensive source documentation. Particular emphasis must be placed on the provision of co-morbid disease information. All conditions likely to affect a patients stay in hospital their mangement or resource usage should be included in proformas and clinical notes.

When a firm diagnosis cannot be made all presenting signs and symptoms should be included on documentation. The main areas of concern when completing the proforma are listed below although in summary and example form.

Primary Diagnosis	Secondary Diagnoses	Co-morbid conditions
Social issues	Complications of treatment	Health Risks
Causes of Injury	Procedures with dates	(presentation list)

Clinicians will preferably validate all episodes or a sample of these in a timely manner. They should also make themselves available for contact with coding staff and to set pre-determined times aside to discuss difficult cases with the coding manager.

Senior clinicians/Clinical leads and Directors will assist in the framing of local policies and sign these off as agreed for the specialty/area concerned. They should also act as champions for the coding function and help raise awareness of coding practice.

Senior clinicians will also attend coding meetings on a regular basis to discuss the clinical and coding issues related to specific topics. This provides a workshop type environment to enhance coders knowledge, to resolve queries and to increase enagement with clinicians.

Senior clinicians will receive coding performance reports and coding audit reports.

9.0 Performance

Performance management and quality assurance will be an embedded process within clinical coding management and the wider trust performance Management structures.

Performance can be measured in three main areas of clinical coding, a) accuracy and consistency of codes, b)timeliness of coding and c) depth and comprehensiveness of diagnostic information.

Measurement of performance in these areas will be regular and contain time series analysis together with peer comparative figures.

9.1 Accuracy

Accuracy is assured by regular audit carried out by the coding manager and senior coding Officer. These are comprised of:

Full Audit: retrieval of a representative sample of casenotes and re-coding. This will examine extraction of information from casenotes and technical competency, they are also scored.

Proforma/Technical: This will examine extraction to the extent of what is included in the proforma and technical competency.

Monthly Random: Technical Only. Random sample looked at for each coder on screen(extract from Business Objects)

Coding Indicator: Business Object queries that are designed to examine some of the basic rules of coding and other areas of interest to the hospitals. Relies on full audit to pin-point areas for further investigation..

Ad-Hoc: These are usually precipitated by a problem arising e.g running a report, clinician or contract query.

Training Audit: This will involve a shadowing exercise where a coder will be accompanied by the auditor for a period of days and audit will be performed as charts are coded and errors explained in a live setting.

System Cross Reference: Comparison between systems on a specific area.

Comparative Reports: All specialties have a series of coding performance indicators provided against peer specialties. Indicators include:uncoded episodes, depth of coding and non-specific coding etc.

All of the above signal areas of error and a focus for re-training through workshops with the coding manager and auditor/trainer.. Coders must attend workshops as and when notified. The aim of workshops is to provide a positive, constructive process of improvement in which coding staff will feel comfortable and valued. Directorate managers and clinical directors are provided with a summary of full audits. HRG, patient safety and comparative analysis implications are highlighted.

9.2 Timeliness

Timeliness is monitored on an at least weekly basis and areas of under performance investigated promptly.. Liaison with team leaders is crucial in resolving problem areas. An uncoded report is circulated to each Directorate and Clinician manager at the end of each month with their specialty performance against other directorates over time in addition to performance against United kingdom hospitals at a specialty level through the coding performance report.

Problems with processes related to timeliness will be addressed by the coding manager within the team and also in liaison with directorate staff where appropriate.

Timeliness is maintained and improved through efficient workload planning from both coders and coding management. The provision of cover for absenteeism provided by the central team is also a vital part of performance.

9.3 Depth

A depth report is circulated to each Directorate and Clinician manager at the end of each month with their specialty performance against other directorates over time in addition to performance against United Kingdom hospitals at a specialty level through the coding performance report.

Depth is maintained and improved through the continued use of casenotes as a source document, clinical coder re-training and audit and the raised awareness of coding issues with clinicians through presentations and other communications.

10.0 Recruitment

Recruitment for vacancies will take place in line with all Trust recruitment policies and procedures and additional interview methods (e.g. test) may be used at the discretion of the panel due to the unique nature of coding posts. At this time all coding staff are Band 4 under Agenda for Change terms, however regular assessment of the potential to recruit at different bands or for assistant posts will be on the recruitment agenda.

11.0 Training

All coders must attain the regional clinical coding certificate in ICD10 and OPCS4 as soon as possible after recruitment. Depending on availability of courses which are supplied by HSC Board this should be completed within six months. Training will cover all specialties, diagnoses and procedures.

This will be preceded/co-exist with in-house training from the Trainer/Auditor and coding manager. The coding trainer will then provide an in-depth one to one course for approximately 6 to 10 weeks based on duties. The coder will commence coding when this is deemed possible and regular checks on almost all of a new coders work will be carried out for a further 8 weeks with a gradual decrease. Completion of a computer based training package may also be required.

Internal training thereafter involves workshops where coders discuss and learn from audits carried out in their area with the manager and trainer, picking up on errors etc in a

very constructive and positive training environment. Ad-hoc communications and coding updates and circulars follow on from this.

Coding Clinic and Circulars from national coding bodies and from the coding manager which provide updates on technical coding issues will be received, filed and adhered to.

Interviews are held with each coder twice yearly under the Staff Development and Review Scheme which applies to all Trust personnel. This allows objective setting and performance appraisal to be discussed with coders and the coding manager. It also allows identification of training needs where necessary.

Regionally supplied training courses are mandatory for all coding staff and these will include refresher courses and courses for new revisions of OPCS/ICD.

12.0 Awareness

Awareness of the clinical coding function throughout the Trust is carried out through a series of induction meetings for Consultant staff and the provision of electronic induction packs for junior doctors. Awareness is increased through the provision of additional programmes for service groups and clinical groups:

- Clinical Indicator programmes
- Mortality programmes
- Commissioning Programmes
- HRG Awareness sessions

The coding manager will ensure links with medical staff are maintained and that medical staff contribute to any major coding issues. Clinical Directors will receive copies of coding performance reports.

Clinical coders are also responsible for raising the awareness of clinical coding in their day to day tasks and must open avenues of contact with ward clinicians for resolving queries etc.

13.0 Feedback to Coders.

All coders should have a close working relationship with the management team. Apart from day to day technical issues and audits coding meetings will be held once per month or more if a situation necessitates this. Coders will also be presented with coding performance reports as they are published during coding meetings.

These reports will give performance across depth, accuracy and timeliness at a Trust, site and specialty level.

Samples of reports which demonstrate the use and vital nature of clinical coding will be included for each coders own area.

Coders will also receive all national and regional newsletters and be kept up to date with any developments.

14.0 Reporting to Directorates

Directorates and Clinical directors will receive monthly copies of the coding performance report which will provide performance information across issues of depth, accuracy and timeliness with time series and peer components. Issues arising which require liaison will be brought to the attention of the coding management team on an ad-hoc basis or through Information liaison meetings.

Coding audits will also be circulated where relevant on a specialty basis etc. and actions identified for consideration by Directorates.

15.0 Disciplinary Issues and Complaints.

These issues will be dealt with by the coding manager where necessary according to trust guidelines. Less formal complaints and problems relating to working relationships between coders and other staff will be dealt with by the coding manager and team leader..

16.0 Disposal of Proformas

Discharge proformas (coders copy) taken from charts should be stored securely in a lockable location as in accordance with patient confidentiality. These should be retained for a minimum of six months depending on each directorates own needs. This will facilitate clinical coding audit and contract query resolution. Proformas for disposal will be placed in confidential waste bags for collection by the waste contractor.

17.0 Patient Confidentiality

Clinical coding staff will adhere rigorously to patient confidentiality guidelines set in place in the trust. This will involve securing patient documentation, non-disclosure of any details relating to any patient to anyone other than to resolve a coding issue and then only with authorised hospital staff i.e. coding staff and clinicians. This applies to all situations within and outside the trust.

Passwords for the trust PAS system will not be disclosed to anyone except the relevant PAS staff, this applies to disclosure to other coders also. Patient confidentiality is perhaps a more salient issue with clinical coding staff than other administrative positions due to the specific clinical information involved, thus adherence to guidelines should be utmost in the coders mind.

18.0 Classification Management and Version Control

The management team will ensure all new releases of ICD 10 and OPCS are introduced and adhered to within the Trust. This will involve liaison with the DHSSPSNI/PMSID externally and with the Medical Records/Systems manager within the Trust. Advance testing of new codes will be carried out in a timely manner in order to validate changes and detect potential errors. Clinical coders will receive all relevant training before release of new classifications in order to code effectively on live dates.

19.0 Ongoing Objectives

- Increase trust level as opposed to site level coding with staff rotating between and across sites more frequently to allow increased continuity when staffing issues etc. arise.
- Consultant Validation which will allow each individual episode to benefit from consultant validation of diagnostic and procedural information.
- Automation of source documents which will allow much more timely and detailed access to a patients diagnostic and procedural information in order to improve quality.
- Ascertain any new technologies to enhance the coding process e.g. encoders, HRG optimisation software.
- Encourage coders to achieve the National Accreditation.
- Pro-actively pursue and share best practice in collaboration with other trusts and NHS bodies
- SOPs for specific procedure/ diagnoses coding
- SOPs for specific processes such as query resolution.
- Proforma development with prompts to elucidate best information available.

Appendices

Appendix 1.Specialty Profile

Appendix 2.Source Documents

Appendix 3. Performance Report