Clinical Coding Policy

During the COVID19 crisis, please read the policies in conjunction with any updates provided by National Guidance, which we are actively seeking to incorporate into policies through the Clinical Ethics Assurance Group.

Document Author	Authorised
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Lead Director: Director of Finance, Estates and IM&T	
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DOCUMENT HISTORY

(Procedural document version numbering convention will follow the following format. Whole numbers for approved versions, e.g. 1.0, 2.0, 3.0 etc. With decimals being used to represent the current working draft version, e.g. 1.1, 1.2, 1.3, 1.4 etc. For example, when writing a procedural document for the first time – the initial draft will be version 0.1)

Date of Issue	Version No.	Date Approved	Director Responsible for Change	Nature of Change	Ratification / Approval
29 March 2012	1.1	29 March 2012	Director of Finance	Reviewed logo and wording updated for new organisation	Approved
16 April 2014	1.2	16 April 2014	Director of Finance	Ratified at	Risk Management Committee
23 April 2014	2.0	23 April 2014	Director of Finance	Approved at	Policy Management Group
February 2017	2.1		Executive Director of Financial and Human Resources	Policy reviewed	
14 March 2017	3.0	14 March 2017	Executive Director of Financial and Human Resources	To be approved	Corporate Governance & Risk Sub-Committee
Feb 2020	3.1		Director of Finance, Estates and IM&T	Scheduled review of policy	
5th March 2020	3.1		Director of Finance, Estates and IM&T	Endorsed at	Information Steering Group
23 April 2020	4.0	23 April 2020	Director of Finance, Estates and IM&T	Approved via Chairs Action at	Policy Management Sub-Committee

NB This policy relates to the Isle of Wight NHS Trust hereafter referred to as the Trust

Contents

1 Executive Summary

The Trust is committed to ensuring adequate accurate and timely capture of its inpatient and outpatient activity using ICD-10 and OPCS 4 classifications.

This policy defines the expectations of the organisation for the coding of clinical activity for performance and capacity purposes and meets the payment by results initiative currently in practice.

2 Introduction

2.1 Clinical Coding is "The Translation of medical terminology, as written by the clinician, to describe a patient's complaint, problem, diagnosis, treatment or reason for seeking medical attention, into codes that can be easily tabulated, aggregated and sorted for statistical analysis in an efficient and meaningful manner" (NHS Classifications Service, National Clinical Coding Standards ICD-10 5th Edition).

2.2 There is wide recognition in the NHS of the importance of good quality coded clinical data and the fundamental role it plays in the management of hospitals. The Modernisation of the NHS to provide a seamless service for patients and a first class NHS requires that the information to be exchanged between healthcare professionals is of a consistent high quality. Accurately coded clinical data is pivotal to the success of this and has a major impact on planning and commissioning of appropriate and affordable services in the best possible setting; and optimisation of treatment effectiveness and quality care. Increasing emphasis on performance and resource management through the Payment by Results reform of NHS financial flows puts pressure on organisations to ensure they are judged on accurate data.

3 Definitions

ICD-10 – International statistical classification of diseases and related health problems used for diagnostic coding.
OPCS 4 – Classification of Interventions and Procedures used for procedural coding.
SUS PbR – Secondary User Service Payment by Results
HSCIC – Health and Social Care Information Centre
CDS – Commissioning Data Set
ACC – Accredited Clinical Coder
NHSIA – National Health Service Information Authority

4 Scope

4.1 This policy provides a framework within which the NHS IOW must adhere to, it outlines the responsibilities of clinical and administrative staff and the timescales in which coding should be completed.

4.2 This policy is for use by all Trust staff involved in the coding of patient activities and should be read in conjunction with the Records Management policy, Data Quality Policy and Information Governance policy Inc. The Management of Information Risks.

5 Purpose

5.1 The Trust will use all appropriate and necessary means to provide accurate, complete, timely coded clinical information to support commissioning, local information requirements and the information required for Commissioning Data Set (CDS) and Central Returns.

5.2 To adhere to national standards and classification rules and conventions as set out in the WHO ICD-10 Volumes 1-3, National Clinical Coding Standards, ICD-10 and OPCS-4 and publications of the *Coding Clinic* and such local variations as agreed.

5.3 To input to the Patient Administration System (PAS) accurate and complete coded information within designated time scales to support the information, commissioning and service requirements of the Trust.

5.4 To ensure all staff involved in the clinical coding process receive regular training to develop and maintain their clinical coding skills, regardless of experience and length of service.

5.5 To ensure continual improvement of clinical coded information within the Trust through systematic audit and quality assurance processes.

5.6 To ensure all staff are aware of the Trusts security and confidentiality policies when using patient identifiable information.

5.7 To follow Information Governance Policy Inc. The Management of Information Risks guidance at all times (see the Information Security Management Policy for further information).

6 Roles and Responsibilities

6.1 Organisational Responsibilities

This policy applies to all staff (whether permanent, temporary or contracted). Non-executive directors and contractors are responsible for ensuring that they are aware of the requirements Incumbent upon them and for ensuring that they comply with these on a day-to-day basis. Managers at all levels are responsible for ensuring that the staff for whom they are responsible are aware of and adhere to this policy.

6.2 Executive Responsibility

The Chief Executive is responsible for the statutory duty of quality clinically coded data and the financial and statistical elements that are produced from this data and takes overall responsibility of this policy.

6.3 Directors and Managerial Responsibility

The Assistant Director of PIDS (Performance Information and Decision Support) is responsible for co-ordinating Clinical Coding protocols and communication within the Trust. This includes ensuring that the Trust processes Clinical Coding in a legal, secure and effective manner.

The Clinical Coding Manager is responsible for co-ordinating all aspects of Clinical Coding within the Trust. This involves over-seeing day-to-day Clinical Coding issues, raising awareness of Clinical Coding and developing and maintaining polices procedures and guidance.

The Clinical Directorates are responsible for ensuring that staff within their area supports the need for accurate, timely and complete clinical information. They should ensure that the policy and its supporting standards and guidelines are built into local processes. They are also responsible for ensuring that staff are updated in regard to any changes in this policy

6.4 **Consultants SpR's/Staff Grades**

Consultants, Specialist Grades (SpR's)/Staff Grades and other junior doctor grades will be specific when recording patients' diagnoses, procedures and Interventions. All relevant information pertaining to the care including co-morbidity information pertaining to the patient must be recorded.

Consultants are responsible for the quality of the clinical information gathered by the doctors for whom they clinically supervise, on the patients for who the Consultants have clinical responsibility.

They will adhere to the Royal College of Physicians (RCP) generic record keeping standards

6.5 All staff who handles casenotes must be aware of the strict deadlines that the Clinical Coding department must adhere to and support the department in the need for timely availability of the clinical case note. The department will be flexible in attending wards and prioritising workload to ensure that the needs of the Trust as a whole are considered.

7 Policy detail/Course of Action

7.1. The Clinical Coding department uses ICD-10 and OPCS-4.

7.2 **Source Documents**

7.2.1 The Trust currently codes approximately 90% of episodes from the full clinical casenotes and 10% from the discharge summary completed in E-Care Logic. Currently paediatrics, mental health and ambulatory care are coded from discharge summary as it was felt that there would be little or no benefit to coding from casenotes for these specialities.

7.2.2 Discharge Summary

The primary and secondary diagnoses, procedures/interventions as well as relevant co-morbid conditions should be duly recorded on the summary by the clinical staff, on or prior to, the patient's discharge from hospital. In the absence of a discharge summary the Clinical Coder will assign a primary diagnosis/procedure based on the information found in the casenotes. A record of each patient without a discharge summary will be recorded in E-Care Logic.

7.2.3 Access to supporting information is necessary to ensure accurate code assignment and enhance the source information. I.e. Symphony, Sectra, pathology and radiology results are also accessed via the E-Care Logic portal. Reports from various sources such as the PAS system and Xcelera System are also provided from the PIDS department to further aid complete episodic coding.

7.2.4 Clinical Casenotes

The clinical casenotes either in a physical or electronic format will contain a complete record of the patient's care and will include all information held that is relevant to that patient, e.g. discharge summaries, clinical notes, test results, operation sheets and related clinical correspondence

On the rare occasion that a complete Clinical record cannot be found it may be necessary for the Clinical Coding team to assign codes based on available electronic information pertaining to the patients' admission i.e. A&E records, pathology reports. This practice is only to be undertaken when all efforts to locate the complete Clinical record have been exhausted and with approval from the Clinical Coding Manager. An electronic record will be maintained within the SimpleCode Encoder record to indicate this process has taken place which will be available for any future Clinical Coding Audit. A Datix incident form will be completed by the Clinical Coding Clerical Officer to investigate the lost record. This will then be followed up by the Clinical Coding Manager to assess for any potential loss of income and that procedures are in place to prevent reoccurrences.

7.3 Current Clinical Coding Practices

7.3.1 Clinical Coding is administered centrally as a discrete section of the Finance Directorate.

7.3.2 Clinical Coding staff are trained to code all clinical specialties provided by the Trust.

7.3.3 Information regarding the patient's diagnosis and treatment is extracted from the patient's health record (casenotes) by Clinical Coding staff.

7.3.4 Information is then translated into the appropriate coded classification format and entered onto the PAS within agreed timescales that support the service and business needs of the Trust.

7.4 Coding From the Clinical Casenotes

7.4.1 Casenotes will be automatically sent to Clinical Coding following discharge. The Clinical Coding Clerical Officer will chase any outstanding casenotes.

7.5 Manual handling of casenotes

7.5.1 Due to the high volume of casenotes within the Clinical Coding department each member of staff must attend a manual handling course and complete online training.

7.6 Clinical Casenotes in the department

7.6.1 Casenotes held overnight within the department are booked on Patient Centre in specific locations within the Clinical Coding office; these locations are known to the Health Records on call team.

7.7 **Pathology Results**

7.7.1 If a patient has any treatment/procedure where a histological study has been carried out, it is the Trusts Policy to wait for the report to be completed before coding can commence, these reports can be viewed via the E-Care Logic system enabling improved accurate code assignment.

7.8 **Radiology Results**

7.8.1 If the Clinical Coder is made aware through details on the discharge summary or Clinical Casenote that the patient has attended the radiology department within the relevant episode of care then the coder will access the reports via E-Care Logic to view and obtain additional information from the reports of such attendances.

7.9 Inputting Clinical Codes into PAS (SimpleCode)

7.9.1 The use by any member of staff of the PAS data facility is strictly governed by set hospital policies and therefore training is only ever instigated and provided by members of staff from the Information System support section. Each coder must use Patient Centre to locate each patient and all Outpatient Coding done in the Coding team and around the Trust is done using the coding input function within Patient Centre.

7.9.2 SimpleCode is the chosen coding programme for the Trust. It is launched from Patient Centre and offers a precise and adaptable way of coding for the team. This is a specific programme that is only used by the Coding team for inpatient episodes. Once the codes are input by the coder it flows back through to Patient Centre in order to be in the correct format to be submitted to SUS.

7.9.3 Woodwards Associates are responsible for training/queries/issues relating directly to Simplecode.

7.10 Local Coding Variations

7.10.1 Any variations to the way clinical coding is applied locally will be agreed and clearly documented separately in the clinical Coding Local Policy Document. All such variations, agreed between the clinical coding department and individual clinicians will be formally documented. In all such situations changes to the application of the clinical code MUST NOT contravene national standards or classification coding rules and conventions.

7.11 Changes in National Coding Practices

7.11.1 The Clinical Coding Manager will ensure that all details of any such changes in national coding practices are conveyed to all coding staff and users of the information. National Coding Practice changes are usually notified via Coding Clinics, Data Quality Review (DQR), (Information Standards Board – ISB - ISN) or Data Set Change Notices (DSCN)

7.12 Requests for Data Analysis, specifically Coding Pulling Lists

7.12.1 All requests for data analysis are to be made in writing to the Clinical Coding Manager. They will decide what resource is needed, resolve any technical queries that arise from the request and identify the most appropriate person to respond to the request.

7.13 Departmental Clinical Coding Timescales

7.13.1 The deadline for achieving 100% coding completion is defined by the SUS PbR submission timetable.

7.13.2 PIDS team provides the Clinical Coding team with a list of the outstanding un-coded episodes which is updated daily. This is primarily used by the Clinical Coding Clerical Officer to focus on the casenotes needed to achieve deadline.

7.13.3 The Information Systems team are responsible for CDS submissions.

7.13.4 If the deadlines are threatened this will be reported as soon as possible to the Deputy Director of Information.

7.14 Departmental structure

7.14.1 The Trust has a centralised Clinical Coding Function that is part of the Finance structure.

7.14.2 There are currently five Accredited Clinical Coders in the Trust including a Clinical Coding Manager. Two Trainee Clinical coders are also in their first year of training. On average it takes two years of training and development to attain a 'competent' level; therefore Clinical Coders should be regarded as a valued resource/asset to the Trust.

7.15 Communications in Clinical Coding

7.15.1 This section includes details of arrangements in place for the receipt and dissemination of relevant documentation relating to clinical coding across the department to endorse consistency and accuracy of coded information.

7.16 The Coding Query Mechanism

Internal Query

7.16.1 The Trust will in the first instance in an attempt to resolve a query, refer to all current clinical coding material such as the National Clinical Coding Standards, ICD-10 and OPCS-4, Coding Clinic Collection and HSCIC clinical coding guidelines.

7.16.2 Queries are discussed amongst the team and with the Clinical Coding Manager to determine whether the query can be resolved internally.

7.16.3 Clinical Coders will liaise with the appropriate clinician on applicable ICD-10 and OPCS-4 codes. At all times; ensuring that the advice given does not contravene the rules and conventions of the classifications or national standards.

7.16.4 If the query cannot be resolved internally then it has to follow the external query route detailed below.

External query

7.16.5 Where the query cannot be resolved internally the Coder will need to search the Query Resolution Database on Delen to see if a previously recorded query can help with the assignment of the appropriate code.

7.16.6 If there is no previous resolution recorded the coder must seek out further research by consulting the NICE Interventional Procedure Guidance (IPG) if it relates to OPCS or the ICD-11 Coding Tool and Browser if it relates to ICD-10 and Coders are encouraged to use the internet to learn more about the diagnosis/procedure.

7.16.7 The NHS Digital SNOMED CT Browser must be consulted to check for Classifications maps to ICD-10/OPCS-4 if a condition is not available in the Alphabetical Index.

7.16.8 If this does not bring about a satisfactory code assignment then an anonymised account of the diagnosis/procedure should be sent to the Query Database on Delen, providing this is within the scope of the Clinical Classifications Product Support Helpdesk

7.16.9 If the query is outside of the scope of the Support Helpdesk, involvement from the Coding Manager and Clinicians within the Trust should be sought to assign the most appropriate code. It is recommended that discussions should take place with neighbouring Trusts and nationwide via the Clinical Coding Manager's Workspace on Delen to ensure coding consistency and ongoing development.

Internal Meetings

7.16.10 Internal meetings between the Clinical Coding Manager and the Deputy Director of Information occur weekly where possible but at least once a month.

7.16.11 Clinical Coding Office meetings take place once a month. Coders are encouraged to add agenda items onto a central electronic agenda regarding any issue they intend to raise and this enables the Coding Manager to ensure suitable time is set aside to discuss.

7.17 Amendments to the Clinical Coding Instruction Manual ICD-10 and OPCS-4

7.17.1 All Clinical Coders will receive a copy of the amendments to the Clinical Coding Standards, ICD-10 and OPCS-4.

7.17.2 All Clinical Coders sign to acknowledge that they are in possession or acknowledge receipt of amendments to the Clinical Coding Standards ICD-10 and OPCS-4.

7.17.3 All Clinical Coders are provided with sufficient time to update their reference standards in line with implementation dates as described by HSCIC. The Clinical Coding Manager will determine the time frame allowed in accordance with the changes made.

7.17.4 The amendments and implications of the amendments are discussed fully by all of the Clinical Coders.

7.18 Coding Clinics

7.18.1 All Clinical Coders will acknowledge with a signature receipt of the Coding Clinics held as an electronic file on the shared drive.

7.18.2 Coding Clinic changes have an agreed implementation date as set by either the HSCIC or internally by the Clinical Coding Manager.

7.18.3 The amendments and implications of the Coding Clinics are discussed fully by all of the clinical coders.

7.19 Data Quality Review

7.19.1 The amendments and implications of the Data Quality Review newsletter are discussed fully by all of the clinical coders.

7.19.2 A copy of the Data Quality Review newsletter is held on file. This remains within the Department at all times and is signed by all of the coders to confirm receipt.

8 Consultation

8.1 The review of this policy has been consulted and shared with Medical Director and Information Governance Lead Officer.

8.2 The policy has been discussed at the Information Steering Group

9 Training

This Clinical Coding Policy does not have a mandatory training requirement but the following non mandatory training is undertaken:

9.1 Training for Clinical Coders

9.1.1 Details of training courses attended and scheduled are held by the Clinical Coding Manager in a training and development electronic file.

9.1.2 The Clinical Coding Training and Audit Consortium and the participating members have agreed a programme of Clinical Coding training and audit. The Trust, as a participating member, recognises the need for Clinical Coders to participate in all of the relevant training courses. This is to endorse national standards, rules and conventions of ICD-10, OPCS-4 and Clinical Terms (The Read Codes). Also to create an awareness of the importance and eventual use of the data, e.g. Clinical Governance, local management and national statistics etc.

9.1.3 There is an induction and training programme for all new clinical coding staff which includes attendance on the Clinical Coding Standards Course and specialist workshop training, with continual on-going in-house training via ACC qualified mentorship. Attendance is also required on the Trust's own induction course which covers Security and Confidentiality, Health and Safety, Risk Management etc.

9.1.4 The Trust in accordance with the Data Security Standard 3 will maintain the following:

- Attendance is required on a Clinical Coding Standards Course within six months of appointment for all new coding staff.

- Attendance is required on the Clinical Coding Refresher Training Course every three years for experienced Clinical Coding staff.

- Attendance is required on updated Clinical Coding speciality workshops as necessary.

9.1.5 All training will be delivered by an NHS Classifications service approved Clinical Coding Trainer using only materials developed by the NHS Classifications service as specified in the Data Security Standard 3

9.1.6 Attendance is required on relevant computer training courses to update IT skills and to reinforce Information for Health objectives.

9.1.7 All Clinical Coding staff are required by contract to sit and attain the National Clinical Coding Qualification (UK) within a reasonable time scale (i.e. two years).

9.2 Training Programme for Non-clinical Coding Staff

9.2.1 As the new junior doctors change over every six months, training in their role to clinical coding and ensuring data quality is now incorporated into the induction process. A slot at every induction course has been allocated specifically to Clinical Coding. Training is delivered by the Clinical Coding Manager by way of a presentation, handouts and a question and answer session.

9.2.2 The Clinical Coding department aim to train and highlight to all healthcare professionals the importance of clinical coding and the impact incorrect coding can have on the trust as a whole, initiatives such as attending ward rounds to assist in the real-time completion of discharge summaries and regular communication with key staff are at the forefront of the coding departments desired outcomes.

9.3 Internal Audit

9.3.1 Only coders trained by the NHSIA in Clinical Coding auditing can undertake an audit.

9.3.2 A limited amount of Clinical Coding is now input by staff outside the coding department. This only applies to the very basic coding of outpatient clinics where only the OPCS-4 procedure code is entered. A suitably qualified Clinical Coder/ Clinical Coding Outpatient Clerk is required to audit these and the results when necessary are shared with the relevant department.

9.3.3 Other internal audits are undertaken when a specific query arises that requires an audit.

9.4 External Audit

9.4.1 Data Quality Audit focused on Clinical Coding, is a crucial part of a robust assurance framework required for both PbR and the development of the NHS care records service (NHS CRS). Clinical Coding Audit is an essential component of the Payment by Results Data Assurance Framework. This method of data quality assurance is designed to measure results achieved by the NHS in a way that is meaningful to the

public, to healthcare professionals and to NHS managers; and to correlate NHS funding with clinical activity and outcomes. Healthcare information at local and national level is crucial to support epidemiological studies, clinical audit, disease prevention programmes, management planning and monitoring of healthcare services.

9.4.2 External audits are undertaken annually in accordance with the Data Security Standard 1. The Audit will be undertaken by NHS Classifications Service approved Clinical Coding Auditors who have adhered to the Clinical Coding Auditor Code of Conduct with the last twelve months, prior to submission of the Information Governance Toolkit.

9.5 Audit Outcome

9.5.1 The Clinical Coding Manager and all of the Clinical Coders will fully discuss the findings of the audit report in a documented meeting.

9.5.2 Any resulting changes to procedure will be investigated and implemented as necessary. Related training issues will also be addressed.

9.5.3 All coding staff are made aware of the changes; a summary of which is circulated and kept on file.

9.5.4 Lead Clinicians for the chosen specialities that have been audited will be approached if significant errors have arisen that the Clinical Coding Manager feels necessary to bring to their attention.

9.6 Dissemination

9.6.1 When approved this document will be available on the Intranet and will be subject to document control procedures. Approved documents will be placed on the Intranet within five working days of date of approval once received by the Risk Management Team.

9.6.2 When submitted to Corporate Governance for inclusion on the Intranet this document will have fully completed document details including version control. Keywords and description for the Intranet search engine will be supplied by the author at the time of submission.

9.6.3 Notification of new and revised documentation will be issued on the Front page of the Intranet, through e-bulletin, and on staff notice boards where appropriate. Any controlled documents noted at the Trust Leadership Committee will be notified through the e-bulletin.

9.6.4 Staff using the Trust's intranet can access all procedural documents. It is the responsibility of managers to ensure that all staff are aware of where, and how, documents can be accessed within their areas of work.

9.6.5 It is the responsibility of each individual who prints a hard copy of any document to ensure that the printed hardcopy is the current version. Current versions are maintained on the Intranet.

9.7 Equality Analysis

9.7.1 This procedure has undergone an equality analysis please refer to Appendix B.

9.8 Review And Revision Arrangements

9.8.1 This policy will be ratified in accordance with the Document Control policy.

9.8.2 The Clinical Coding Manager will be responsible for reviewing the policy within three years from the updated policy.

10 Monitoring, Compliance and Effectiveness

10.1 Quality Checks

10.1.1 To achieve confidence in information produced as part of any process, the underlying data must be of high quality and demonstrated to be 'fit for purpose'. The provision of high quality data to support a range of initiatives depends on the quality of the management processes surrounding the collection, processing and use of data.

10.1.2 If data collected is routinely validated and audited it is more likely to be recognised as a quality product by the users. Good management practice in data recording, abstracting, encoding and processing producing good quality data ensures confidence in the information used both within the organisation and the wider local health economy, as well as in the NHS as a whole.

10.1.3 All Coded episodes by new staff members are 100 % checked initially and gradually reduced as the Coder gains competence.

10.1.4 Dependent upon the level of competence/experience each Clinical Coder has set objectives regarding productivity and accuracy which need to be maintained in order to achieve pay progression at appraisal.

10.1.5 Quality and Accuracy are monitored by the Clinical Coding Manager. On a monthly basis 10% of each Coders completed episodes are checked, the findings are shared with the Coder and any issues arising from such quality checks are managed accordingly i.e. further support with additional Training.

10.1.6 A competency level of 90% accuracy is expected although the Trust strives for a 95% accuracy level and subsequent attainment of the Information Governance Toolkit requirement 505 at level 3.

10.1.7 Clinical Coders are encouraged to initiate peer review for difficult cases and are therefore able to review cases and request support from each other and the Clinical Coding Manager on a daily basis.

10.1.8 If a decision cannot be reached within the department, by utilising the information available in resources such as the Clinical Coding Standards or Coding Clinic Releases the query is resolved via the Clinical Coding Query Mechanism as detailed in point 6 of this policy.

10.2 Validations

10.2.1 A week prior to submission deadline to SUS a validation is performed on the month's coded data undertaken by the Coding Manager or delegated ACC. This is done via the LiveAudit programme.

10.2.2 LiveAudit selects a mixture of coded data that have odd code assignment, previously coded co-morbidities that are missing on the present coded episode and/or specific specialties that are advisable to validate against the casenotes.

10.2.3 Any errors found are corrected in SimpleCode and added to the coding monthly meetings to discuss and encourage learning.

10.2.4 The Clinical Coding Manager is involved in the discussion of accuracy of coding the diagnosis sepsis. The Trust lead for sepsis undertakes weekly validation on all patients diagnosed with sepsis to ensure this is an accurate diagnosis and code assignment..

11 Links to other Organisational Documents

Records Management Policy
Health and Care Records Policy
Records Management Policy
Data Quality Policy
Information Governance policy Inc.The Management of Information Risks
Information Security Policy
Confidentiality -Code of Practice
Counter Fraud and Corruption Policy
Discharge IOW Policy
Missing or Misplaced Clinical Records Standards Operating Procedure

12 References

Heath and Social Care Information Centre: - http://www.hscic.gov.uk/

Royal College of Physicians – Record keeping standards:-
https://www.rcplondon.ac.uk/resources/generic-medical-record-keeping-standards

13 Appendices

Appendix A Financial and Resourcing Impact Assessment on Policy Implementation

Appendix B Equality Impact Assessment (EIA) Screening Tool

Appendix A

Financial and Resourcing Impact Assessment on Policy Implementation

NB this form must be completed where the introduction of this policy will have either a positive or negative impact on resources. Therefore this form should not be completed where the resources are already deployed and the introduction of this policy will have no further resourcing impact.

Document title	**Clinical Coding Policy**

Totals	**WTE**	**Recurring £**	**Non Recurring £**
Manpower Costs	**0**	**0**	**0**
Training Staff	**0**	**0**	**0**
Equipment & Provision of resources	**0**	**0**	**0**

Summary of Impact:

Risk Management Issues:

Benefits / Savings to the organisation:

Equality Impact Assessment

- Has this been appropriately carried out? YES/NO
- Are there any reported equality issues? YES/NO

If "YES" please specify:

Use additional sheets if necessary.

Please include all associated costs where an impact on implementing this policy has been considered. A checklist is included for guidance but is not comprehensive so please ensure you have thought through the impact on staffing, training and equipment carefully and that ALL aspects are covered.

Manpower	**WTE**	**Recurring £**	**Non-Recurring £**
Operational running costs	0	0	0
Totals:	0	0	0

Staff Training Impact	**Recurring £**	**Non-Recurring £**

	0	0
Totals:	0	0

Equipment and Provision of Resources	**Recurring £ ***	**Non-Recurring £ ***
Accommodation / facilities needed	0	0
Building alterations (extensions/new)	**0**	**0**
IT Hardware / software / licences	**0**	**0**
Medical equipment	**0**	**0**
Stationery / publicity	**0**	**0**
Travel costs	**0**	**0**
Utilities e.g. telephones	**0**	**0**
Process change	**0**	**0**
Rolling replacement of equipment	**0**	**0**
Equipment maintenance	**0**	**0**
Marketing – booklets/posters/handouts, etc	**0**	**0**
Totals:	**0**	**0**

- Capital implications £5,000 with life expectancy of more than one year.

Funding /costs checked & agreed by finance:	
Signature & date of financial accountant:	
Funding / costs have been agreed and are in place:	
Signature of appropriate Executive or Associate Director:	

Appendix B

Equality Impact Assessment (EIA) Screening Tool

Document Title:	Clinical Coding Policy
Purpose of document	This policy confirms the processes of Clinical Coding
Target Audience	Clinical and Non-Clinical staff
Person or Committee undertaken the Equality Impact Assessment	Clinical Coding Manager

1. To be completed and attached to all procedural/policy documents created within individual services.

2. Does the document have, or have the potential to deliver differential outcomes or affect in an adverse way any of the groups listed below?

If no confirm underneath in relevant section the data and/or research which provides evidence e.g. JSNA, Workforce Profile, Quality Improvement Framework, Commissioning Intentions, etc.

If yes please detail underneath in relevant section and provide priority rating and determine if full EIA is required.

		Positive Impact	Negative Impact	Reasons
Gender	Men	N/A	N/A	
	Women	N/A	N/A	
Race	Asian or Asian British People	N/A	N/A	
	Black or Black British People	N/A	N/A	
	Chinese people	N/A	N/A	
	People of Mixed Race	N/A	N/A	
	White people (including Irish people)	N/A	N/A	

	People with Physical Disabilities, Learning Disabilities or Mental Health Issues	N/A	N/A	
Sexual Orientation	Transgender	N/A	N/A	
	Lesbian, Gay men and bisexual	N/A	N/A	
Age	Children	N/A	N/A	
	Older People (60+)	N/A	N/A	
	Younger People (17 to 25 yrs)	N/A	N/A	
Faith Group		N/A	N/A	
Pregnancy & Maternity		N/A	N/A	
Equal Opportunities and/or improved relations		N/A	N/A	

Notes:
Faith groups cover a wide range of groupings, the most common of which are Buddhist, Christian, Hindus, Jews, Muslims and Sikhs. Consider faith categories individually and collectively when considering positive and negative impacts.

The categories used in the race section refer to those used in the 2001 Census. Consideration should be given to the specific communities within the broad categories such as Bangladeshi people and the needs of other communities that do not appear as separate categories in the Census, for example, Polish.

3. Level of Impact

If you have indicated that there is a negative impact, is that impact:			
		YES	**NO**
Legal (it is not discriminatory under anti-discriminatory law)			
Intended			

If the negative impact is possibly discriminatory and not intended and/or of high impact then please complete a thorough assessment after completing the rest of this form.

3.1 Could you minimise or remove any negative impact that is of low significance? Explain how below:
3.2 Could you improve the strategy, function or policy positive impact? Explain how below:
3.3 If there is no evidence that this strategy, function or policy promotes equality of opportunity or

improves relations – could it be adapted so it does? How? If not why not?	
Scheduled for Full Impact Assessment	Date:
Name of persons/group completing the full assessment.	
Date Initial Screening completed	