

Data Security Standard 1 Data Quality

**Clinical Coding Audit Guidance – Acute
and Mental Health Trusts**

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Purpose

This document replicates guidance to support a robust data quality and clinical coding audit programme associated with the Data Quality section of Data Standard 1 in the [Data Security & Protection Toolkit](#) and can be used by clinical coding departments when completing their annual assessments for the Data Security & Protection Toolkit.

Overview

There are established procedures in place at Acute and Mental Health Trusts for regular quality inspections of the coded clinical data using the Terminology and Classifications Delivery Service' Clinical Coding Audit Methodology to demonstrate compliance with the clinical classifications OPCS-4¹ and ICD-10², associated national clinical coding standards³, and the organisation's commitment to continual improvement of its coded clinical data. **NB:** For Mental Health Trusts, this Standard only covers data recorded for submission to the Admitted Patient Care (APC) Data Set and the requirement for OPCS-4 collection is only where the organisation's Patient Administration System has the functionality to collect OPCS-4 codes.

The clinical coding audits are undertaken by a Terminology and Classifications Delivery Service Approved Clinical Coding Auditor. The results including findings, conclusions and recommendations of any clinical coding audits conducted within the last 12 months are noted by the organisation and there must be documented evidence that any recommendations have been actioned/progressed by the organisation.

Guidance

Robust Data Quality and Clinical Coding Audit Programme

Introduction

1. Organisations⁴ and clinical coding staff depend on clear, accurate coded clinical data in order to provide a true picture of patient hospital activity and the care given by clinicians. Coded clinical data is important for a number of reasons, for example:
 - monitoring provision of health services across the UK
 - research and monitoring of health trends
 - NHS financial planning and payment
 - clinical governance.
2. The Terminology and Classifications Delivery Service provides a working model for carrying out coded clinical data audits.

¹ OPCS-4 Classification of Interventions and Procedures Version 4.8 (2017) – the procedure/intervention classification in use in the UK by members of the clinical coding profession.

² ICD-10 – International statistical classification of diseases and related health problems (10th revision)

³ National Clinical Coding Standards ICD-10 5th Edition and OPCS-4 reference books Terminology and Classifications Delivery Service

⁴ Organisation in this context is referring to both NHS and non-NHS organisations responsible for the delivery of patient care.

Audit Programme – Data Quality (Clinical Coding)

3. Data Quality Audit, focused on clinical coding, is a crucial part of a robust quality assurance framework supporting and helping to ensure the provision of statistically meaningful coded clinical data. This in turn facilitates the information and clinical governance agendas for both payment and the development of electronic care records.
 - a. A regular programme of clinical coding audits focused on data quality in accordance with the guidance set out below.

This programme may be in the form of, either:

- i. a continuous clinical coding audit programme comprising several small audits undertaken throughout the course of the year as part of routine maintenance of standards (see also 15);
- ii. a single one-off audit, which should be undertaken every twelve months.

Data Quality (Clinical Coding) Audit Specification

4. For the purposes of this requirement, clinical coding audits are performed as part of a continuous data quality programme. These audits must be based on the most recent version of the service Clinical Coding Audit Methodology and be undertaken by a service Approved Clinical Coding Auditor who has complied with all of the requirements of the Terminology and Classifications Delivery Service [Clinical Coding Auditor Programme](#). The auditor may or may not be employed by the organisation but must abide by Caldicott Guardian requirements. The overall % accuracy scores should be greater than or equal to the levels indicated in the guidance below.
5. Documented evidence that recommendations made in previous clinical coding audits have been noted and actioned/progressed must be made available to the auditor.
6. Organisations should routinely undertake audits of their data as part of good practice in keeping under review their performance in providing good quality data (refer to the detailed guidance provided in the [Approved Clinical Coding Auditor Code of Conduct](#)).

The Terminology and Classifications Delivery Service Clinical Coding Audit Methodology

7. In order to monitor the quality of coded clinical data, organisations should adopt a procedure for regular audit, review and improvement. This should incorporate processes to ensure recommendations made at audit are tracked through to completion and must be made available to the auditor.
8. The aim of the audit is to check that clinical coding processes are in place and to ensure the inputted data complies with national clinical coding standards. Any clinical data that cannot be referenced against ICD-10 Volumes 1-3, OPCS-4 Volumes I-II, the National Clinical Coding Standards ICD-10 5th Edition reference book, the National Clinical Coding Standards OPCS-4 Edition reference book, the National Tariff Chemotherapy

Regimens List, the National Tariff High Cost Drugs List, Chemotherapy Regimens Clinical Coding Standards and Guidance, High Cost Drugs Clinical Coding Standards and Guidance or the *Coding Clinic* will not be pursued.

9. Generally mental health clinical coding is undertaken by professional clinical coders who are fully knowledgeable in the national clinical coding standards of both ICD-10 and OPCS-4. However, the Terminology and Classifications Delivery Service recognises that some Mental Health Trusts do not employ dedicated clinical coders who have been provided with training in all aspects of these classifications and that the recording of coded clinical data may be captured using other methods. Therefore, provisions have been put in place, and this Data and Security Protection Toolkit Standard takes into account that Mental Health Trusts may now be using electronic records (e.g. EPR) and that audits will be performed based on the data available in the full clinical record, whether this is a paper or an electronic version.
10. The Clinical Coding Audit Methodology describes the full range of analyses that are carried out on all diagnostic and procedure codes. These include analysis of both primary and secondary diagnosis and procedure codes for:
 - correct and incorrect codes;
 - incorrect sequencing of codes;
 - irrelevant codes and omitted codes.
11. A summary of the Methodology titled '[A Guide to Clinical Coding Audit Best Practice](#)' is available for reference by non-Approved Clinical Coding Auditors.
12. The clinical coding audit also examines the process undertaken for coding and the documentation (either paper or electronic) available for use during the coding process.
13. Selection of the sample for the audits may be informed by the results of national benchmarking and/or previous audits. Other examples include specialty specific audits or a general sample which is representative of the casemix, specialty and type of admission of the organisation. The clinical coding auditors have a responsibility to satisfy themselves that the sample is random within this constraint.
14. For clinical coding audit the requirements for achieving attainment of mandatory and advisory for clinical coding analysis within information quality assurance are that:
 - a) Organisations should have carried out a clinical coding audit programme undertaken by a Terminology and Classifications Delivery Service Approved Clinical Coding Auditor within the last 12 months*, prior to the final submission of the Information Quality Assurance scores for this version of the Data Security and Protection Toolkit.
 - b) The approved auditor must have met and complied with all requirements of the Clinical Coding Auditor Programme (CCAP) and adhered to the latest version of the

Terminology and Classifications Delivery Service' Clinical Coding Audit Methodology and the Approved Clinical Coding Auditor Code of Conduct.

The minimum requirement for an **Acute Trust** is for coding audits totalling a **minimum of 200*** Consultant Episodes (or 2%*, whichever is the smaller) to be undertaken over the year either as a one-off audit, or as a series of smaller audits that add up to a minimum of 200 Consultant Episodes (or 2% if smaller) to assure the quality of information as part of a local audit programme.

The minimum requirement to assure the quality of information as part of a local audit programme for a **Mental Health Trust** is for coding audits totalling a **minimum of 50** Consultant Episodes.

Beyond this published minimum, each organisation needs to decide a meaningful number of consultant episodes to be audited across each of its sites (and specialties) in order to underpin its data quality. This should be discussed by members of the organisation's Data Quality team.

- c) Within the report there should be an analysis of reasons for the errors identified which distinguish between coder and non-coder error. For example, whether the error is due to the incorrect code assigned or due to problems with documentation or process not being fit for purpose. However, for the purposes of information quality assurance, an error due to either cause would be deemed an inaccuracy. Organisations are urged to note that many issues with clinical coding may arise not from the coders, but from problems with the information given to the coders to code from, and that these issues will need to be addressed.
- d) Organisations should use the analysis contained in their clinical coding audit reports to understand the reasons behind any errors and ensure that any recommendations made in the previous clinical coding audits have been noted and actioned. The auditor will ask to see those documents which evidence that recommendations from previous audits have been tracked to completion, for example, an Action Log or Audit Tracker, changes within the Clinical Coding Departmental Policy and Procedure document etc.
- e) The Terminology and Classifications Delivery Service provides the following percentage accuracy scores (Figure 1 = Acute Trust, Figure 2 = Mental Health Trust):

FIGURE 1:

Acute Trust	Mandatory	Advisory
Primary Diagnosis	$\geq 90\%$	$\geq 95\%$

Secondary Diagnosis	$\geq 80\%$	$\geq 90\%$
Primary Procedure	$\geq 90\%$	$\geq 95\%$
Secondary Procedure	$\geq 80\%$	$\geq 90\%$

FIGURE 2:

Mental Health Trust	Mandatory	Advisory
Primary Diagnosis	$\geq 85\%$	$\geq 90\%$
Secondary Diagnosis	$\geq 75\%$	$\geq 80\%$
Primary Procedure*	$\geq 85\%$	$\geq 90\%$
Secondary Procedure*	$\geq 75\%$	$\geq 80\%$

* Where systems allow the capture of OPCS-4 codes, the clinical coding must comply with national clinical coding standards.

Trusts must meet or exceed the required percentage across all four areas in order to meet mandatory (or advisory).