Clinical Coding Procedure

CLIN-0066-v5

Status: Approved
Document type: Procedure

Contents

1 Purpose

Following this procedure will help the Trust to:-

- Provide accurate, complete and timely coded clinical information to support commissioning, local information requirements and the information required for information data sets, *e.g.,* the Mental Health Services Data Set;
- Adhere to national standards and classification rules and conventions as set out in the WHO ICD-10 Volumes 1-3, Clinical Coding ICD-10 Standards, OPCS-4 manual and publications of the Coding Clinic;
- Produce accurate and complete coded information within the designated time scales to support the information requirements and commissioning of the Trust;
- Provide accurate, consistent and timely information to support clinical governance and the Data Accreditation process;
- Ensure continual improvement of clinical coded information within the Trust through systematic audit and quality assurance procedures.

2 Related documents

This procedure describes what you need to do to implement sections 4.1.5 and 4.2.2 of the Data Management Policy.

The Data Management Policy defines staff responsibilities for using Trust information systems which you must read, understand and be trained in before carrying out the procedures described in this document.

This procedure also refers to:-

- ✓ Confidentiality and Sharing Information Policy
- ✓ Consultant Coding E- learning

3 Key Themes

3.1 Coding Rules

3.1.1 Codes must be entered following ICD-10 and OPCS-4 national standards.

3.1.2 On the day of discharge or consultant transfer the ICD-10 diagnosis should be entered onto PARIS in the Consultant Episode Coding Module. All ICD-10 codes must be populated into the PARIS E-discharge / transfer care document.

3.1.3 Only assign definitive diagnosis codes; any diagnosis given as ‘possible’, ‘likely’ or marked ‘?’ should be ignored, however a diagnosis marked as ‘probable’ or ‘treat as...’ can be coded as a definitive diagnosis.

3.1.4 Where there is no definitive diagnosis, code the main symptom, abnormal findings or problem.

3.1.5 Assign all codes necessary to give an accurate clinical picture of the patient’s diagnosis, problems or other reason for hospital stay.

3.1.6 The recording of electroconvulsive therapy is mandatory for mental health trusts. Always code ECT procedures as per OPCS-4 national standards.

3.1.7 Do not assign a code if there is no documented, supporting evidence within Paris. Unsupported codes will be removed from the system.

3.1.8 Do not use the Consultant Episode Coding module for differential diagnoses.

3.1.9 Do not code resolved medical conditions that are no longer active and which do not influence the health care currently provided.

3.1.10 Do not use external cause codes (V01 - Y98) as the primary diagnosis.

3.1.11 Do not add a 5th digit indicating whether the condition is a somatic syndrome or not. This is not acceptable as Hospital Episode Statistics (HES) data.

3.1.12 Do not include the decimal point when using the Consultant Episode Coding module, e.g. F70.1 would be entered as F701.

3.1.13 Do not use Z03.2 in the primary position if there is a diagnosis or symptom code that would take precedence.

3.1.14 If an episode of self-harm has been treated outside of the Trust before being admitted here then it should be documented as a history of self-harm using the code Z91.5.

3.1.15 Asterisk codes can be assigned in the primary position when the manifestation of a disease is the primary focus of care. This must be accompanied by the corresponding Dagger code.

3.2 Dagger and Asterisk Coding

The dagger and asterisk system is used where there are two codes for diagnostic statements containing information about both an underlying generalised disease and a manifestation of that disease in a particular organ or site which is a clinical problem in its own right.

The 'Dagger' code is for the underlying disease and is marked with a dagger (†); an additional code for the manifestation is marked with an asterisk (*). This system was provided because coding to underlying disease alone was often unsatisfactory for compiling statistics relating to particular specialties, where there was a desire to see the condition classified to the relevant chapter for the manifestation when it was the reason for medical care.

For example, consider the condition dementia in Alzheimer's disease with late onset. Codes for which can be found on page 149 of the Alphabetical Index, *i.e.* G30.1† F00.1*. This implies that a patient suffers dementia caused by Alzheimer's disease of late onset.

Do not assign the Asterisk code without the corresponding Dagger code. From the example above; if F00.1 is entered into the coding module of PARIS then it must be immediately followed by the G30.1. Please note that Paris will not prompt the user to follow this mandatory coding standard.

Due to an ongoing Paris system constraint Dagger and Asterisk codes may **not** be entered as described above for **Community Contacts,** however both codes must still be assigned individually.

3.3 Coding Process

Medical staff document a primary diagnosis in PARIS. (If Paris becomes unavailable and Business Continuity Plans are implemented, coders will refer to paper records for diagnoses). Coder's firs tpoint of contact will be medical secretaries and ward clerks.	Once a diagnosis is known it must be documented in the care record as soon as possible, ideally as a case note entry.
↓	
Medical staff or coders enter the relevant code into PARIS	The documented diagnosis should be translated into an ICD-10 code using the classification's rules and conventions and this code should be added to PARIS using the Consultant Episode Coding Module. Codes must not be input into the 'Diagnosis Information' area of PARIS. There is an agreement with AMH, MHSOP and LDS that coders will enter appropriate codes in the ICD-10 coding module. Clinical staff in other directorates must ensure codes are entered in the clinical coding module. In this situation coders will verify codes assigned by clinicians and agree on any amendments.
↓	
Clinical coders verify the primary code and assign all the relevant secondary codes	Comparisons will be made with the diagnostic documentation on PARIS and assigned ICD-10 code to look for discrepancies. Any ICD-10 codes in place without documented evidence will be removed and any physical co-morbidities or acute conditions will be added.
↓	
Clinical coders use monthly reports to check for errors or omissions	The Integrated Information Centre (IIC) is used monthly to flag up FCEs without ICD-10 codes and reminder emails will be sent out to the appropriate consultant.
↓	
Information analysts transfer clinical coding data to the Department of Health.	The Commissioning Datasets (CDS) & Mental Health Services Data Set (MHSDS) are returned to Secondary Use Service (SUS) around the 20th of each month.

3.4 Coding Audit

The Trust's clinical coding will be audited on an annual basis by an auditor who is listed on NHS Digital's register of clinical coding auditors. The auditor will comply with the Code of Practice for Coding Auditors.

The audit will comply with the requirements and standards within the NHS Clinical Classification Service Audit Methodology. This methodology describes the full range of analyses that are carried out on all diagnosis codes and procedure codes. These include analysis of primary and secondary diagnosis and procedure codes, for correct and incorrect codes, incorrect sequencing of codes, irrelevant codes and omitted codes. The coding audit also examines the process undertaken for coding and the documentation available for use during the coding process.

The audit sample will be random and will represent the case-mix of the trust; usually a sample of 100 Finished Consultant Episodes (FCEs) across all clinical directorates, Children & Young People, Adult Mental Health, Mental Health Services for Older People, Learning Disabilities Service and Forensic.

A copy of the clinical coding audit report will be sent to the NHS Clinical Classifications Service to ensure that analysis of issues and trends can be made, and that issues that are best addressed nationally can be flagged up.

4 Glossary of Terms

Term	Definition
Clinical Coding	The translation of medical terminology into a coded format that is recognised both nationally and internationally. It is the application of a national set of codes that every NHS trust must use to record the clinical care given to inpatients and day cases to record the resources used for inpatients while they are in hospital care.
Co-morbidities	The presence of one or more disorders or diseases in addition to the primary disorder or disease. Any co-morbidities that affect the management of the patient must be recorded and coded to provide an accurate clinical picture.
Consultant Episode of Care	The period of time an inpatient was under the care of a consultant. Once a consultant episode of care is complete, the episode is closed and referred to as a Finished Consultant Episode (FCE), i.e. on discharge, transfer to another consultant or transfer to another hospital.
Primary Diagnosis	The main condition treated or investigated during the relevant episodes of healthcare. Where there is no definitive diagnosis, the main symptom, abnormal findings or problem should be selected as the main condition.
Secondary Diagnosis	In addition to the primary diagnosis, record all secondary diagnoses to accurately reflect all the care received by the patient during the consultant episode of care. Secondary diagnoses can have significant impact on

	patient treatment, period of hospitalisation or discharge destination, particularly in the outcome measurements used in the clinical indicators and for clinical governance.

5 How this procedure will be implemented

- This procedure will be published on the Trust's intranet and external website.
- The Clinical Coding Manager will disseminate this procedure to all Trust Clinical Coders.
- The Paris training team will disseminate this procedure to all Trust medical staff who undertake Paris training.
- Medical secretary line managers will disseminate this procedure to medical secretaries who input ICD-10 codes into the inpatient coding module.

5.1 Training needs analysis

Staff/Professional Group	Type of Training	Duration	Frequency of Training
Responsible Clinicians	E-Learning	30 mins	In line with changes to national coding standards and trust electronic systems.
Medical secretarial staff	E-Learning	30 mins	In line with changes to national coding standards and trust electronic systems.
Clinical Coding staff	Formally delivered from an approved trainer in line with mandatory professional requirements.	4-5 days	Every 18 – 24 months

6 How the implementation of this procedure will be monitored

Auditable Standard/Key Performance Indicators		Frequency/Method/Person Responsible	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group).
1	Sequence 514 of NHS Digital's Mental Health Information	Annual/External Audit/ Trust Clinical Coding Manager	Externally monitored by the Department of Health through the

	Governance Toolkit. External Clinical Coding Audit of at least 100 FCEs across all clinical specialties.		NHS Digital Clinical Classifications Service. Internally monitored by the Trust's Information Strategy & Governance Group.

7 References

A Guide to Clinical Coding Audit Best Practice 2015 to 2016

Code of Conduct for Payment by Results 2013 - 2014

ICD-10 5th Edition Key Learning Points

8 Appendix 1 Clinical Coding Examples

Respite Care

Service users who are admitted for holiday relief (respite care) and only receive the care and attention that would normally be given at home by the carer should have a primary code of Z75.5 (Holiday relief care) followed by their chronic condition(s).

For example - service user with autism is admitted for 2 weeks respite care. No additional treatment other than normally given at home was required.

Primary diagnosis	Z75.5	Holiday relief care
Secondary diagnosis	F84.0	Childhood autism

If a condition occurs that needs treatment and extends the length of stay then that condition will become the primary diagnosis.

For example - service user with autism admitted for 2 weeks respite care. Whilst in hospital, the patient developed bronchopneumonia which was treated and extended the length of stay.

Primary diagnosis	J18.0	Bronchopneumonia
Secondary diagnoses	F84.0 Z75.5	Childhood autism Holiday relief care

Electro Convulsive Therapy Coding (ECT)

The recording of ECT for mental health trusts was made mandatory from 1st April 1999. There are national standards around the coding of ECT and there should be documented evidence of when this has taken place and also how many treatments are considered part of the same course. The code A83.8 is used for the first session in a course of ECT and the code A83.9 for all subsequent sessions in the same course.

For example - patient with recurrent depressive disorder, current episode severe with psychotic symptoms and type II diabetes received one course of ECT comprising of 4 treatments.

Primary diagnosis	F33.3	Recurrent depressive disorder, current episode severe with psychotic symptoms
Secondary diagnosis	E11.9	Non-insulin-dependent diabetes mellitus
Primary procedure	A83.8	Other specified electroconvulsive therapy
Secondary procedures	A83.9 A83.9 A83.9	Electroconvulsive therapy unspecified Electroconvulsive therapy unspecified Electroconvulsive therapy unspecified

For example - a patient with severe depressive episode, without psychotic symptoms is transferred into the trust after receiving the first 2 treatments of a course of ECT as an outpatient and received a further 3 treatments as an inpatient.

Primary diagnosis	F32.2	Severe depressive episode, without psychotic symptoms
Secondary diagnosis	n/a	n/a
Primary procedure	A83.9	Electroconvulsive therapy unspecified
Secondary procedures	A83.9 A83.9	Electroconvulsive therapy unspecified Electroconvulsive therapy unspecified

Self-harm

If a patient self-harms and is treated in an acute unit before being transferred to a psychiatric unit then it should be coded as a history of self-harm.

For example - patient with a deliberate drug overdose of paracetamol and alcohol treated at acute unit then transferred to psychiatric unit for treatment of acute depression.

Primary diagnosis	F32.9	Depressive disorder, unspecified
Secondary diagnosis	Z91.5	Personal history of self-harm

If a patient self-harms whilst admitted it should be coded as an acute event.

For example - patient treated at psychiatric unit for acute depression, attempted suicide by slashing wrist with scissors - to be transferred to acute unit for further treatment of injury.

Primary diagnosis	F32.9	Depressive disorder, unspecified
Secondary diagnoses	S61.9	Open wound of wrist and hand part, part unspecified
	X78.2	Intentional self-harm by sharp object (occurred in hospital = .2)

Bi-polar in remission

Affective and depressive disorders that have regressed to a state of remission should not be assigned as such in a primary diagnostic position.

If for example, a service user is discharged from service with a diagnosis of bi-polar affective disorder in a state of remission but, was admitted due to a manic presentation; the manic presentation would be the reason for admission and therefore the main condition treated. The primary diagnosis coding should reflect this.

9 Appendix 2 Forms

The following pages contain template forms that are kept up-to-date and held by the clinical coding team.

FORM A

LOCAL CODING POLICIES

This form details local policies that have been implemented to give clarification on coding issues where no formal guidance is available. There are currently six local clinical coding policies in use as detailed in the table below.

Each local policy will be signed by the relevant consultant on an annual basis and this form will be signed by the clinical coders to confirm receipt of the policy.

The signed policies are held by the trust's coding team and they are published on the Information Governance pages on the trust intranet site.

Policy ref. no.	Policy description	Name of Coder	Signature of Coder	Date
01	*Learning disability versus mental retardation*	Tim Turnbull		
02	*Alzheimer's dementia (late onset)*	Tim Turnbull		
03	*Respite care*	Tim Turnbull		
04	*Coding dementia in Alzheimer's and other diseases*	Tim Turnbull		
05	*Electro Convulsive Therapy coding*	Tim Turnbull		
06	*Co-morbidities coding*	Tim Turnbull		

Reference 01: Local Clinical Coding Policy: Learning Disability versus Mental Retardation

Local coding policy for the Learning Disabilities and Forensic Learning Disabilities directorate

The local coding policy for Tees, Esk and Wear Valleys NHS Foundation Trust is to code all learning disabilities as mental retardation (F70 to F79) unless developmental disorder of scholastic skills is mentioned. If scholastic skills are mentioned, the code F81 will be assigned.

Signed:

Dr Kirsty Passmore, Senior Clinical Director Adult Learning Disabilities
Date:

This policy was first ratified at the Clinical Directors meeting on the 30th June 2011 and signed off by Dr Chandi Siriwardana, Clinical Director Learning Disabilities

Reference 02: Local Clinical Coding Policy: Alzheimer's dementia (late onset)

Local coding policy for the Mental Health Services for Older People Directorate (MHSOP)

The local coding policy for Tees, Esk and Wear Valleys NHS Foundation Trust is to code all Alzheimer's dementia as '*late onset*' (G30.1) unless '*early onset*' is mentioned.

Signed:

Dr Tolulope Olusoga, Senior Clinical Director Mental Health Services for Older People

Date:

This policy was first ratified at the MHSOP clinical leads meeting on the 21st September 2011 and signed off by Dr Ruth Briel, Clinical Director Mental Health Services for Older People.

Reference 03: Local Clinical Coding Policy: Respite Care

Local coding policy for the coding of respite care across all clinical directorates

The local coding policy for Tees, Esk and Wear Valleys NHS Foundation Trust is to code all admissions to the trust's respite units (for example Baysdale, Holly, Unit 2 Bankfields Court and Aysgarth) as respite care (Z755) unless otherwise specified. This code will be assigned as the primary diagnosis unless another condition is treated and extends the length of stay.

Note: The respite units listed above is not an exhaustive list of the respite units within the trust.

Signed:

Dr Nick Land, Medical Director

Date:

This policy was ratified at the Clinical Leaders and Operational Directors group meeting on the 26th January 2012 and signed off by Dr Nick Land, Medical Director.

Reference 04: Local Clinical Coding Policy: Coding of dementia in Alzheimer's and other diseases.

It is to be local policy for Tees, Esk and Wear Valleys NHS Foundation Trust to code dementia in Alzheimer's and other diseases with the dementia code (asterisk) before the underlying generalised disease code (dagger).

Signed:

Dr Tolulope Olusoga, Senior Clinical Director Mental Health Services for Older People

Date:

This policy was initially signed by:

Sarah McGeorge, Acting Clinical Director Mental Health Services for Older People, Durham and Darlington on 22nd June 2012

Dr Prathiba Nirodi on 5th July 2012

Dr Hashim Mohammed on 10th February 2012

Reference 05: Local Clinical Coding Policy: Coding of Electro Convulsive Therapy

The local coding policy of Tees, Esk and Wear Valleys NHS Foundation Trust is to allow the ECT team members to assign all OPCS 4 ECT procedure codes under supervision of the Clinical Coding Dept.

Signed:

Date:

Approved by Dr Vinod Chaugule Consultant Psychiatrist, March 2016
First approved by Lesley Mawson, Associate Director of Nursing and Compliance, July 2013

Reference 06: Local Clinical Coding Policy: Coding policy for the coding of co-morbidities

It is to be local policy for Tees, Esk and Wear Valleys NHS Foundation Trust to regard the following co-morbid 'conditions' as clinically relevant co-morbidities, and as such will to be coded whenever documented in the care record during the relevant hospital spell:

- Personal hx of drug abuse
- Personal hx of stroke
- Person hx of other physical trauma
- Presence of PEG
- Personal hx of non-compliance
- Personal hx of TIA
- Personal hx of abuse
- Unemployment
- Homelessness
- Dependence on wheelchair
- Personal Hx of Neoplasm
- Family hx of alcohol abuse
- Family hx of drug abuse
- Family hx of other mental disorders
- Family hx other substance abuse
- Family hx of mental retardation

Dr Nick Land, Medical Director

Signed

Date: (Ratified) July 2013

FORM B

RECEIPT OF RESOLUTION

This form documents that coders have received a copy of a NHS Classifications Service resolution to a coding query.

Query number and descriptor	Name of Coder	Signature of Coder	Date

FORM C

AUDIT REPORT

This form documents that coders have read clinical coding audit reports and understood any errors reported.

Audit	Name of Coder	Signature of Coder	Date

FORM D

AMENDMENTS TO CLINICAL CODING INSTRUCTION MANUAL ICD-10 AND OPCS-4

This form includes details of amendments made to the Clinical Coding Instruction Manual for ICD-10 and OPCS-4. All coding staff should be in receipt of the amendments. Anyone not in receipt of the amendments should contact the NHS Classifications Service, NHS connecting for Health.

Amendments seen by:

Amendments	Name of Coder	Signature of Coder	Date

FORM E

UPDATES TO CODING CLINICS

This form documents that coders have received and read and understood updates to the coding clinic and any necessary amendments have been made to their reference books.

Date of update	Name of Coder	Signature of Coder	Date

10 Document control

Date of approval:	15 March 2017	
Next review date:	15 September 2020	
This document replaces:	Clinical Coding Procedure CLIN-0066-v4	
Lead:	Name	Title
	Lorraine Sellers	Head of Compliance & Standards
Members of working party:	Name	Title
	Tim Turnbull	Clinical Coder
This document has been agreed and accepted by: (Director)	Name	Title
	Patrick McGahon	Director of Finance and Information
This document was approved by:	Name of committee/group	Date
	RADAA	7th March 2017
This document was ratified by:	Name of committee/group	Date
	Information Strategy and Governance Group	15th March 2017
An equality analysis was completed on this document on:	3rd March 2017	

Change record

Version	Date	Amendment details	Status
3.0	19 Mar 2014	Rewritten as a procedure as part of policy profile redesign	Obsolete
4.0	6 Apr 2016	Reviewed to take account of 5th edition of ICD-10	Obsolete
5.0	20 Feb 2017	Reviewed on account of organisational change procedure; roles and team names edited. Text included in coding process regarding business continuity.	Published
5.0	07/08/2019	Amended document control for lead and director	Published
5.0	23/04/2020	Review date extended from 15 Mar 2020 to new date of 15 Sep 2020	Published

Appendix 1 - Equality Analysis Screening Form

Please note; The Equality Analysis Policy and Equality Analysis Guidance can be found on InTouch on the policies page

Name of Service area, Directorate/Department i.e. substance misuse, corporate, finance etc.	Information Department					
Name of responsible person and job title	Theresa Parks, Information Governance Manager					
Name of working party, to include any other individuals, agencies or groups involved in this analysis						
Policy (document/service) name	Clinical Coding Procedure					
Is the area being assessed a;	Policy/Strategy		Service/Business plan		Project	
	Procedure/Guidance			X	Code of practice	
	Other – Please state					
Geographical area	Trustwide					
Aims and objectives	To provide guidance to staff on the accurate clinical coding of Finished Consultant Episodes (FCEs). Clinical coding is an important data quality item and the trust is performance measured on its accuracy of ICD-10 and OPCS-4 coding through the IG toolkit. Clinical codes are data items populating mandatory datasets.					
Start date of Equality Analysis Screening (This is the date you are asked to write or review the document/service etc.)	2nd March 2017					
End date of Equality Analysis Screening (This is when you have completed the analysis and it is ready to go to EMT to be approved)	2nd March 2017					

You must contact the EDHR team as soon as possible where you identify a negative impact. Please ring Sarah Jay on 0191 3336267/3542

1. Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?
All service users, and trust employees that assign and input clinical codes. Service users will know their diagnosis and corresponding ICD-10 and OPCS-4 codes when they are given a copy of their discharge / transfer documents. The rules of coding embedded in the procedure will give staff a high level overview of the rules and conventions of clinical coding.
2. Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups below?

Race (including Gypsy and Traveller)	No	**Disability** (includes physical, learning, mental health, sensory and medical disabilities)	No	**Gender** (Men, women and gender neutral etc.)	No
Gender reassignment (Transgender and gender identity)	No	**Sexual Orientation** (Lesbian, Gay, Bisexual and Heterosexual etc.)	No	**Age** (includes, young people, older people – people of all ages)	No
Religion or Belief (includes faith groups, atheism and philosophical belief's)	No	**Pregnancy and Maternity** (includes pregnancy, women who are breastfeeding and women on maternity leave)	No	**Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners)	No

All inpatient service users irrespective of any protected characteristic will be assessed and given a diagnosis. In the absence of a diagnosis the presenting symptoms will be documented and coded.

3. Have you considered other sources of information such as; legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.? **If 'No', why not?**	**Yes**	**X**	**No**	

Sources of Information may include: • Feedback from equality bodies, Care Quality Commission, Equality and Human Rights Commission, etc. • Investigation findings • Trust Strategic Direction • Data collection/analysis • National Guidance/Reports		• Staff grievances • Media • Community Consultation/Consultation Groups • Internal Consultation • Research • Other (Please state below) • Complaints that arise after disclosure of records through a Subject access Request.

4. Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the following protected groups?: Race, Disability, Gender, Gender reassignment (Trans), Sexual Orientation (LGB), Religion or Belief, Age, Pregnancy and Maternity or Marriage and Civil Partnership

Yes – Please describe the engagement and involvement that has taken place

No – Please describe future plans that you may have to engage and involve people from different groups

There are no future plans to engage service users of any group. Service users may gain access to their care records through a Subject Access Request. All assigned clinical codes documented in the record will correspond to known diagnoses and procedures or symptoms identified at the point of care. Should a service user question a diagnosis and subsequently have this changed, then the corresponding code will change to reflect this. Changing a diagnosis is not the responsibility of a clinical coder. A clinical coder can only advise on the selection of the correct corresponding code.

5. As part of this equality analysis have any training needs/service needs been identified?					
Yes	Please describe the identified training needs/service needs below				
A training need has been identified for clinical coders. All clinical coders must complete an approved clinical coding standards course, either a mental health course or a full standards course. This is documented in the Clinical Coder Training Plan for 2017/2018. Any contract coders employed by the Trust will have to meet this training standard.					
Trust staff	Yes	Service users	No	Contractors or other outside agencies	Yes
Make sure that you have checked the information and that you are comfortable that additional evidence can provided if you are required to do so					
The completed EA has been signed off by: You the Policy owner/manager: Theresa Parks				Date: 02/02/2017	
Your reporting (line) manager: Louise Eastham				Date: 07/02/2017	
If you need further advice or information on equality analysis, the EDHR team host surgeries to support you in this process, to book on and find out more please call: 0191 3336267/6542 or email: sarahjay@nhs.net					

Appendix 2 – Approval checklist

To be completed by lead and attached to any document which guides practice when submitted to the appropriate committee/group for consideration and approval.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Clinical coding Procedure**		
	Is the title clear and unambiguous?	yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	yes	procedure
2.	**Rationale**		
	Are reasons for development of the document stated?	yes	
3.	**Development Process**		
	Are people involved in the development identified?		
	Has relevant expertise has been sought/used?	yes	
	Is there evidence of consultation with stakeholders and users?	no	
	Have any related documents or documents that are impacted by this change been identified and updated?		
4.	**Content**		
	Is the objective of the document clear?	yes	
	Is the target population clear and unambiguous?	yes	
	Are the intended outcomes described?	yes	
	Are the statements clear and unambiguous?	yes	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?		
	Are key references cited?	yes	
	Are supporting documents referenced?		
6.	**Training**		
	Have training needs been considered?	yes	
	Are training needs included in the document?	yes	
7.	**Implementation and monitoring**		

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	Does the document identify how it will be implemented and monitored?	yes	
8.	**Equality analysis**		
	Has an equality analysis been completed for the document?	yes	
	Have Equality and Diversity reviewed and approved the equality analysis?	Yes, previously	
9.	**Approval**		
	Does the document identify which committee/group will approve it?	yes	
Signature:		Theresa M Parks	