NHS
University Hospitals
Coventry and Warwickshire
NHS Trust

Clinical Coding Policy

eLibrary ID Reference No: *This id will be applied to all new Trust-wide CBRs by the Quality Department and will be retained throughout its life span.*	**GOV-POL-008-08**

Newly developed Trust-wide CBRs will be allocated an eLibrary reference number following Trust approval. Reviewed Trust-wide CBRs must retain the original eLibrary reference number.

The Quality department will progress all new, re-written and reviewed CBRs for final Trust approval.

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As a controlled Trust-wide CBR, this record should not be saved onto local or network drives but should always be accessed from eLibrary.

Summary of Trust-wide CBR: *(Brief summary of the Trust-wide Corporate Business Record)*	Outlines procedures, standards, development and training for clinical coders together with information requirements for clinical coding purposes
Purpose of Trust-wide CBR: *(Purpose of the Corporate Business Record)*	To ensure accurate and complete clinical coding by fully trained staff
Audience *(Who the CBR is intended for)*	Clinicians, Clinical Coders, Clinical Group Managers
Trust-wide CBR to be read in conjunction with:	N/A

(List overarching/underpinning strategies, policies and procedures – refer to CBR Evidence Summary)	
Relevance: *(State one of the following: Governance, Human Resource, Finance, Clinical, ICT, Health & Safety, Operational)*	Governance
Superseded Trust-wide CBRs (if applicable): *(Should this CBR completely override a previously approved Trust-wide CBR, please complete the 'Request for Removal of CBR' form and submit to Quality Dept – please refer to eLibrary and state full title and eLibrary reference number and the CBR will be removed from eLibrary)*	GOV-POL-008-08 V4.0

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Version	**Consulting & Endorsing Stakeholders, Committees/Meetings/Forums etc for this version only** *List **all** Consulting & Endorsing Stakeholders for this version, this can include direct consultation with individuals, Committees/Forums/Bodies/Groups, refer to guidance pack.*	**Date**
5.0	Clinical Coding Department supervisors	Feb 2018
5.0	Chief Medical Officer and Director of Quality	Feb 2018
5.0	Information Governance Committee	8 March 2018

Corporate Business Record Policy/Procedure Summary

Clinical Coding Policy

Purpose of CBR
This policy has been produced with the intention of promoting good practice and consistency of the Clinical Coding function within University Hospitals Coventry and Warwickshire NHS Foundation Trust

Description of vision of CBR
It has been designed to ensure, information produced during the coding process is accurate, timely and adheres to local and national policies whilst achieving national standards.

Who does CBR affect?
It is of relevance to the clinical coders, Trust clinicians, Group and ward managers.

Key Points of CBR
Clinical coders depend on clear, accurate information in order to produce a true picture of hospital activity and the care given by clinicians. Coded data is important for a number of reasons, including:

- Monitoring provision of health services across the UK
- Research and monitoring of health trends
- NHS financial planning and payment
- Clinical governance
- Mortality performance

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1.0 SCOPE

1.1 This framework document has been published with the intention of promoting good practice and consistency of information produced during the clinical coding process at University Hospitals Coventry and Warwickshire NHS Trust. It has been designed to ensure that the coding process is performed timely, accurately and consistently. In addition, the coded information adheres to the local and national policies and achieves national standards. It is of relevance to the clinical coders, Trust clinicians, Group and ward managers.

2.0 INTRODUCTION

2.1 Clinical Coding definition

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 a coded format using Classification systems which are nationally and internationally recognised to support both statistical and clinical uses.

Clinical coders depend on clear, accurate information in order to produce a true picture of hospital activity and the care given by clinicians. Coded data is important for a number of reasons, including:

- Monitoring provision of health services across the UK
- Research and monitoring of health trends
- NHS financial planning and payment

- Clinical governance
- Mortality performance

2.2 The Clinical Coding department is under the managerial remit of the Director of Performance and Programme Management Office.

2.3 All procedures involved in the capture of information for clinical coding purposes are clearly defined in this Policy to ensure compliance and clarification of individual coding processes.

2.4 All quality assurance procedures for the clinical coding department are detailed in this document including audit and data quality measures, to ensure continual improvements in the standard and quality of coded data in the Trust.

All changes to clinical coding policies and/or procedures are detailed in this document in the appropriate manner to ensure all contributors are in agreement with the current practice. Any alterations to clinical coding practice have change and implementation dates recorded within the local policy folder held in the clinical coding department, and comply with national standards and classification rules and conventions.

2.5 Standard training plans for members of the clinical coding department are clearly defined in this document.

2.6 Details of communication arrangements are detailed to ensure effective dissemination of information regarding coding, resolutions to queries and changes in coding practice to all coding staff.

2.7 All confidentiality and security issues encountered during the coding process are detailed in this document to ensure adherence to local and national policies, and have been agreed by the person responsible for the coding staff.

3.0 STATEMENT OF INTENT

3.1 Clinical Coding to adhere to the national standards, classification rules and conventions as set out in the WHO ICD-10 Volumes 1-3 – Fifth edition, Operations and Interventions (OPCS),National Clinical Coding Standards ICD-10, OPCS – 4,High Cost Drugs list, Chemotherapy Regimen List including publications of Coding clinic, and any subsequent amendments and updates as mandated nationally.

3.2 To input onto the Trust hospital computer system, iPM, and any subsequent changes of Patient Administration System, accurate and complete coded information within the designated time scales to support the information requirements and commissioning of the Trust.

3.3 To ensure continual improvement of clinical coded information within the Trust through systematic audit and quality assurance procedures

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

3.5 To ensure all staff are aware of the Trust's security and confidentiality policies when using patient identifiable information.

4.0 DETAILS OF POLICY

4.1 **Clinical Coding Procedures**

Source Document

The patient's full health record will be the primary source document for clinical coding this includes information from hospital clinical systems – Clinical Results Reporting Systems (CRRS), MOSAIQ, BADGER, Evolution, K95 Renal system, DENDRITE, Ward books. Clinical management as clinically documented in the

relevant hospital spell will be used for coding purposes. Clinical coders will attempt to capture all comorbid conditions within the source document. Every effort should be made to find as much information relating to the episode as possible.

Point of Coding

The coding process will be completed as close to patient discharge as possible. This should be primarily undertaken from the coding office based at UHCW and Rugby.

Time Scales

The team will aim to code all episodes within four working days of discharge. This will be monitored by the Team supervisor and Deputy coding Manager on a daily monitoring report. Should problems arise relating to missed deadlines these will be addressed accordingly by the Deputy Coding Manager.

Clinical coding activity will be completed by hospital spell in line with Trust internal and external deadlines. In the majority of cases the clinical information will be extracted by the clinical coder from case notes held on the ward. It is best practice that the same coder extracts the information, translates it into codes and inputs to the PAS for a particular spell.

The health record can be held electronically or on paper or a combination of both. The coder can access information from CRRS and other systems or databases as appropriate to supplement the information they have extracted.

A fully completed e-discharge should be available at the point of discharge which the coder can access as an electronic record on CRRS. The discharge summary will give details of all relevant comorbidities as well as identifying the primary diagnosis and any operative and post-operative details. The standards for the clinical structure and content of patient records can be downloaded from the Royal College of Physicians website. Operative procedures will be recorded in the case notes; this may be printed or handwritten. Some will also be available on

CRRS.

It is the clinician's responsibility to ensure that full and accurate information including primary diagnosis, acute conditions and any chronic comorbidities, detail of any investigations, procedures and treatments undertaken and any post-operative complications or conditions is available to the clinical coding department in relation to each episode for which they are clinically responsible.

In situations where coding is completed solely from electronic systems or databases rather than from the full case records, it still remains the responsibility of the clinician to provide all the clinical information required to complete coding accurately and in depth. It would also be the responsibility of the Group and ward managers to ensure a process has been agreed with the Coding Department so coders have access to all necessary information and systems.

Where there needs to be agreement with clinicians regarding specific clinical terminology or the coding of specific procedures which otherwise would not be able to be coded, these will be documented as Local Policies. They will be held within the Coding Department as hard copies and on the Clinical Coders shared drive. They will be signed off by the Clinical Coding Manager and either the relevant Clinical Director or the Medical Director. Each local policy will be signed as seen by every member of the clinical coding team and their coding books annotated accordingly. Local Policies will be reviewed on a yearly basis, and coders will annotate their books accordingly to ensure consistent coding across the team.

Case notes that were missing from the ward at the time of information extraction will be tracked down so that, wherever possible, the clinical information for coding is taken from the full set of notes.

To ensure the Coding Department maintains a robust coding knowledge and skills base, coders will be expected to rotate to routinely code other specialties at regular intervals.

4.2 Validation of Clinical Coding Information

Clinical Coding Audit

The coding department will comply with the Department of Health's Information Governance (IG) Toolkit requirement 505 *"An audit of clinical coding, based on national standards, has been undertaken by a Clinical Classifications Service (CCS) approved clinical coding auditor within the last 12 months"*.

The minimum requirement of IG Toolkit 505 is that an annual audit of a minimum of 200 FCEs is completed by an HSCIC Approved Clinical Coding Auditor. The audit can be carried out either as one whole or as smaller audits throughout the twelve months in question.

- External Audits: February 2018
- Internal Audits:
  Speciality audits to streamline Quality of Clinical documentation and Clinical coding: Clinical Coding Manager - Trainee Auditor. The aim of the programme is to ensure coding accuracy and depth is improved and maintained by reinforcement of learning and clinician engagement.
- Audit of individual coder's performance on a monthly basis with updates to the team - Trainee Auditor. The aim of the programme is to ensure coding accuracy and depth is improved on an individual coder capacity and consistently maintained across the team.

4.3 Regular Data Quality Monitoring

Monthly/Weekly coding reports programmed by Coding Manager based on Healthcare resource groupings, ICD -10 and OPCS codes will be generated by Trust IT systems. The Coding Data Quality Lead and Deputy Manager will

address the coding errors identified accordingly to the team. This will be followed by correction, validation and staff training.

4.4 Implementing Changes

The Coding Manager has responsibility for the implementation of any change of procedure. Staff will be informed at regular staff meetings and this document will be amended, dated and signed accordingly. Where appropriate, each member of the team will be given a printed copy of these changes.

The department will respond positively to all ad hoc requests for audits which may necessitate adjustments to the audit programme schedule.

Coding completed by trainee coders will be checked by a member of the clinical coding leadership team until they are satisfied with their coding accuracy and depth for each specialty undertaken.

Whilst coding, if the clinical coders find any information on iPM that they deem to be incorrect, i.e. incorrect clinician transfers, they will notify the appropriate department for correction.

4.5 Quality Assurance

Quality of coding is measured internally in the following ways:

- Internal and External Audits
- There is a Trust proposed plan to implement a Clinical Encoder and its applications within 6 months that will improve quality and efficiency of clinical coding.

4.6 Input from medical staff

The coding team will make every effort to discuss appropriate coding with the clinician involved. For complex cases notes will be returned to the clinician by the coder for their assistance.

Validation of coded data between clinician and coder takes place for Stroke, Neurology, Renal and Haematology discharges.

4.7 Variations from Coding Standards

In the event a variation from national standards in coding rules or conventions is requested then the following will apply:

- The requester will discuss the local variation required with the Clinical Coding Manager.
- Agreement will be reached which does not conflict with national standards. All locally agreed codes will be documented as local agreements and reviewed annually.
- These will be authorised by the Medical Director and the Clinical Coding Manager.
- The Clinical Coding Manager will then be responsible for ensuring the coding team are aware of and have signed the agreement.

4.8 Updating National clinical coding standards

The coding team are responsible for updating their own manuals in line with receipt of amendments and coding clinics. This should be done within one week of receipt of the relevant document.

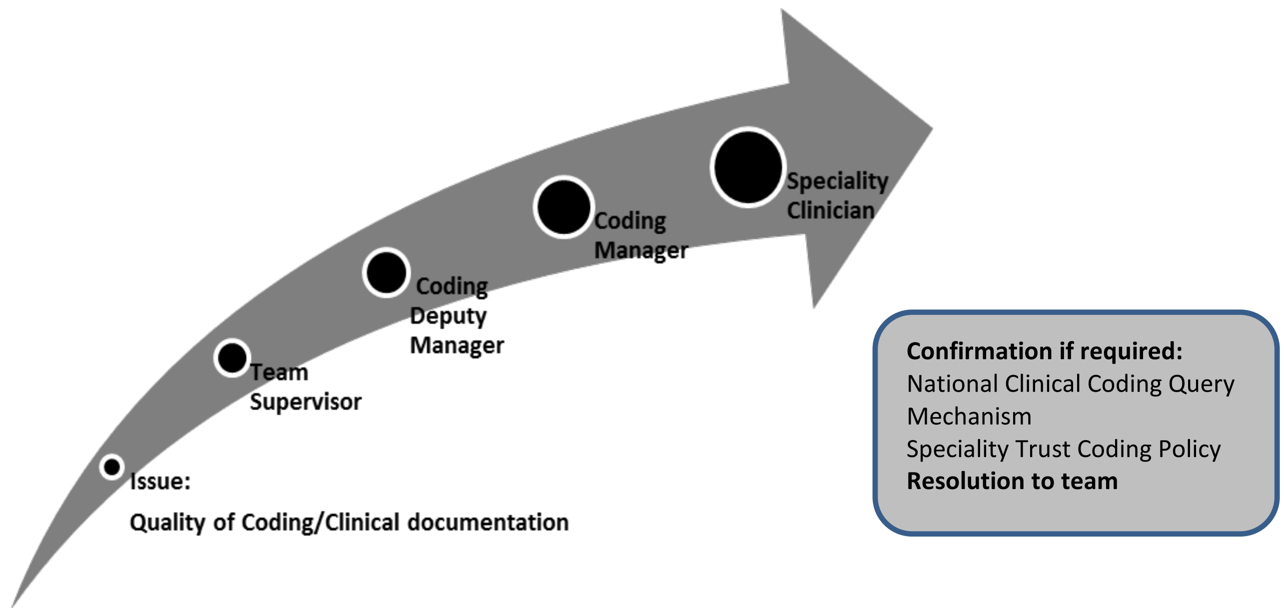
For larger updates such as classification updates, the coding team must update their new books within three months, ensuring that they follow the 4 step process and current coding standards for anything previously noted in their books

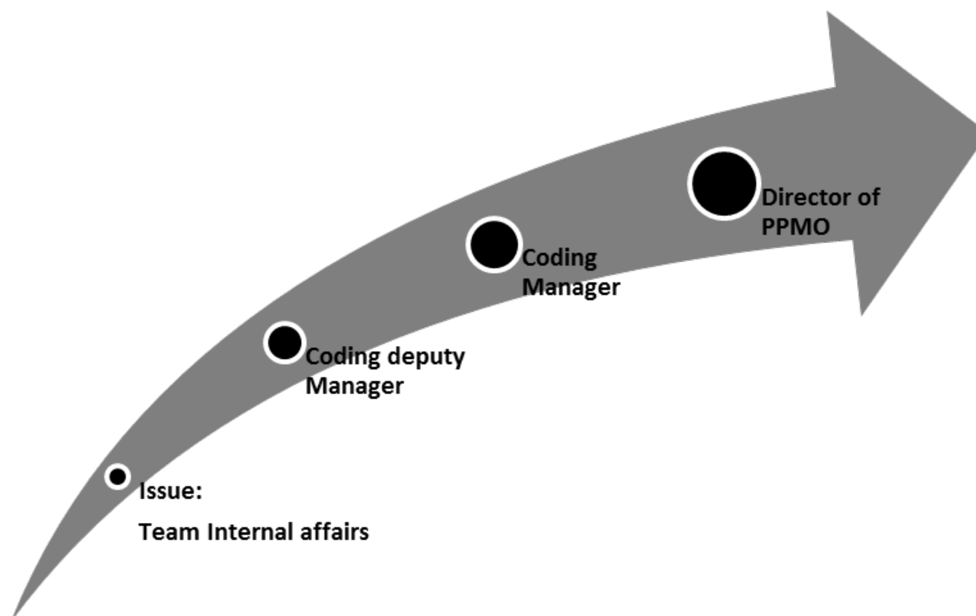
4.9 Communication in Clinical Coding

To endorse consistency and accuracy of coded information the following steps are in place:

- Clinical Coding Instruction manuals ICD-10 and OPCS – 4.9, High Cost drugs list, Chemotherapy regimen list, Coding Clinic and NHS Connecting for Health's Clinical Coding Guidelines are used.
- Standardised Coder - Clinician pathway for every speciality is reinforced in the department by Coding Manager.
- Coders to liaise with speciality clinician for clarification of clinical documentation. Clinical Coders must ensure that the advice given does not contravene the rules and conventions of the classifications or national standards. Standards agreed with clinicians are documented appropriately.
- Refer to Team supervisor – Deputy Manager – Coding Manager to determine whether the query can be resolved internally.
- Referring any query to the National Clinical Coding Query Mechanism including completion of the relevant query proforma information if appropriate.
- Distribute the resolution to the team
- Any Data quality issues – team to liaise with Trust Data Quality Manager.

- **Problem escalation pathways**





Regular meetings will be held within the Coding Department. These will be used as a forum to disseminate new information and any changes to coding policy, update on any changes to coding guidance/standards such as coding clinics, and ensure alignment to the strategic direction. They may include presentations from

the leadership team or clinicians giving talks on specific topics. Notes of the meetings or presentation slides will be made available on the shared drive.

Clinical coders will work closely with clinicians and other members of the specialty team to ensure that the Trust's activity is accurately and completely captured. This may take the form of regular meetings to validate coding of individual cases, ad hoc meetings to discuss best practice coding for complex procedures, attendance at specialty team meetings or ad hoc emails or verbal discussions to clarify general or specific coding queries.

The clinical coding manager will monitor the efficacy of any departmental or specialty processes and will suggest improvements when appropriate.

4.10 Clinical Information Query Resolution

In the event of a need for clarification of clinical information, the clinical coder will make contact with the appropriate clinician. If there is no response the coder will inform a member of the clinical coding leadership team who will attempt to resolve the situation, if they are unable to do so then the request will be escalated to the lead clinician or group manager for resolution. If advice is given that contravenes national standards then a query will be raised with the classifications service to seek guidance.

To ensure an appropriate audit trail is maintained, all clarification of clinical information should be documented, and signed by the clinician if necessary. A copy of email correspondence should be filed in the coding department for audit reference if necessary.

4.11 New Services and Procedures

In the event of new services and/or procedures being initiated which are likely to impact on the activity of the coding department; it is the responsibility of the

group manager to make contact with the coding department in order to agree an efficient process for data collection in relation to clinical coding.

4.12 Transfers/Discharges to Other Hospitals

When it is planned to move a patient to a hospital outside the Trust, every effort must be made by all staff involved in the process to ensure that the case notes are copied as per the Standards for the Contents of Health Records policy in order that the UHCW notes are retained on site allowing the coding department access to relevant information as per normal processes.

4.13 Coding of Deceased Patients

A designated member of the clinical coding team will visit the Bereavement Office daily to view the case records of deceased patients. Checks will be made to ensure all records are seen. The coding supervisory team will be contacted to view the records of any patients whose case notes cannot be retained until their next visit.

If there is an alert from an external organisation concerning a deceased patient, the coding leadership team will prepare an information sheet detailing the clinical coding entered for the patient, review the case notes of the patient in order to note and record any errors, and make the information available to the clinician reviewing the case records.

4.14 Clinical Coding Department structure and Training

In accordance with IG Toolkit 510 *“Training programmes for clinical coding staff entering coded clinical data are comprehensive and conform to national clinical coding standards”* all Clinical Coders will undertake the mandatory Clinical Coding Refresher Course every three years. The Refresher will be conducted by an HSCIC Approved Experienced Clinical Coding Trainer using approved training materials.

- The Deputy Manager will provide In-house training sessions on a weekly basis. This is open for all coders but primarily directed towards Trainee coders in preparation for their ACC qualifications.
- The Data quality lead will ensure that the team attends all training as necessary.
- The training requirements are as follows:

    - Clinical Coding Foundation workshop attendance / in- house weekly training sessions within six months of appointment for all trainee coders.
    - Clinical Coding Refresher Training Course attendance every 3 years for experienced clinical coding staff.
    - Regular specialist training courses attendance wherever available.
    - Relevant computer training courses attendance to keep their IT skills up-to date.
    - Other relevant training courses attendance in line with trust policies (e.g. health and safety, fire training, security and confidentiality etc.).
    - Coding data quality errors as reported on hospital IT systems, Data Quality Lead to ensure and confirm all corrections are made within 3 working days.

- In addition and on appointment, all trainee clinical coders will take part in an internal Introduction to Clinical Coding Workshop prior to commencing a Clinical Coding Standards Course within six months of joining the department. The Standards Course will be conducted by and HSCIC Approved Clinical Coding Trainer using approved training materials.

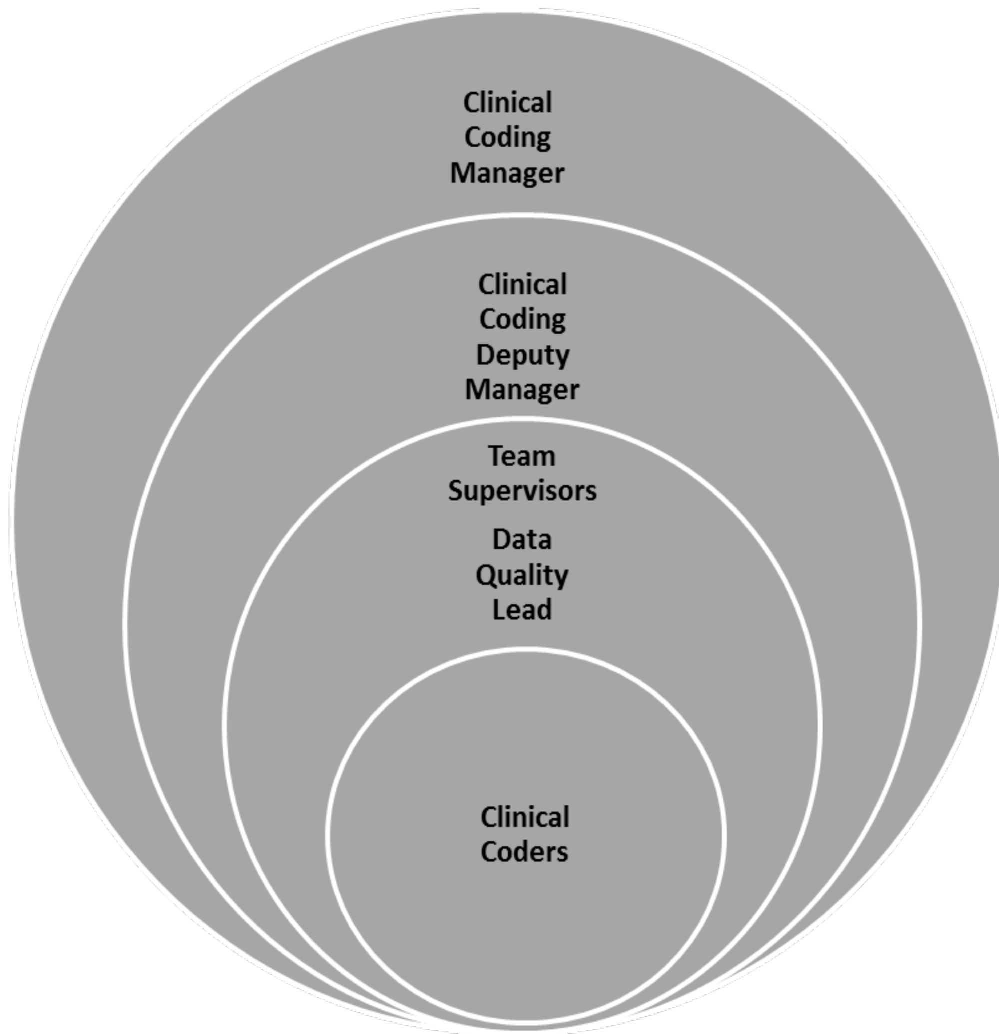
- One year post-Standards Course completion trainee coders will undertake an internal assessment and audit of their work to attain

Clinical Coder status. Expected accuracy levels of 85% practical coding and 60% theory knowledge is required to progress.

- All coders are expected to work towards the National Clinical Coding Qualification (NCCQ) to gain Accredited Clinical Coder (ACC) status. Registration for the national practical and theory examinations would generally be two years post-Standards Course completion. Application for the NCCQ examination will only be approved once completion of in house assessments achieving 90% practical coding and 60% theory knowledge. All necessary support would be provided including attendance at revision courses and study leave given according to local policy.

- The Trust will ensure continued professional development and support improvement in the team's knowledge and skills base by releasing coders to attend specialty-based courses and workshops.

- Career progression will be supported for coders who express a desire to undertake assessment for either the Clinical Coding Auditor Programme of Clinical Coding Trainer Programme.



4.15 Annual Appraisals

Individual performance appraisals and personal development plans will be undertaken annually in line with the trust policies.

4.16 Guidelines for Clinicians

It is the responsibility of the clinical staff at ward level to ensure that a discharge summary is completed for every patient on discharge. This includes patients who

are being transferred to another facility outside of this trust and deceased patients.

They should attempt to ensure that the discharge summary gives clear and specific information relating to the following:

- Primary diagnosis
- Secondary diagnosis
- Primary procedures (with dates)
- Secondary procedures (with dates)
- Co-Morbidities
- Complications occurring at the current episode of care
- Other factors that may have delayed the patients discharge from hospital

Clinical staff can also assist the clinical coding staff in abstraction of relevant information and assignment of correct codes, by supplying advice and clarification on patient diagnosis and treatment when this is requested.

All clinicians will be given a copy of the Trust's "Guidelines for Clinicians" and compliance with the guidelines will be monitored. A copy of the key points of the guidance will be issued to junior doctors at their induction. Specialty specific guidance will be produced for departments when requested.

Tips for Clinicians to help coders:

- Coders are not Clinicians! – The National Training Programme for Coders does not include training / introduction to any Medical /Surgical specialities in any form. The coders are only trained on basic anatomy in their foundation course.
- Clinicians can assist the process of clinical coding in numerous ways, some of which are summarised below.
- Clear and legible documentation on patient notes and discharge summaries.

- Communication of any transfers of care to ward administrative staff. This includes when patients go for an investigation or procedure performed by another clinical team.
- Clear record of all diagnoses, procedures (including those done on the ward) and all co-morbidities in the notes.
- For injuries - note MOI; for overdoses, note drug; and for infections, note organism.
- Include details of all diagnoses and procedures on discharge summaries and TTO's
- If the Primary diagnosis is uncertain, please make sure you detail the main symptoms in the notes or discharge summary.
- Any 'query' diagnosis e.g. likely, maybe, possibly, or diagnoses preceded by a '?' cannot be coded by clinical coding staff. We are able to code a 'probable' diagnosis. If histology is awaited for a definitive diagnosis, please note this down.
- Avoid the use of new or ambiguous abbreviations if possible (e.g. 'M.S.' for a coder could mean multiple sclerosis or mitral stenosis). Clinical coders are not allowed to make any clinical inferences.
- Timeliness of Discharge summaries is vital. Coding staff have strict trust deadlines to meet and delays can have huge implications for the trust.
- Discharge summaries should be complete within 24 hours of discharge to allow for 48 hour post discharge coding completion.

Any queries relating to coding please do not hesitate to contact Coding Manager.

5.0 DUTIES / RESPONSIBILITIES

5.1 The Chief workforce information officer has overall responsibility for the Clinical Coding department.

5.2 The Director of PPMO has strategic responsibility for the clinical coding department.

5.3 The Clinical Coding Manager has day to day responsibility for the strategic direction of the department, ensuring that staff are compliant with trust values, national coding standards and any locally agreed policies.

5.4 The Clinical Coding Deputy Manager has day to day responsibility for the clinical coding team ensuring that deadlines are met and policies are understood and applied by all coding staff. Quality reviews and audits take place regularly to ensure compliance and all staff receives appropriate training to support this.

5.5 The Clinical Coding Data Quality lead is responsible for the validation of coded data, identification and correction of errors and staff training arising from the validation process.

5.6 The Clinical Coding Auditor is responsible for ensuring that internal audits are taking place at regular intervals and if required an external audit is commissioned in order to meet information governance requirements.

5.7 The Clinical Coding Supervisors are Accredited Clinical Coders and are responsible throughout their day to day work for ensuring members of the coding team fulfil the requirements of the policy.

5.8 Clinical Coders are involved in the allocation of codes to describe diagnosis and procedures. They all have a responsibility to ensure that these are accurate and conform to National Clinical Coding Standards. Clinical coders also take responsibility for ensuring they are kept up to date with guidance supplied by

HSCIC and maintain their coding reference books accordingly.

5.9 Clinicians will work with the Clinical Coding Department to develop and maintain robust channels of communication respond promptly and positively to clinical information queries from the clinical coders and discuss the coding of new procedures/treatments with the Coding Department in order to agree appropriate coding.

5.10 Group managers will ensure that the need to fully and accurately code patient attendances is considered when changes are planned to services, ward configurations or processes and that the Coding Department is involved in any discussions. They will
facilitate clinical engagement between the Coding Department and the clinicians within their specialty teams.

5.11 Ward managers will ensure admissions and discharges to their ward areas are appropriately recorded onto the Patient Administration System (PAS) in a timely manner, and will ensure that clinical information is appropriately filed in patient case notes and made readily available to clinical coders within 48 hours of discharge.

6.0 DISSEMINATION AND IMPLEMENTATION

6.1The policy must be disseminated to all medical directors, consultants, modern matrons, ward managers and clinical coding staff. It will be available on the trust intranet site in the master policy library.

7.0 TRAINING

7.1 There are no training requirements for implementation of the policy. National requirements for the training and development of clinical coders exist and will be complied with.

8.0 MONITORING COMPLIANCE

8.1 Monitoring Table

Aspect of compliance or effectiveness being monitored	Monitoring method (ie regular audits/reviews)	Individual/ department responsible for the monitoring	Frequency of the monitoring activity (ie Monthly/ Annually)	Group / committee which will receive the findings / monitoring report	Group / committee / individual responsible for ensuring that the actions are completed
Accuracy and depth of coding	Internal and external audit	Clinical Coding	Small internal audits monthly, external audit at least once per year.	Quality Governance Committee	Clinical Coding Manager
Availability of good quality clinical information	Internal and external audit with participation of clinicians where appropriate	Clinical coding/ medical directors	As above	Quality Governance Committee	Clinical Coding Manager/ Specialty Medical Director
Compliance with IG Toolkit coding requirements	Completion of the IG Toolkit	Clinical Coding	Annual	Information Governance Committee	Clinical Coding Manager

9.0 STAFF COMPLIANCE STATEMENT

All staff must comply with this Trust-wide Corporate Business Record and failure to do so may be considered a disciplinary matter leading to action being taken under the Trust-s Disciplinary Procedure. Actions which constitute breach of confidence, fraud, misuse of NHS resources or illegal activity will be treated as serious misconduct and may result in dismissal from employment and may in addition lead to other legal action against the individual/s concerned.

A copy of the Trust’s Disciplinary Procedure is available from eLibrary.

10.0 EQUALITY & DIVERSITY STATEMENT

Throughout its activities, the Trust will seek to treat all people equally and fairly. This includes those seeking and using the services, employees and potential employees. No-one will receive less favourable treatment on the grounds of sex/gender (including Trans People), disability, marital status, race/colour/ethnicity/nationality, sexual orientation, age, social status, their trade union activities, religion/beliefs or caring responsibilities nor will they be disadvantaged by conditions or requirements which cannot be shown to be justifiable. All staff, whether part time, full-time, temporary, job share or volunteer; service users and partners will be treated fairly and with dignity and respect.

11.0 ETHICAL CONSIDERATIONS

The Trust recognises its obligations to maintain high ethical standards across the organisation and seeks to achieve this by raising awareness of potential or actual ethical issues through the CBR consultation and approval process. Authors of CBRs are therefore encouraged to liaise with the Trust's Clinical Ethics Forum to seek input where necessary.

12.0 DEFINITIONS

ICD-10: International Statistical Classification of Diseases and Related Health Problems 10th Revision.

OPCS 4: Office of Population Census and Surveys Classification of Interventions and Procedures version 4.

HSCIC: Health and Social Care Information Centre

PBR : Payment by Results

PPMO: Performance and Project Management Office

PAS : Patient Administration System

13.0 REFERENCES AND BIBLIOGRAPHY

13.1Standards for the clinical structure and content of patient records, Healthcare record standards https://www.rcplondon.ac.uk/projects/outputs/standards-clinical-structure-and-content-patient-records

14.0 UHCW ASSOCIATED RECORDS

14.1 Standards for the Contents of Health Records policy.

15.0 APPENDICES