Shropshire Community Health NHS Trust

Policies, Procedures, Guidelines and Protocols

Document Details	
Title	Clinical Coding
Trust Ref No	2550
Local Ref (optional)	
Main points the document covers	Process of clinical coding and associated actions, requirements, considerations and training
Who is the document aimed at?	Services responsible for clinical coding activity
Author	Clinical Services Manager – Planned Care
Approval process	
Line Manager approval prior to consultation	Alastair Campbell
Who has been consulted in the development of this policy?	SaTH Clinical Coding Colleagues
Approved by (Group/Committee)	DSPAG
Ratified by (Committee/Director)	Director of Governance
Date of Ratification	23 June 2026
Initial Equality Impact Screening	
Full Equality Impact Assessment	
Lead Director	Clare Horsfield
Category	
Subcategory (If Applicable)	
Next Review date	01 June 2029
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Who the policy will be distributed to	Senior Managers ☐ Line Manager ☐ All ☒
Method	Staff Zone ☒ Public Website ☐

		Other ☐ Specify:
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Required by CQC		
Other		
Amendments History		
No	Date	Amendment (include version?)
1	28.01.26	Draft 1
2	22.04.26	Draft 2
3		
4		
5		

Contents

1 Policy Statement

Shropshire Community Health NHS Trust (hereafter the Trust) is committed to ensuring that that patient experiences are consistently and effectively captured, understood, and used to improve the quality of care provided by our NHS Trust. This policy is intended to promote good practice and consistency of information produced during the clinical coding process for all admitted patient care and is for use by all Trust staff involved in the clinical coding of patient activities.

2 Quality Equality Impact Assessment

Quality and Equality Impact Assessment (QEIA) Screening Checklist

Use the checklist below to establish if there are any negative characteristics that need to be addressed and a full QEIA completed.

QUALITY AND EQUALITY IMPACT ASSESSMENT (SCREENING)			
What impact will this policy have on the following groups in terms of impact on service, delivery, patients and staff. Explain below: *This section must be completed*			
Protected Characteristic	**Positive/ Negative**	**None (why)**	**Actions to be mitigated**
Sex		X	
Gender Reassignment		X	
Age		X	
Disability		X	
Race & Ethnicity		X	
Sexual Orientation		X	
Religion or Belief (or No Belief)		X	
Pregnancy & Maternity		X	
Marriage & Civil Partnership		X	
CORE20PLUS5 **Adults / CYP / Both** (please highlight appropriate)		X	There is no negative direct impact of the policy beyond clinical coding providing data for future service planning via commissioners.

EIA Approval	**Role**	**Name**	**Date**
	Policy Owner		
	Policy Author		

3 Documents, Relationships and Stakeholders

DOCUMENT	OWNER	VERSION
International Classification of Diseases, Injuries and Causes of Death. Volume 1 Tabular List	World Health Organisation	Version 10 2016 Edition
International Classifications of Diseases, Injuries and Causes of Death. Volume 3. Alphabetical Index	World Health Organisation	Version 10 2016 Edition
OPCS Classification of Interventions and Procedure	Health and Social Care Information Centre, Clinical Classification Service	Version 4.10 (2023)
National Clinical Coding Standards OPCS-4 (2026)	NHS Classification Service	OPCS Version 4.11 (2026)
National Clinical Coding Standards ICD-10 5th Edition (2025)	Health & Social Care Information Centre	ICD-10 5th Edition 2025
Basic Anatomy and Physiology Instruction Manual	NHS Classifications Service	April 2017
Chemotherapy Regimens and Clinical Coding Standards and Guidance OPCS-4	Clinical Classification Service	April 2017

- Records Management and Security Policy Records Management and Security Policy
- Information Quality Assurance Policy Information Quality Assurance Policy

4 Purpose

The purpose of this policy is to establish clear and consistent standards for clinical coding, ensuring the accurate and timely representation of patient care episodes.

High-quality clinical coding supports clinical audit, research, and the effective allocation of resources, and underpins informed decision-making at both local and national levels.

Accurate coding is fundamental to effective service planning and ensures consistency and comparability of health information across the NHS

This policy aims to do this by:

- Ensuring that all clinical activity is coded using nationally approved standards, including ICD-10, OPCS-4 and SNOMED CT and that coders apply these rules consistently across all Trust electronic patient record systems e.g. RiO, Careflow)
- Supporting the production of accurate, complete and timely coded data required by commissioning, statutory datasets and internal reporting.
- Set out expectations for documentation quality, coding policies, audit requirements and data quality assurance activities
- Ensure all staff involved in the clinical coding process receive appropriate training and maintain compliance with information governance, confidentiality and data protection requirements
- Promote continual improvement in coding accuracy through regular audit, feedback and quality assurance processes.

5 Scope

This policy applies to all clinical coding activity undertaken within Shropshire Community Health NHS Trust. It covers the coding of all clinical information for all relevant patient activity, including:

- Inpatient episodes within Community Hospital Wards
- Day Surgery Unit Activity at Bridgnorth Hospital
- Dental Services activity recorded through CareFlow EPR
- Any additional services where clinical activity requires National classification coding

6 Applicability

Policies can be found in the Trust's Document Library on the Public Website and the Staff Zone SCHT Staff Zone This document should be read in conjunction with other policies, such as:

- Records Management and Security Policy Records Management and Security Policy
- Information Quality Assurance Policy Information Quality Assurance Policy

This policy applies to:

- Employed staff (including Bank staff)
- Locums
- Agency
- Temporary and fixed term contracts
- Third party suppliers

7 Responsibilities

7.1 **Clinical Coders:** To apply codes accurately, adhering to the 4 step coding process, maintain confidentiality, and participate in all ongoing training.

7.2 **Healthcare Professionals:** To provide clear, comprehensive, and timely clinical documentation.

7.3 **Management:** To support clinical coder training, ensure compliance, and facilitate regular audits.

7.4 **Informatics**: To provide reportable data that is required for national benchmarking, including submission via appropriate national datasets and to assist colleagues in reviewing assurance with compliance

7.5 **Information Governance**: To support the clinical coding and operational teams with audits as required

8 Governance and Compliance

Robust governance arrangements are essential to ensure that clinical coding complies with national guidance and established frameworks.
Oversight is typically provided by designated Operational Managers, who are responsible for monitoring adherence to relevant policies, procedures, and coding standards.

Regular audits and reviews are undertaken, informed by guidance from NHS Digital and other relevant regulatory bodies, to assure the accuracy, consistency, and quality of clinical coding practices.

Compliance is maintained through a programme of ongoing training for clinical coding staff, the implementation of robust quality assurance processes, and the use of up-to-date national coding manuals and guidance.

The governance function reports regularly to the appropriate Board-level forum or Clinical Governance Committee, ensuring clear accountability and providing assurance that any discrepancies or risks are identified and addressed promptly.

This governance structure supports continuous improvement, ensures alignment with national expectations, and safeguards the integrity and reliability of clinical coding across the organisation.

9 Delivery

Clinical Coding Process

A designated consultant or clinical staff member holds responsibility for the patient's care. This consultant/clinical staff member is responsible for ensuring that the patient's medical records accurately and fully document all diagnoses, procedures, and co-morbidities.

These records are then used by the clinical coder to produce the most complete and accurate coded record of the patient's hospital stay.

Outpatient coding

Non-admitted activity is recorded within RiO, these are specific procedures that are undertaken within an outpatient setting and entered on to the system by the medical secretaries.

Coders process

See Appendix 1

10 Data Protection and Confidentiality

10.1. Patients, service users and staff will be informed about how information is processed i.e. collection, recording, organisation, storage, adaptation, retrieval, consultation, use, disclosure, and erasure. Through Privacy notices that will be published on the public website and updated regularly.

10.2. Confidentiality will be maintained and applied in accordance with national and local policies and legislation. The Trust will comply with the Department of Health (DH) 2003 publication Confidentiality: NHS Code of Practice

10.3. Trust staff are aware of the data protection principles and will process information in a lawful way and in accordance with the legislation. Further

information can be found on the Information Commissioner's Office website A guide to the data protection principles | ICO

10.4. All information will be protected and held securely using technical and organisational measures that comply with the data protection legislation.

10.5. Records will be held in accordance with the NHS Records Management Code of Practice.

10.6 Staff will complete mandatory data protection training and security training.

11 Cyber Security

The Trust is committed to ensuring that all digital systems, clinical and non-clinical, are protected to the required standards and that information is safe and secure and that Users are authorised to access information appropriately. All staff receive training to access and administer digital systems. The governance team, in conjunction with digital services, raise awareness across the organisation on cyber security and being vigilant.

There are robust processes in place through the implementation of the Information Risk Policy to manage system security and risk. An Information Asset Administrator (IAO) and Information Asset Administrator (IAA) is assigned to each information asset and provides assurance to the Senior Information Risk Owner (SIRO) that digital systems are safe and secure.

12 Training, Learning and Awareness

Complete, accurate, and high-quality coded clinical data enables Trust managers, government statisticians, and clinicians to access information that is relevant, reliable, and meaningful for their respective needs, supporting informed decision-making.

The effectiveness of achieving this across all purposes is dependent upon clinical coding personnel being appropriately trained in the rules, standards, and conventions of the national classifications ICD-10 and OPCS-4.

This level of training enables coders to develop a high standard of expertise, ensuring consistency, accuracy, and integrity within the Trust's clinical coding output.

Internal Trust Induction

1. All new staff to attend a comprehensive Induction training program as part of the Trust Policy and ongoing mandatory statutory training including fire lectures, Diversity, Confidentiality Training with updates for established staff currently held every two years.

2. Attendance at relevant computer training course to update IT skills and to reinforce Information Health objectives.

Clinical Coding Training

Clinical coders are trained to the national standards and the rules and conventions of ICD-10 and OPCS-4 to create expertise and awareness of the importance and eventual use of the data.

Trust Clinical Coders attend all training as necessary. This is provided externally by NHS Classifications Service Approved Trainers using up to date national standard training materials.

Staff training records are kept electronically by Clinical Coder's line manager. Training programme as follows:

- Attendance on the Introduction/Foundation to Clinical Coding Training Course within six months of appointment for all new staff
- All new staff to receive internal clinical coding training and mentoring
- Attendance on the Clinical Coding refresher Training Course every three years for experienced clinical coding staff
- Attendance on regular specialist training courses wherever available or when required

13 Communication, Implementation and Dissemination

13.1 Those with key responsibilities set out in this document will be responsible for ensuring that this policy is implemented and adhered to.

13.2. The policy will be disseminated across the Trust through a variety of mechanisms, including website, staff zone (intranet), meeting agendas, newsletters and briefings.

13.3 Awareness and communication tools will be used to ensure that staff, patients, services users and others are aware of this document through the Trust's newsletter, email, operational and team meeting agenda team/department meeting agendas, patient and carer forums.

13.4 A communications plan will be in place annually to raise awareness about the delivery of this policy.

14 Review and maintenance

14.1. This policy will be reviewed in accordance with the Trust's Policy Review and Ratification Framework

14.2. This Policy will be reviewed every three years or in response to significant changes due to variations of law and/or changes to organisational or technical infrastructure.

15 Monitoring Compliance

15.1. The governance team will undertake audits to assess the effectiveness of this policy.
15.2. Non-compliance risks and issues will be handled through the risk management process.

16 Contact, Advice and Guidance

16.1 Any questions about this policy should be directed to the Clinical Services Manager for Planned Care.

16.2 Contact details for services included in this policy here: Home | Shropshire Community Health NHS Trust

16.3 The governance team will provide professional and expert advice and guidance to patients, service users and staff with regards services set out in this policy.

17 Appendices

Include specific content that is in addition to the policy statements, such as processes and procedures, useful diagrams, further clarity.

16.1 Appendix 1
16.2 Appendix 2

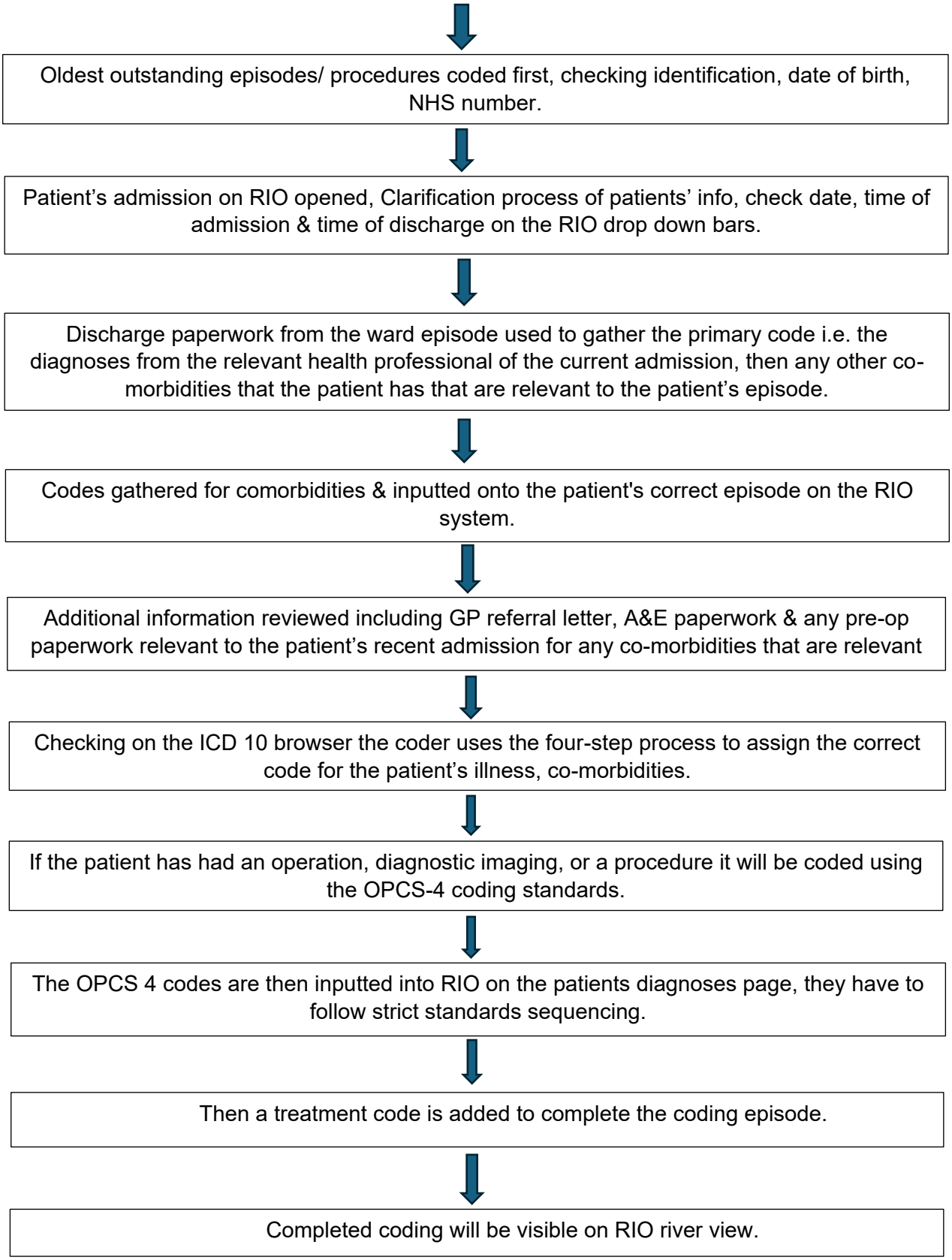
Version control

Version	Date	Author	Changes Made	Remarks

Appendix 1

Important note; staff should refer to any specific documented processes within other services such as dental.

Daily new Uncoded episodes / procedures sheets produced via the informatics data warehouse


Oldest outstanding episodes/ procedures coded first, checking identification, date of birth, NHS number.
Patient's admission on RIO opened, Clarification process of patients' info, check date, time of admission & time of discharge on the RIO drop down bars.
Discharge paperwork from the ward episode used to gather the primary code i.e. the diagnoses from the relevant health professional of the current admission, then any other co-morbidities that the patient has that are relevant to the patient's episode.
Codes gathered for comorbidities & inputted onto the patient's correct episode on the RIO system.
Additional information reviewed including GP referral letter, A&E paperwork & any pre-op paperwork relevant to the patient's recent admission for any co-morbidities that are relevant
Checking on the ICD 10 browser the coder uses the four-step process to assign the correct code for the patient's illness, co-morbidities.
If the patient has had an operation, diagnostic imaging, or a procedure it will be coded using the OPCS-4 coding standards.
The OPCS 4 codes are then inputted into RIO on the patients diagnoses page, they have to follow strict standards sequencing.
Then a treatment code is added to complete the coding episode.
Completed coding will be visible on RIO river view.