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1 Introduction

The Clinical Coding Data Quality Framework provides the activities, roles and protocols which individually and collectively ensure that standards associated with auditing of coded clinical data are met.

The Clinical Coding Auditor Programme (CCAP) provides the training on the application of the methodology to individuals that possess the necessary general and specialist knowledge and skills to conduct an audit.

The success of the audit depends upon the competence of the auditor; the key resource for the inspection of coded clinical data. It is therefore essential that an individual and their organisation understand the base knowledge and skills required as well as the ongoing commitment.

1.1 Purpose of document

The document provides an outline of the CCAP so that the reader has a thorough understanding of:

- Pre-requisite skills and knowledge
- Entry level Assessment Day
- Clinical Coding Audit Course content
- Ongoing post-course requirements and Continued Professional Development to maintain Approved Clinical Coding Auditor status

1.1.1 Audience

Accredited Clinical Coders interested in developing their existing skills and knowledge to become an Approved Clinical Coding Auditor and maintaining these skills through continued professional development.

Line Managers to understand the level of commitment required by the individual and organisation to embed and support a skilled auditor in the department to conduct a regular and robust cycle of clinical coding audit within the organisation / department.

1.1.2 Background

Accurate and comprehensive coded clinical data is essential for reliable and effective clinical and statistical analysis. A regular internal programme of clinical coding audit ensures the quality of coded clinical data and NHS regulatory bodies increasingly use the outcomes of clinical coding audits as evidence that organisations exemplify best practice and promote a culture of continuous improvement.

The Clinical Coding Auditor Programme supports organisations by ensuring only the most highly skilled staff qualify to become Approved Clinical Coding Auditors and that continued professional development in this expert field is maintained.
2 Pre-requisite skills and knowledge

The CCAP pre-requisite criteria ensure that an applicant has the base skills and knowledge required to become an auditor.

A Clinical Coding Auditor must possess a wider range of skills and knowledge than those required for day-to-day clinical coding. Whilst excellent technical coding skills are necessary for someone to become an Approved Clinical Coding Auditor, they are not sufficient.

It is essential therefore, that applicants fulfil all of the following criteria prior to attending the CCAP:

1. Attain Accredited Clinical Coder status (ACC) by passing the National Clinical Coding Qualification (UK) examination and a minimum of 3 years clinical coding experience post accreditation. (Provides certificate) NB: This criteria has been reduced to a minimum of 2 years’ experience post accreditation for 2016-2017 only.

2. Attend a Clinical Coding Standards Refresher Course* (formerly a Clinical Coding Refresher Course) delivered by a Clinical Classifications Service Approved Clinical Coding Trainer within the last 3 years. (*This is not required if already a Clinical Classifications Service Approved Trainer due to mandatory completion of a Trainer Refresher course every three years.) (Provides certificate)

3. Attend a report writing course. (Provides a course certificate/evidence). For 2016-2017 only, applicants must be able to confirm they will be attending a course before 12th July 2016.

4. Have proven expertise and specialist knowledge in the application of the rules and conventions of ICD-10 and OPCS-4 and a thorough understanding of national clinical coding standards for these classifications.

5. Have experience in coding across a wide range of speciality areas including general medicine, general surgery, trauma and orthopaedics and obstetrics as a minimum. (Acceptable evidence includes if the applicant can list dates when they have been responsible for coding these specialties within their organisation)

6. Excellent communication skills both verbal and written to enable effective interaction across multi-professional teams.

7. Excellent planning and organisational skills.

8. Excellent time management skills.

9. Basic analytical skills.

10. Experience in problem solving. (Demonstrates with a practical example)

11. Proven excellence in report writing and the ability to write reports to an acceptable standard for presentation at Board level. (Provides details of previous reports written and a sample report they have written on any subject - this does not
12. Demonstrated commitment to continued professional development.


14. Knowledge of Data Protection laws. (The applicant should have received Information Governance training within their own organisation and be able to provide an up to date certificate as evidence of this training). For further information see Information Governance Toolkit Requirement 112. (Provides certificate)

15. Knowledge and understanding of the principles of the Approved Auditor Code of Conduct

16. Knowledge and understanding of A Guide to Clinical Coding Audit Best Practice

**IMPORTANT INFORMATION:**

**Criteria 1 to 3 and 14** – Will be evidenced by provision of certificates.

**Criteria 4 to 12** – Will be evidenced within the applicant’s CCAP Curriculum Vitae through the provision of practical examples and any other requested supporting information (for example criterion 11 requires a sample audit report in addition to details of other previous reports written).

**Criteria 4 to 16** - Will be demonstrated through successful completion of the CCAP Assessment Day. (Also see CCAP Assessment Day Bibliography.)

It is important that the applicant and Line Manager work together to ensure the applicant meets all of the criteria listed above.
3 Applying to attend the Clinical Coding Auditor Programme (CCAP)

The Clinical Coding Auditor Programme is very popular and places are offered on a first come first served basis, subject to availability. Available places can only be secured by submitting a fully completed course Booking Form, a CCAP CV clearly evidencing ALL the necessary listed criteria and all other required documentation with the initial application. (See IMPORTANT INFORMATION in section 3. Pre-requisite skills and knowledge)

The course Booking Form and CCAP CV can be downloaded from our webpages at: http://systems.hscic.gov.uk/data/clinicalcoding/trainingaccred/codertrainingprog/cctpdates/ccapdates.

3.1 The Clinical Coding Auditor Programme Curriculum Vitae

The Clinical Coding Auditor Programme Curriculum Vitae (CCAP CV) is the applicant’s first step towards demonstrating they have the necessary qualifications and skills to become an Approved Clinical Coding Auditor and should be compared to reviewing a job description and matching key skills when applying for a job.

Entry onto the CCAP is subject to the applicant evidencing within the CCAP CV that they fully meet skills 4 to 12 of the pre-requisite criteria.

Applicants must provide practical examples demonstrating use of skills 4 to 12 in either a current or previous role. Just stating ‘I have problem solving skills’/’I have attended report writing course’ does not evidence application of these skills, nor does it demonstrate excellent written communication skills, which is also a fundamental criteria for attending this programme.

All of the required information must be present within the CCAP CV template. If you attach your own CV document, stating “Please see CV” (or similar) on the CCAP CV template, the application will be declined.

We do not provide feedback as to why a CV has been declined. The CCS would encourage all applicants prior to their application being submitted to review and discuss their CV with their line manager to ensure they have provided clear practical examples that evidence each skill.

Applicants are allowed two submissions of their CV. If unsuccessful at the second attempt the applicant will be advised to re-apply the following year/next available programme.
4 The Clinical Coding Auditor Programme

Assessment Day

4.1 Overview

The Assessment Day ensures only competent, experienced and accredited clinical coders are admitted onto the Clinical Coding Auditor Programme (CCAP).

4.2 Purpose

- The applicant’s second step towards demonstrating that they have the skills and knowledge to become an Approved Clinical Coding Auditor
- An opportunity for applicants to network with potential Approved Clinical Coding Auditors from other organisations

4.3 Attendance Criteria

The Assessment Day is open to existing accredited clinical coders (ACC) who have submitted a CCAP CV that evidences the pre-requisite criteria skills 1 to 12 and provided the appropriate certificates/documents with their application. The applicant and their line manager must both confirm their ongoing commitment to all aspects of the CCAP on the course Booking Form.

4.4 Assessment Day Objectives

Attendees must meet the required pass marks and skills criteria in all aspects of the Clinical Coding Auditor Assessment Day before being invited to complete the Clinical Coding Auditor Programme These are set out below:

- Correctly answer at least 95% of questions in the written Practical Pre-assessment Paper. (Demonstrates pre-requisite criteria 4, 5, and 8)
- Correctly answer at least 90% of questions in the written Theory Pre-assessment Paper. (Demonstrates pre-requisite criteria 4, 5, 6, 8, 9, 10, 12, 13, 14, 15 and 16)
- Write three valid conclusions and three associated recommendations from the findings in the given audit report scenario. (Demonstrates pre-requisite criteria 6, 8, 9, 10, 11 and 12)
- From criterions 6 to 12, only select three key pre-requisite skills and in a 5 minute PowerPoint presentation outline how you use these in your current (or a previous) role, explaining why you think these are essential for a good clinical coding auditor. (Demonstrates pre-requisite criteria 6, 7, 8, 10 and 12. May also demonstrate criterions 9 and 11 depending on criteria selected.)

Important information

To support selection of individuals with the highest level of skills and knowledge the CCAP Assessment Day is challenging. The CCAP Bibliography is a useful preparation tool for candidates preparing for the Assessment Day to provide an indication of the various sources of questions in the written assessment papers.

Due to the limited amount of question topics, past Assessment Day papers are NOT available.
Both papers allow delegates to further demonstrate that they possess all of the pre-requisite criteria for attending the CCAP. Applicants must also note the following:

- The practical paper contains quick fire questions for both ICD-10 and OPCS-4 and some case studies. (Demonstrates pre-requisite criteria 4, 5, 8 and 9)
- The theory paper contains sections to assess delegates’ understanding of current national coding standards, data extraction and analysis skills, problem solving skills and the ability to effectively communicate key facts about current national coding standards. (Demonstrates pre-requisite criteria 4, 5, 6, 8, 9, 10 and 12)
- The theory paper also contains a section of questions about clinical coding audit. These short-answer questions amount to approximately one-third of the theory paper score and are all based on the content listed in the CCAP Bibliography. (Demonstrates pre-requisite criteria 8, 12, 13, 14, 15 and 16)

There are no anatomy and physiology, or medical terminology questions in the theory assessment paper.

### 4.5 Reference Materials

**NB**: Delegates can refer to National Standard reference products when completing the Practical and Theory Assessment Papers.

Each applicant must supply their own reference books for use during the Assessment Day:

- Volumes 1 and 3 of ICD-10 5th Edition (fully updated to reflect the errata published in the Coding Clinic Ref 112 and Ref 114
- OPCS-4.7 Volumes I and II
- National Tariff Chemotherapy Regimens List*(current version)
- National Tariff High Cost Drug List*(current version)
- Chemotherapy Regimens Clinical Coding Standards and Guidance OPCS-4* (current version)
- High Cost Drugs Clinical Coding Standards and Guidance OPCS-4* (current version)
- National Clinical Coding Standards OPCS-4 (2016) reference book*

**NB**: Delegates are welcome to bring laptops/tablets to access electronic versions of the products highlighted with an*. Delegates may also use the OPCS-4.7 e-Version*. These products can be downloaded via TRUD:
https://isd.hscic.gov.uk/trud3/user/guest/group/0/home

- **Coding Clinic Ref 88**: Coding of Co-morbidities

**NB**: Delegates can download the latest version of the Coding Clinic onto their laptops/tablets if desired.
4.6 Assessment Day Timings

08.45-16.00*

*Based on previous Assessment Days and may be subject to change. Times will be verified in the Assessment Day Joining Pack sent to all successful applicants 3 weeks prior to the Assessment Day.

4.7 Registration

All aspects of the registration form (with Terms and Conditions) and all associated required documentation must be completed and returned by each applicant. Should the applicant be unsuccessful in passing the assessment day a nominal charge will be made to cover costs.

Applicants requiring overnight accommodation prior to the Assessment Day will need to arrange this separately. If booking hotel accommodation as an NHS applicant, always ask for Government rate where this is available. Please see the Booking Form for further details.

4.8 Next Steps

Successful completion will result in an invitation to attend the Clinical Coding Audit Workshop.
5 CCAP Assessment Day Bibliography

5.1 Purpose
Everyone who attends the Clinical Coding Auditor Programme (CCAP) Assessment Day must be prepared to further demonstrate that they have the pre-requisite skills and meet criteria 4-16 in order to be accepted onto the CCAP. The bibliography provides a list of the documents and publications used to source the questions for the written assessment papers. Applicants should also refer to section 5. Clinical Coding Auditor Programme Assessment Day for information about content of the Assessment Day.

5.2 Bibliography
Delegates are expected to refer to the most current versions available for all documents and publications listed in this bibliography when studying for the Clinical Coding Auditor Programme (CCAP) Assessment Day. Links are provided to web based products.

5.2.1 References needed for Paper 1 - Practical and Case Studies and Paper 2 – Clinical Coding Auditor Programme Assessment Day Theory

Available to purchase from The Stationery Office book shops. For details of how to order the three volumes visit:

http://systems.hscic.gov.uk/data/clinicalcoding/codingstandards/icd10/icd10updates/index_html


  Available for download via the Terminology Reference Update-data Distribution (TRUD) service website subject to registration:
  
  http://www.uktcregistration.nss.cfh.nhs.uk/trud3/user/guest/group/0/home

- **OPCS Classification of Interventions and Procedures, Version 4.7 (April 2014) Volumes I Tabular list and Volume II - Alphabetical Index.**

  Available to purchase from The Stationery Office:
  
  http://www.tsoshop.co.uk/bookstore.asp?FO=1160007&DI=639368&CLICKID=002289

  - **National Clinical Coding Standards OPCS-4.7 reference book (2016)**

    Available for download via the Terminology Reference Update-data Distribution (TRUD) service website subject to registration:
    
    http://www.uktcregistration.nss.cfh.nhs.uk/trud3/user/guest/group/0/home
• National Tariff Chemotherapy Regimens List,
• National Tariff High Cost Drug List,
• Chemotherapy Regimens Clinical Coding Standards and Guidance OPCS-4,
• High Cost Drugs Clinical Coding Standards and Guidance OPCS-4

All available for download via the Terminology Reference Update data Distribution (TRUD) service website subject to registration
http://www.uktcregistration.nss.cfh.nhs.uk/trud3/user/guest/group/0/home

• The Coding Clinic

Publication providing updates to national clinical coding standards and guidance published by the Clinical Classifications Service. Available from Clinical Classifications Service website:
http://systems.hscic.gov.uk/data/clinicalcoding/codingstandards/publications/codingclinic

A Guide to Clinical Coding Audit Best Practice

A summary guide to the clinical coding audit methodology. Available from the Clinical Classifications Service website:
http://systems.hscic.gov.uk/data/clinicalcoding/codingstandards/audit/methodology

• The Clinical Coding Auditor Code of Conduct

A document outlining the key principles, standards and protocols an approved clinical coding auditor is required to follow when using the Clinical Coding Audit Methodology. Available from the Clinical Classifications Service website:
http://systems.hscic.gov.uk/data/clinicalcoding/codingstandards/audit/profile

• Information Governance Toolkit Requirements 505 and 514

The Information Governance Toolkit Requirements for clinical coding audit in an acute and mental health setting. Available from the Information Governance web site:

• The Guide to Data Protection

Outlines the legal obligations and principles that must be applied when handling personal information under the Data Protection Act 1998. Available from the Information Commissioner’s Office web site:
https://ico.org.uk/media/for-organisations/documents/1607/the_guide_to_data_protection.pdf

• Other useful information
Section 8. Maintaining Approved Clinical Coding Auditor Status and Continual Professional Development

http://systems.hscic.gov.uk/data/clinicalcoding/codingstandards/audit

- **Current versions of the ICD-10 and OPCS-4 Exercise and Answers Booklets** are available on request from information.standards@hscic.gov.uk.

**NB:** Some of the above links may be subject to change.
6 Clinical Coding Audit Workshop

6.1 Workshop Overview

This workshop has as its primary objective to develop an experienced Accredited Clinical Coder into an Approved Clinical Coding Auditor. The workshop teaches delegates the correct application of the Clinical Classifications Service’ Clinical Coding Audit Methodology to measure the quality of ICD-10 and OPCS-4 code assignment to identify areas of best practice and those requiring improvement.

This is a unique three-day course developed, updated and delivered by the Clinical Classifications Service (CCS) – the authoritative source of clinical classifications (ICD-10 and OPCS-4) and coding standards that underpin the health, public health and social care systems by providing quality information to support evidence-led care to patients and populations. The workshop covers the four main areas of clinical coding audit:

1. Background and the principles of clinical coding audit
2. The pre-audit process
3. The audit
4. The post-audit process

6.2 Benefits to the delegate

- Provides an optimal learning environment
- Gives access to highly experienced and skilled Clinical Classifications Service-based Approved Clinical Coding Trainers/Auditors
- Provides understanding of the correct application of the CCS Clinical Coding Audit Methodology
- Develops delegate confidence to conduct clinical coding audit back in the workplace, through practical application and assessments at each stage of a clinical coding audit
- Gives a greater understanding of the role and importance of clinical coding audit within the delegate’s working environment
- Provides the national clinical coding audit methodology and associated templates to support an ongoing programme of local clinical coding audit
- Supports an ongoing record of continued professional development through access to the CCS on-line Approved Clinical Coding Auditor Log Book
- Provides an opportunity to network with Approved Clinical Coding Auditors from other organisations

‘Excellent trainers who obviously know their stuff! Very professional teaching sessions and quick to pick up when anyone was struggling. Encouraging and patient. Thank you.’

‘Enjoyed the course, trainers created a relaxed atmosphere whilst ensuring learning was the focus.’
6.3 Benefits to the organisation

- A skilled Approved Clinical Coding Auditor who can deliver clinical coding audits that comply with the Clinical Classifications Service Clinical Coding Audit Methodology
- A skilled Approved Clinical Coding Auditor who understands the need for accurate, high quality coded clinical data to support healthcare planning, reimbursement, management of services, statistical analysis and research
- Increased effectiveness of formal and informal clinical coding audits providing specific, measurable, achievable, realistic and timely (SMART) recommendations for improving clinical coding processes and procedures
- The opportunity to deliver a more cost-efficient in-house clinical coding audit programme to satisfy internal data quality and Information Governance, Clinical Governance and other NHS regulatory body requirements

6.4 Attendance Criteria

This course is only available to existing accredited clinical coders (ACC) who have demonstrated that they meet all the Clinical Coding Audit Programme Pre-Requisite Criteria; have successfully met the required pass marks in all aspects of the Clinical Coding Auditor Assessment Day and have confirmed, along with their line manager, their ongoing commitment to all aspects described on the Booking Form.

Delegates will be able to:

- List 6 areas where potential errors could arise at the pre-audit stage, using the given pre-audit questionnaire (Marked Assessment 1).

- Extract relevant data to assign ICD-10 and OPCS-4 codes to at least 95% accuracy for the two given case studies (Marked Assessment 2).

- Allocate at least 80% of the error keys correctly, using the Meadows Hospital Trust audit worksheets (Marked Assessment 3).

- Use the completed Meadows Trust audit worksheets to correctly analyse the percentage of different errors (Marked Assessment 4).

Following the course, delegates must score at least 80% in their Meadows Hospital Trust coding audit report. Only on successful completion of all marked assessments and their Meadows coding audit report (Marked Assessment 5) will delegates be awarded Approved Clinical Coding Auditor status.
6.5 What will the course cover?

Preparing for a clinical coding audit
- Identifying the information required prior to the audit commencing and why this information is necessary
- Using the CCS Clinical Coding Audit Methodology pre-audit templates
- Planning and preparing appropriate coding audit resources
- Communicating audit/auditor requirements

Conducting clinical coding audit
- Time management
- Correct application of all aspects of the CCS Clinical Coding Audit Methodology
- The necessary skills to audit correct application of the four step coding process, national coding standards and rules and conventions of the classifications
- Using the audit worksheets to assign clinical codes
- Comparing Trust coded clinical data against your clinical codes
- Differentiating between coder and non-coder errors
- What the different audit error keys are and when they should be assigned
- Analysing the audit data

Facilitating the post clinical coding audit process
- Using the CCS Clinical Coding Audit Methodology post-audit templates
- Generating a positive climate in feedback sessions
- How to use the audit authentication mechanism
- Required structure of the Meadows Audit Report - Marked Assessment 5. (The report content will be based on the information the delegates have gathered during from practical activities and assessment during the three-day workshop)

NB The structure is for the Meadows Marked Assessment only. How an auditor structures their report/presents their findings once qualified is entirely up to them/their organisational preference or commissioner requirements.

Ongoing requirements
- Maintaining Approved Auditor status
- Continued professional development

6.6 Course Materials

Each delegate receives:
- Delegate course folder
- Written exercises and handouts
- Samples of a number of CCS Clinical Coding Audit Methodology templates

6.7 Reference Materials
Each delegate must supply their own reference books for use during the course:
6.8 Course Timings
Day One: 09.15-17.00*
Day Two: 09.00-17:15*
Day Three: 09.00-16.00*

*Based on previous Audit Workshops and may be subject to change. Times will be verified in the Clinical Coding Audit Workshop Joining Pack sent to all successful applicants 3 weeks before the course.

6.9 Registration
All aspects of the Booking Form (with Terms and Conditions) must be completed for each delegate.

The price includes all tuition, materials and refreshments on the three-day course (*unless otherwise indicated in the Course Joining Pack*).

Delegates requiring overnight accommodation during the course will need to arrange this. If booking hotel accommodation as an NHS delegate, always ask for Government rate where this is available.

6.10 Next Steps
Following successful completion of the course, each delegate receives:

- Clinical Classifications Service Approved Clinical Coding Auditor certificate
- Clinical Coding Audit Methodology and all associated templates
- Access to the Shared Auditor Workspace and their individual auditor folder and Approved Clinical Coding Auditor Log Book
7 Maintaining Approved Clinical Coding Auditor Status and Continual Professional Development

To maintain Approved Clinical Coding Auditor status, auditors must evidence continued professional development (CPD). This is done by maintaining an on-line Approved Clinical Coding Auditor Log Book (to be submitted to the Clinical Classifications Service no later than 31 March every year), attending one of two-yearly Approved Clinical Coding Auditor Forums and attending a three-yearly Clinical Coding Standards Refresher Course (or dedicated Trainer Refresher Course if also an approved clinical coding trainer). Failure to comply with all ongoing requirements will result in approved status being revoked.

7.1 Approved Clinical Coding Auditor Log Book

The Approved Clinical Coding Auditor Log Book provides evidence of continued professional development, including;

- qualifications, experience and training
- completion of a minimum of 20 audit days in each financial year (includes time spent on preparation, audit and writing of the report)
- newly qualified auditors should start populating the Auditor Log Book straightaway and will be asked to evidence up to 5 audit days per financial year quarter since qualifying. For example, should approved auditor status be gained in September, 10 audit days will need to be evidenced in the log book for that financial year
- completion of at least one written audit report each financial year
- auditor evaluation to be completed by audit commissioner and the auditor’s Line Manager
- reflection on what went well or any particular acknowledgements lessons learned from each audit to support ongoing improvements

7.2 Approved Clinical Coding Auditor Forum

7.2.1 Overview

These are one-day interactive events designed to inform and update Approved Clinical Coding Auditors and provide the opportunity for input into the ongoing development of the Clinical Coding Audit Framework.

The forum is part of the Clinical Coding Auditor Programme, is held every two years and attendance is mandatory for all Approved Clinical Coding Auditors (existing and newly qualified).

The content will vary but the general format will include presentations / interactive sessions facilitated by the Clinical Classifications Service and guest speakers, where possible. The forum will:

- Inform of classification updates and changes to national coding standards
- Advise on planned updates to the Clinical Coding Quality (Audit)Framework
- Promote group discussion and input into future updates
- Encourage sharing best practice
7.2.2 Benefits to the delegate

- Provide the opportunity to network with other approved clinical coding auditors
- Share audit experiences and best practice
- Opportunity to network with Approved Clinical Coding Auditors from other organisations
- Provides a tool to support a Trusts in developing and maintaining their internal data quality programme
- Access to highly experienced and skilled Clinical Classifications Service-based Approved Clinical Coding Trainers/Auditors
- Promotes continual professional development (CPD)
- Is one of the criteria for maintaining Approved Clinical Coding Auditor status

7.2.3 Benefits to the organisation

- A skilled Approved Clinical Coding Auditor who is up-to-date on the latest classification updates and changes to national clinical coding reference products and who has a commitment to their ongoing CPD.

- The continued opportunity to deliver a more cost-efficient in-house clinical coding audit programme to satisfy internal clinical data quality and Information Governance, Clinical Governance and other NHS body requirements, in accordance with the Clinical Classifications Service Clinical Coding Audit Methodology.

- Sharing best practice processes with other NHS organisations.

7.2.4 Attendance Criteria

This Forum is open to existing Approved Clinical Coding Auditors and must be attended once every two years.

Failure to comply with all ongoing requirements will result in approved status being revoked.

7.2.5 Course Materials

Each delegate receives:

- Copies of all slide handouts
- A Clinical Classifications Service Approved Clinical Coding Auditor Forum certificate of attendance

7.2.6 Reference Materials

It is generally not necessary for delegates to bring any reference materials with them on the day; just thoughts and ideas they can share with fellow delegates.

7.2.7 Forum Timings

09.30-16.00 *
* Based on previous Auditor Forums and may be subject to change. Times will be verified in the delegate Auditor Forum Pack issued 3 weeks before the Forum.

7.2.8 Registration

All aspects of the Booking Form (with Terms and Conditions) must be completed for each delegate.

All materials and refreshments on the Forum are included *(unless otherwise indicated in the Joining Pack).*

Delegates requiring overnight accommodation will need to arrange this separately. If booking hotel accommodation as an NHS delegate, always ask for Government rate where this is available.

7.3 Consultations

Approved clinical coding auditors are expected to contribute comments/feedback to at least one standard and/or audit consultation a year. These standards/consultations are published on the Shared Auditor Workspace.

8 Other Useful Information

8.1 The Health Informatics Career Framework (HICF)

The HICF provides a structure for careers within Health Informatics

https://www.hicf.org.uk/Index.aspx

8.2 Informed: An introduction to the use of informatics in healthcare

This is an e-learning course developed by the Department of Health. The course is available for NHS employees who want to expand their knowledge of health informatics:

http://www.e-lfh.org.uk/programmes/health-informatics/

8.3 SNOMED CT Foundation course

This is an eLearning course developed by IHTSDO (International Health Terminology Standards Development Organisation). The course is available to anyone seeking to acquire or demonstrate a broad foundational knowledge of SNOMED CT.

Study itself is expected to require a total of 30-35 hours. The course must be completed within a maximum of four months, but it is possible to complete it within as little as a week. Registration is required.

http://www.ihtsdo.org/snomed-ct/learn-more/elearning-overview
8.4 NHS Data Dictionary eLearning

There are demonstrations available developed by the HSCIC which cover a wide range of topics within the Data Dictionary, which can be accessed on a modular basis depending on the information required.

Knowledge can be tested by the completion of quizzes.

The content of these demonstrations is for training purposes only and therefore may not match the current content of the NHS Data Model and Dictionary.

http://www.datadictionary.nhs.uk/web_site_content/pages/help_pages/demonstrations.asp?shownav=0

8.5 ICD-11 Browser

This is available by accessing the hyperlink below.

http://apps.who.int/classifications/icd11/browse/l-m/en

Google Chrome may need to be used to access all the options available within the browser, for example the Coding Tool (available under the Linearizations tab)

This is a beta (draft) version and as a result is a working document, frequently updating. The document itself goes before the World Health Assembly in 2018.

8.6 NIB Strategy

The NIB (National Information Board) role is to put data and technology safely to work for patients, service users, citizens and the professionals that serve them. It brings together national health and care organisations from the NHS, public health, clinical science, social care and local government, along with appointed independent representatives to develop the strategic priorities for data and technology.

https://www.gov.uk/government/organisations/national-information-board/about

Personalised health and care 2020: a framework for action was published in November 2014 in partnership with the Department of Health.

It can:

- give patients and citizens more control over their health and wellbeing  
- empower carers  
- reduce the administrative burden for care professionals  
- support the development of new medicines and treatments

This framework has been developed based on evidence from many sources, including civil society and patient organisations, as well as directly from service users.
This is not a strategy in the conventional sense. It is not a national plan, but a framework for action that will support frontline staff, patients and citizens to take better advantage of the digital opportunity.

The National Information Board will report annually on progress made against the priorities detailed in this framework and review them each year to reflect changing technology and accommodate new requirements from the public and staff. The proposals in this framework are not comprehensive but they represent the core and immediate priorities for delivery of modern digital health and care services.