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SCCI0021: ICD-10 5th Edition: Change Paper

Document Management

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This information standard (SCCI0021) has been approved for publication by the Department of Health under section 250 of the Health and Social Care Act 2012.

Assurance that this information standard meets the requirements of the Act and is appropriate for the use specified in the specification document has been provided by the Standardisation Committee for Care Information (SCCI), a sub-group of the National Information Board.

This information standard comprises the following documents:

- Requirements Specification
- Change Specification (this document)
- Implementation Guidance
- Codes and Titles and Metadata File Specification

An Information Standards Notice (SCCI0021 Amd 10/2014) has been issued as a notification of use and implementation timescales. Please read this alongside the documents for the standard.

The controlled versions of these documents can be found on [the HSCIC website](#).

Date of publication 18 September 2015.

Glossary of Terms

Term	Acronym	Definition
International Statistical Classification of Diseases and Related Health Problems – Tenth Revision	ICD-10	The World Health Organisation (WHO) International Statistical Classification of Diseases and Related Health Problems – Tenth Revision is an existing NHS Information Standard.
Department of Health	DH	The Department of Health (DH) helps people to live better for longer. We lead, shape and fund health and care in England, making sure people have the support, care and treatment they need, with the compassion, respect and dignity they deserve. https://www.gov.uk/government/organisations/department-of-health/about
World Health Organisation	WHO	World Health Organisation is the directing and coordinating authority for health within the United Nations system. It is responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends.
The Health and Social Care Information Centre	HSCIC	The Health and Social Care Information Centre is a non-departmental public body of the Department of Health. http://www.hscic.gov.uk/
Clinical Classifications Service	CCS	The Clinical Classifications Service is part of the Architecture, Standards and Innovation Directorate within the Health and Social Care Information Centre (HSCIC). It is responsible for the development of ICD-10 for UK implementation. http://systems.hscic.gov.uk/data/clinicalcoding
National Casemix Office	NCO	The National Casemix Office develops clinical grouping methodologies (including Healthcare Resource Groups) and software products to support the NHS. http://www.hscic.gov.uk/casemix
Standardisation Committee for Care	SCCI	The SCCI is a sub-group of the National Information Board (NIB). Empowered by the Health and Social Care Act 2012, the SCCI has delegated

Information		responsibility for approving information standards for the health and social care system in England. The SCCI membership is drawn from a range of organisations operating within health and social care. www.hscic.gov.uk/isce
OPCS Classification of Interventions and Procedures, version 4.7	OPCS-4	The OPCS Classification of Interventions and Procedures version 4.7 is a UK classification and is an existing NHS Information Standard.
SNOMED Clinical Terms	SNOMED CT	SNOMED CT, the 'Systematized Nomenclature of Medicine Clinical Terms'. It is a clinical terminology with comprehensive scientifically validated content. SNOMED CT has been adopted as the standard clinical terminology for the NHS in England. A standard clinical terminology is essential for the interoperability of electronic health records.
Secondary Uses Service	SUS	The Secondary Uses Service is designed to provide anonymous patient-based data for purposes other than direct clinical care such as healthcare planning, commissioning, public health, clinical audit and governance, benchmarking, performance improvement, medical research and national policy development.
Technology Reference data Update Distribution Service	TRUD	Distribution service for users to download reference files from the Architecture, Standards and Innovation Directorate of the HSCIC. https://isd.hscic.gov.uk/trud3/user/guest/group/0/home
Commissioning Data Sets	CDS	The Commissioning Data Set is the basic structure used for the submission of commissioning data to the Secondary Uses Service and is designed to be capable of individually conveying many different Commissioning Data Set structures encompassing Accident and Emergency Attendances, Out-Patient Attendances, Future Attendances, Admitted Patient Care and Elective Admission List data etc.
National Tariff Payment System		A set of prices and rules to help local NHS providers and commissioners provide best value to their patients produced by Monitor and NHS England.
Healthcare Resource Group	HRG	Healthcare Resource Groups are standard groupings of clinically similar treatments which use common levels of healthcare resource. They are currently used as a means of determining fair and equitable reimbursement for care services delivered

		by Health Care Providers. Their use as consistent 'units of currency' supports standardised healthcare commissioning across the NHS.
Extensible Markup Language	XML	Extensible Markup Language is a markup language that defines a set of rules for encoding documents in a format that is both human-readable and machine-readable.
Delimiter Separated Values	DSV	Delimiter Separated Values (DSV) format Specifically, the variant is "Tab Separated Values" (the delimiter being a tab character).
ISO 9001: 2008		ISO 9001 is the internationally recognised standard for the quality management of businesses. What is it? <ul style="list-style-type: none"> • applies to the processes that create and control the products and services an organisation supplies • prescribes systematic control of activities to ensure that the needs and expectations of customers are met • is designed and intended to apply to virtually any product or service, made by any process anywhere in the world
Mental Health Services Data Set	MHSDS	http://www.hscic.gov.uk/mhds

Document Control:

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1 Introduction

This document provides details of the change to the existing information standard known as the International Statistical Classification of Diseases and Related Health Problems – Tenth Revision (ICD-10), produced by the World Health Organisation (WHO). The change is provided by the WHO and constitutes updates to the classification to provide improved classification of medical conditions and indexing. The update is referred to by WHO as the ICD-10 5th Edition.

The document is part of the single stage submission to the Standardisation Committee for Care Information (SCCI) with regard to the updates to create ICD-10 5th Edition for NHS implementation on 1 April 2016.

This submission was previously presented to SCCI in August 2014 and subsequently deferred because WHO advised of their intention to issue a major release in 2016. All data files and documents have been updated, as required, to reflect the additional changes – see table at 6.1 for volume of new changes. The Summary of Changes document identifies the additional changes.

This update to the standard is a continuance of the regular review and uplift to ICD-10 in line with the recommended best practice of keeping clinical classifications aligned with advances in health care.

2 Summary of the standard

This table below contains a summary of the information standard:

Standard	
Standard Number	SCCI0021
Standard Title	International Statistical Classification of Diseases and Health Related Problems – Tenth Revision (ICD-10)
Description	<p>ICD-10 is a comprehensive classification of causes of morbidity and mortality and is published by the World Health Organisation.</p> <p>ICD-10 permits the systematic analysis, interpretation and comparison of morbidity data collected in different areas. The specified purpose of the ICD-10 is to provide a means of classifying diagnoses and is defined as a system of categories to which morbid entries are assigned according to established criteria.</p>
Applies to	<p>The following bodies must have regard to this information standard:</p> <ul style="list-style-type: none"> • the Secretary of State • NHS England • Monitor • public bodies exercising functions in connection with health services or adult social care • anyone providing publicly funded health services or adult social care commissioned by or on behalf of a public body.

	In addition, this information standard applies to: <ul style="list-style-type: none"> NHS IT system and software suppliers who build/update software to support NHS business functions and interoperability, according to new and existing contractual arrangements public sector organisations providing information support to NHS health care providers.
Release	
Release Number	Amd 10/2014
Release Title	International Statistical Classification of Diseases and Health Related Problems – Tenth Revision, 5 th Edition (ICD-10 5 th Edition)
Description	ICD-10 5 th Edition contains updates released by the World Health Organisation (WHO), but not yet implemented in the UK.
Implementation Completion Date	1 April 2016

2.1 Related Documents

Ref #	Title
1	SCCI0021 Amd 10/2014 Information Standards Notice
2	NHS Data Model and Dictionary Change Request 1412
3	International Statistical Classification of Diseases and Health Related Problems – Tenth Revision 5 th Edition (ICD-10 5 th Edition) - Implementation Guidance
4	Summary of Changes from ICD-10 4 th Edition to ICD-10 5 th Edition

2.2 Supporting Documents

Ref #	Title
5	ICD-10 5 th Edition Codes and Titles and Metadata File Technical Specification
6	National Clinical Coding Standards – ICD-10 5 th Edition, reference book

2.3 Related Standards

Ref #	Reference	Title
7	ISB 0084 Amd10/2013 http://www.isb.nhs.uk/library/standard/130	OPCS Classification of Interventions and Procedures
8	ISB 0160 http://www.hscic.gov.uk/isce/publication/isb0160	Clinical Risk Management: its Application in the Deployment and Use of Health IT Systems
9	ISB 0129 http://www.hscic.gov.uk/isce/publication/isb0129	Clinical Risk Management: its Application in the Manufacture of Health IT Systems

3 Background

The ICD classification is a well-known international standard and has a long history of use in the NHS. Earlier versions of the classification have been in use across the NHS supporting time series analysis prior to 1995. It is therefore a widely understood classification for the purposes of central returns, comparative analyses and more recently reimbursement. ICD-10 is an existing mandated NHS Information Standard implemented on 1 April 1995. See table for implementation dates:

Year	Version of ICD
01-Apr-1979 to 31-Mar-1995	ICD-9
01-Apr-1995 to 31-Mar-2004	ICD-10
01-Apr-2004 to 31-Mar-2012	ICD-10 Reprinted (with corrections and updates) 2000
01-Apr-2012 to 31-Mar-2016	ICD-10 4 th Edition
01-Apr-2016	ICD-10 5 th Edition

WHO has established an updating cycle with minor changes notified every year and major changes every 3 years to ensure the classification reflects current clinical knowledge. The latest updates have not yet been implemented by the NHS and therefore it does not benefit from the more recent clinical knowledge or improved indexing of diseases.

ICD-10 5th Edition has been accepted by SCCI and mandated for use from 1 April 2016.

The Health and Social Care Information Centre (HSCIC) Clinical Classifications Service has responsibility for this information standard on behalf of the UK and will be taking forward the work to support implementation across the NHS.

4 Details of the standard

ICD-10 is a comprehensive classification of causes of morbidity and mortality. ICD-10 permits the systematic analysis, interpretation, and comparison of morbidity data collected in different areas and at different times. Thus, the specified purpose of ICD-10 is to provide a means of classifying medical terms and is defined as a system of categories to which morbid entries are assigned according to established criteria.

Categories have been chosen and logically sequenced to facilitate the statistical study of disease phenomena. A specific disease entity that is of particular public health importance, or that occurs frequently, has its own category. Otherwise, categories are assigned to groups of separate but related conditions. Each category has a title reflecting its composition, and an alphanumeric code as a means of unique identification.

All NHS inpatient episodes and day cases that contain diagnoses must be recorded to the mandated version of ICD.

The WHO provides ICD-10 as a three volume set which consists of:

- Volume 1 is the Tabular List, comprising a descriptive classification of diseases and injuries, supplementary classifications, and appendices.
- Volume 2 is the Instruction Manual. It contains the World Health Organisation's coding guidelines.
- Volume 3 is the Alphabetical Index to diseases and nature of injury. It covers external causes of injury and provides a Table of drugs and chemicals.

The specification for the Tabular List and Alphabetical Index (paper copy) is held within the document structure provided by WHO.

4.1 Change to standard

The change entails the addition and deletion of codes and descriptions and changes to code descriptions in ICD-10.

The WHO has removed the Morphology of Neoplasms Table from Volume 1 and replaced it with a link to a webpage. Code references have been removed from the Index – Volume 3. Additionally the Instruction Manual – Volume 2 – has been updated to reflect the change. The Morphology codes are not part of the ICD-10 Information standard - see Out of Scope section 5.1.

There is no change to the architecture of ICD-10.

5 Concept of Operation

The ICD-10 is a vital component of existing hospital-generated national data sets, including the Secondary Uses Service (SUS), National Schedule of Reference Costs, National Service Frameworks, Care Pathways and Performance Indicators. The classification underpins key information initiatives which support the monitoring of specific diseases (e.g. cancer registries) and health events (e.g. Francis Inquiry - Mid Staffordshire, Bristol Royal Infirmary Inquiry). It is vital to stakeholders for monitoring morbidity and health trends e.g. the Department of Health. The UK has a mandatory obligation to collect and submit data to the WHO for statistical and epidemiological analyses as a member of the World Health Assembly.

The ICD-10 classification is used to code the diagnoses of all inpatient episodes and day cases to support a number of data collections including Admitted Patient Care Commissioning Data Sets, Central Returns and Secondary Uses Service.

The terminology, Systematized Nomenclature of Medicine – Clinical Terms (SNOMED CT), is mapped to ICD-10. The maps are provided with the terminology releases.

The ICD-10 is used by NHS suppliers to build/update software to support NHS business functions and interoperability.

The HSCIC National Casemix Office uses the codes to design Healthcare Resource Groups (HRGs), for example, to generate diagnoses-driven HRGs and to qualify procedure-driven HRGs.

5.1 Out of Scope

The following are items considered outside the scope of this standard:

- Interventions and procedures captured by the OPCS Classification of Interventions and Procedures version 4.7, known as OPCS-4.7.
- Specialty adaptations such as the International Classification of Diseases for Oncology used principally in cancer registries for coding the site (topography) and the histology (morphology) of neoplasms. The WHO provided an undertaking to ensure that any such classifications endorsed by them will be fully compatible with the main classification at the fourth character level, but will not necessarily be compatible either at fifth character level or with each other. For instance, the meaning of a fifth character in one Specialty adaptation can be quite different in another.
- Point of care recording by the clinician – ICD-10 is not intended or designed for point of care recording by a clinician. It is a statistical tool that requires adherence to and application of specified definitions and rules to enable accurate, consistent and comprehensive capture of data for secondary purposes. SNOMED CT enabled electronic health records incorporate national cross-maps to the classifications to enable interoperability and derivation of classification data for secondary use purposes.
- Cross-mappings provide the link from the SNOMED CT terminology to ICD-10 5th Edition classification. The cross-mapping data files are issued with the terminology release.
- Cross-mappings provide the link from legacy terminologies (The Read Codes V2, Clinical Terms V3) to ICD-10 5th Edition classification.
- Administrative functions or demographic detail.
- Diagnostic activities typically undertaken in General Practice for example prescribing, practice administration, General Medical Services (GMS) or Personal Medical Services (PMS) contracts.
- Healthcare Resource Groups (HRGs) are standard groupings of clinically similar treatment which use common levels of healthcare resource. They are used as the unit of currency to determine fair and equitable reimbursement for care services delivered by providers. The HSCIC National Casemix Office is responsible for the mapping of ICD-10 codes to HRGs for use in associated groupers. The ICD-10 updates will be incorporated into HRGs to ensure the codes are accepted in the grouper(s) to be used from April 2016 onwards.

5.2 Data Sets (excluding Commissioning Data Sets)

Data sets for cancer, mental health, diabetes etc must use the mandated version of ICD-10 from the 1 April 2016.

Important Note: Updates to the classifications and coding standards are implemented at the start of the fiscal year, ie 1 April, rather than potentially taking place at any point throughout the fiscal year, for example, 1 January. Having a regular fixed point for changes enables analysts to extract meaningful statistics for local / national purposes, including time series data and the NHS payment system data.

Data set owners and analysts must be mindful of changes to a data set that overlap the fiscal year, for example, the implementation date for the new Mental Health Services Data Set (MHSDS) is 1 January 2016. In this instance, the January to March quarter of the MHSDS will be coded to the Fourth Edition of ICD-10 and the April to June quarter to the Fifth Edition of ICD-10.

5.3 Working Practices

ICD-10 is used by clinical coders to classify diagnoses to support the collection of information for secondary uses. Health care managers use ICD-10 data to support operational and strategic planning. ICD-10 coded data are also used by clinicians, the healthcare informatics community, healthcare financial accountants, Department of Health (DH) performance analysts/statisticians, audit organisations (eg Audit Commission), NHS system and software suppliers. The National Casemix Office uses it to support the National Tariff Payment System.

Clinical coders are trained to use ICD-10. They assign the codes according to the rules of the classification using information recorded in the source documentation by the clinicians. ICD-10 may also be used by other staff depending on local operational requirements. Where there are electronic records in place, diagnoses are captured in SNOMED CT. Software, using maps issued as part of the terminology releases, generates maps from SNOMED CT to ICD-10 codes and the legacy terminologies (Read Codes). See section 12 Cross-mapping from terminologies to classifications. These maps are not always 1 to 1. Consequently, the maps must be reviewed and supplemented by coders as necessary.

An encoder, containing an electronic version of ICD-10, may also be used to support the assignment of ICD-10 codes. Data Analysts within Informatics Departments, the National Casemix Office and the DH use the codes to create algorithms to support operational and strategic planning, commissioning and producing various statistical outputs. Clinicians may use the codes to support medical audit.

5.4 WHO ICD-10 5th Edition Volumes 1-3

The WHO publishes the hard copy ICD-10 5th Edition, Volumes 1-3. Clinical coders need the full volume set. See section 10 for costs.

5.5 Training and education

The benefits to be gained from the ICD-10 5th Edition updates are dependent upon:

- clear, concise and accurate clinical information provided within current source documentation for the episode of care
- accurate, consistent and complete application of the classification to reflect the diagnoses detailed in the clinical record.

Healthcare providers need to ensure that those staff groups affected by the updates are aware of the ICD-10 5th Edition implementation and the mandatory requirement for all Finished Consultant Episodes and day cases that finish on or after 1 April 2016 to be recorded to the ICD-10 5th Edition.

The ICD-10 5th Edition changes are not as extensive as the changes introduced in the 4th Edition. However those responsible for clinical coding in Trusts are encouraged to arrange awareness sessions. Targeted training sessions can benefit those groups of staff and specialities most impacted by the updates. This includes clinical, information, finance and

other staff groups that provide information (in the case of clinicians) or use the data to support mandatory data collections as well as local service planning and delivery.

Local awareness materials for these staff groups can be based on the summary of changes, key learning points and self-teach PowerPoint presentations provided by the Clinical Classifications Service.

Clinical coding managers need to ensure that clinical coding staff receive adequate training so that the updates can be accurately and consistently applied as part of the coding process. The type of training will be dependent on local circumstances.

The Clinical Classifications Service provides national reference and training materials to support the coding community as follows:

- The ICD-10 5th Edition National Clinical Coding Standards reference book for clinical coders is updated to reflect changes made to ICD-10. The reference book contains the national clinical coding standards, rules and conventions pertaining to ICD-10, and is a reference manual for clinical coders applying ICD-10 codes. The updates to ICD-10 to create the 5th Edition do not change the fundamental Four Step Coding Process.
- Awareness/training materials are provided to support the coding community, as necessary.

A range of national clinical coding training materials are provided including a train-the-trainer programme, to ensure well-defined standards and to improve the quality of clinical data coded to ICD-10 and OPCS-4. All existing materials are updated to reflect enhancements to the classifications.

Key Learning Points outlining the main changes / key differences are published on the Clinical Classifications Service website to prepare the coding community for the implementation of ICD-10 5th Edition.

The examination to accredit clinical coders is delivered by the Institute of Health Records and Information Management - the awarding and administrative body. Examinations are held twice e.g. September and March in every financial year. The syllabus covers coding standards for ICD-10 and OPCS-4 and examinations held in 2016/17 are based on the mandated classification at the time of the examination.

6 About the changes to the standard

The WHO releases regular ICD updates to reflect the latest clinical knowledge for country implementation.

The UK has a mandatory obligation to collect and submit data to the WHO for statistical and epidemiological comparison.

In 2010 the Government's White Paper – Equity and excellence: Liberating the NHS - required the implementation of ICD-10 updates from 1 April 2012 to support quality improvements. Thereafter, DH required regular implementation of ICD 10 updates to support key business requirements. A three year release plan was agreed with the DH and the former Payment by Results Programme Board.

The updates to ICD-10 reflect the cumulative changes released by the World Health Organisation. New ICD-10 codes and changes to descriptions enable more accurate and detailed coding of the diagnoses included in consultant episodes. This is important to help

identify trends in health, locally, nationally and internationally in addition, to the provision of a robust platform for local service planning and delivery.

The National Tariff Payment System published by Monitor relies largely on two standard classifications – ICD-10 and OPCS-4 - to process clinical data on acute care.

6.1 Volume of changes

There are a total of 455 changes to ICD-10 4th Edition provided by the WHO. The table below provides the total number and type of changes included in the ICD-10 5th Edition. It includes changes up to and including January 2016 as stated on the WHO list of updates.

Five changes, listed in the WHO updates, are excluded from the total figures below because they refer to changes to codes not used in the NHS.

The WHO list of changes are used for the rigorous testing, analysis and verification of the ICD-10 data files received from WHO.

INSTRUCTION	Number of instances (2015)	Number of instances added (2016)	Totals
New block	1	0	216
New category	8	0	
New subcategory	69	3	
New inclusion term	72	11	
New exclusion term	28	4	
New note	16	3	
New supplementary sub-classification	1	0	

Delete Block	1	0	70
Delete category	7	0	
Delete subcategory	18	2	
Delete inclusion term	25	8	
Delete exclusion term	4	1	
Delete note	4	0	

Modify block description	2	0	169
Modify category description	7	2	
Modify subcategory description	32	6	
Modify subcategory code (add or delete dagger or asterisk)	0	1	
Modify inclusion term	36	16	
Modify exclusion term	44	11	
Modify note	10	2	

TOTAL		455
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6.2 Summary of changes

The change entails the addition of new codes and descriptions to ICD-10, modification to existing descriptions and deletion of existing codes and descriptions. The new entries fall within existing chapters. There is no change to the architecture of ICD-10.

The Clinical Classifications Service publishes the *Summary of Changes from ICD-10 4th Edition to ICD-10 5th Edition*. The summary provides WHO changes to the codes and descriptions contained in the ICD-10, Volume 1, Tabular List and specifically the section titled 'Tabular list of inclusions and four-character subcategories'. This summary list does not reflect changes made to the introduction, excludes, includes, code ranges or notes at chapter or individual code level within this section or to other sections of ICD-10 Volume 1, ICD-10 Volume 2 Instruction manual or the Volume 3 Alphabetical index.

The summary is available at:

<http://systems.hscic.gov.uk/data/clinicalcoding/codingstandards/icd10/ICD10Updates>

7 Consultation

The implementation of the ICD-10 5th Edition was deferred until 2016 to incorporate further changes issued by the World Health Organisation. Section 7.1 describes the outcome of the initial consultation in 2015. Section 7.2 describes the consultation on the additional 2016 changes.

7.1 ICD-10 5th Edition (2015)

The Draft Summary of Changes ICD-10 4th Edition to ICD-10 5th Edition was published for public consultation which was open from 26 March 2014 to 25 April 2014.

The document was aimed at NHS healthcare providers, NHS suppliers that build / update software to support NHS business functions and interoperability, as well as clinical coding and other health information, financial and commissioning professionals.

The majority of respondents to the survey rated the impact as minor or medium with one major. The major impact was about the cost of purchasing books. This will be mitigated by the ICD-10 eVersion which will be available from TRUD under a Royalty-free licence, subject to conditions imposed by WHO.

New codes were generally welcomed as they better reflect the information recorded in the notes by the clinicians. The codes will satisfy requests for information that could not previously be met.

Respondents expressed the need for systems to be updated on time and the timely availability of supporting documentation and books. The Clinical Classifications Service is addressing these matters by release of the data files in November 2015 and an extensive and comprehensive communications plan.

Feedback on implementation support has been considered and in particular, the development timeline for training materials has been brought forward to address the call for earlier delivery.

7.2 ICD-10 5th Edition (2016)

The updated Draft Summary of Changes was re-issued for consultation on 20 May, after the lifting of the UK general election purdah, until 19 June 2015.

This survey did not expose any new significant issues in relation to the Standard

However some respondents expressed concern about the removal of the Morphology codes, which is not part of the Standard. See “ICD-10 5thEdition-RemovalMorphologyCodes” document. It outlines the issues and way forward. Available on request from the Information Standards Helpdesk. Email: information.standards@hscic.gov.uk

8 Data files and format

There is no change to the format of the ICD-10 data file.

The data file specification is held in the ICD-10 5th Edition Codes and Titles and Metadata File Specification. This document is provided with the release data files via the Technology Reference data Update Distribution (TRUD) service found at:

<https://isd.hscic.gov.uk/trud3/user/guest/group/0/home>

The data files are released in two formats:

- Extensible Markup Language (XML) which is the required standard for the NHS and,
- Delimiter Separated Values (DSV) format. Specifically, the variant is “Tab Separated Values” (the delimiter being a tab character).

Further information is available in the ICD-10 5th Edition: Codes and Titles and Metadata file specification accompanying the release data.

8.1 Tables of Equivalence

The Clinical Classifications Service releases Tables of Coding Equivalences. The tables provide backward and forward equivalences from/to ICD-10 5th Edition. Specifically, for every new code a suitable equivalent to the old version is provided. The tables show the result of the comparison between the two versions of ICD-10 and answer the following questions:

- To which code or codes of the target dataset (old version) should a code of the source dataset (new version) be mapped?
- To which code or codes of the target dataset (new version) should a code of the source dataset (old version) be mapped?

The tables provide 1:1, 1:none, 1:many, many:1 mapping alternatives and combinations with contextual information where applicable to support trend analyses.

The mappings pose no more and no fewer problems than previously experienced when implementing changes to a classification.

The cut-off date of the old version and implementation of new version supports comparative analysis of historical data. The implementation date of 1 April 2016 requires all consultant episodes that end on or after 1 April 2016 to be coded using ICD-10 5th Edition.

8.2 Development and testing of data files

The WHO provides HSCIC with the ICD-10 Classification Markup Language (CLaML) data files under the UK licence arrangements. An electronic platform has been developed to

manage the data and to generate the necessary data outputs to support the NHS and NHS system suppliers.

The data are fully tested to ensure that it meets ICD-10 constraints such as field width and composition of code. Point of entry validation helps to prevent data entry errors. All data files are quality assured by classification experts before they are released to licence holders.

UK metadata parameters, such as age and gender scrutiny checks and Tables of Coding Equivalences are developed by classification experts in line with classification principles. Clinical input was sought as necessary.

9 Distribution

The HSCIC on behalf of the Secretary of State holds a licence with WHO to distribute the data files to NHS and NHS system suppliers for UK Government purposes.

The updated ICD-10 data files are licensed and distributed via the Technology Reference data Update Distribution (TRUD) Service subject to registration and acceptance of the terms and conditions. The TRUD Service can be found at:

<https://isd.hscic.gov.uk/trud3/user/guest/group/0/home>

10 Costs

ICD-10 is an existing information standard used to support classification of diagnoses in mandatory data collections for secondary uses. It is managed by the HSCIC Architecture, Standards and Innovation Directorate.

Overhead costs for the implementation of the new edition within NHS organisations are catered for in the NHS Standard Contract.

Trusts need to ensure that resources are available to meet implementation costs which will include the necessary updating of IT systems and the cost of staff training and may include the purchase of the ICD-10 5th Edition Volumes 1-3, if a Trust chooses to purchase hard copies rather than download the HSCIC ICD-10 5th Edition eVersion under the Royalty free licence, subject to conditions imposed by WHO, from TRUD.

HSCIC provides the funding for the development, maintenance and resources to support the implementation of updates to ICD.

The WHO publishes the hard copy ICD-10 Volumes 1-3 should Trusts wish to purchase the hard copies volume set for clinical coders. The full cost for the ICD-10 volume set is £365. They will be made available to the NHS at a discounted price of £190. Further details will be published on the Clinical Classifications Service website.

11 Maintenance

See ICD-10 5th Edition Maintenance Plan. Available on request from the Information Standards Helpdesk. Email: information.standards@hscic.gov.uk

12 Cross-mapping from terminologies to classifications

The HSCIC Clinical Classifications Service provides the national cross-maps from SNOMED CT to the classifications (ICD-10 and OPCS-4). The cross-maps support the standard and are distributed as part of the regular terminology releases to appropriately licensed NHS suppliers and other users via TRUD.

The work is therefore closely aligned to the definitive national source for the development of definitions, standards and rules for these particular classifications and associated products. The linkage between these elements is essential to support the derivation of management data from clinical information systems. The classifications are the UK standard for the coding of admitted patient care clinical data and their use is fundamental to the production of statistical data by the four national administrations.

The classifications provide the underlying data for the National Tariff Payment system in England and are therefore key to the funding of Trusts. The provision of national standards for cross-maps is pivotal to users of SNOMED CT in order to support reimbursement.

The cross-maps from SNOMED CT to ICD-10 5th Edition will be available to the NHS in the mid-March 2016 terminology release for 1 April 2016 implementation and thereafter as part of the usual terminology releases.

12.1 Withdrawal of legacy terminologies (Read Codes)

As clinicians increasingly use electronic records, and the momentum to flow data across the NHS continues, the clinical risks from multiple terminologies becomes greater. Clinicians who work in multiple locations cannot be expected to work with different terms in different systems, and as the take up of SNOMED CT increases in secondary care, some SNOMED Clinical Terms will not map to Read codes without loss of information, which can hamper safe electronic information flow.

The National Information Board has recognised this and the SCCI has confirmed that the last updated release of Read V2 will be April 2016 and for primary care to move to SNOMED CT before 1 January 2017. In 2014 Information Standards Notices were issued in relation to the withdrawal of both Read V2 and Read V3. See ISN ISB 1553 and 1552 at <http://www.hscic.gov.uk/isce/publication/isn/2014>

The Clinical Classifications Service will therefore cease maintaining the cross-maps to legacy terminologies (Read V2 and Read V3 (also known as CTV3)) following the April 2016 terminology release. Static legacy cross-maps files will continue to be available from HSCIC, on request.

13 Data Quality

The national clinical coding audit methodology and associated auditor workshop will be updated where appropriate to reflect changes to the classifications. The methodology describes a framework for audit of coded clinical data in ICD-10 and OPCS-4. It enables auditors to have confidence in their findings, provides the necessary information to make relevant changes and achieves continuous quality improvement, resulting in a robust data

quality cycle. The methodology and audit requirement are part of the Information Governance Toolkit.

The audit methodology has been used for the DH Data Assurance Framework clinical coding audits. The Clinical Classifications Service will ensure that the clinical coding auditors employed by Monitor to undertake the work are provided with relevant information on updates through the Key Learning Points.

14 Information Governance

The ICD-10 does not use patient identifiable data or affect patient safety in itself. However, the data generated from coding activity provides a rich source of information and when utilised with other parameters, it can contribute to the identification of cohorts of patients for more detailed analysis.

Should a local organisation use classification data for clinical purposes such as clinical audit or transfer clinical coding as part of inter-provider transfer of care the organisation should follow clinical safety standards:

- ISB 0160 Clinical Risk Management: its Application in the Deployment and Use of Health IT Systems
- ISB 0129 Clinical Risk Management: its Application in the Manufacture of Health IT Systems

There are no known adverse events to date. The change should not alter this position.

In the event of an adverse incident this would be logged with the Information Standards helpdesk and tracked for either resolution or escalation as part of the Service Level Agreement for incident management. If an incident arose involving HSCIC data files due process would be activated. Where information is known to be used inappropriately, the Clinical Classifications Service would approach the organisation about the incident and seek a satisfactory resolution. If further action is required, it may necessitate the matter being referred depending on the severity.

15 Postponement of an ICD-10 update – management

An ICD implementation may be delayed because all the essential artefacts may not be available on time from the WHO or a release may be delayed in order to incorporate important content from the next annual WHO update.

The impact of postponing a release depends on the timing of the notice. Postponement before the issue of the electronic data files in November may have little impact on the majority of users in terms of wasted effort.

Impact of postponing an update

There are advantages and disadvantages associated with a delayed release – see below. The significance will depend on the specific circumstances. If the release contains codes critical to government policy, postponement could be unacceptable and the matter would be escalated to the highest authorities at DH and the WHO for resolution. However, if the changes are routine, it may be acceptable to delay implementation to the following year.

Negative

- Unable to align with the latest clinical knowledge in the WHO classification to provide improved classification representation of medical conditions and indexing for clinical coders.
- Unable to support the government commitment made in 2010 to support quality improvements and requirement for a 3 yearly update cycle.
- Unable to support government initiatives with latest clinical knowledge, such as the classification of Female Genital Mutilation (FGM).
- Dissatisfaction by clinical coders and data users at inability to assign codes published by WHO.
- Loss of an opportunity to produce better statistics to improve patient care and management of health care delivery.

Positive

There would be no requirement for

- Trusts to update patient administration and other systems to accommodate the changes.
- System suppliers to update trust systems.
- Updating implementation guidance, training materials and delivering training and awareness sessions on the changes.
- HSCIC to update SUS and HRG Grouper(s), data steward database and Hospital Episode Statistics.
- Trusts, clinical commissioning groups, analysts etc to update their data.

Mitigation

The Clinical Classifications Service aligns their release schedule with the WHO release schedule to reduce the risk of WHO artefacts not being available on time. The Clinical Classifications Service, through close liaison with the WHO, seeks to identify delays as soon as possible.

If it becomes apparent that the release cannot go ahead, the Developer will contact SCCI about the issue of a postponement notice to all stakeholders.

The Clinical Classifications Service would follow the steps below to mitigate the impact on the NHS of a change to the ICD implementation date by:

- working closely with the WHO to identify and resolve issues that may be detrimental to the HSCIC ICD-10 release schedule.
- carefully assessing the likelihood of potential delays to artefacts before the release of the electronic data files to avoid wasted effort by system suppliers and other stakeholders.
- escalating any issues to higher management immediately where the updates are critical to government policy.
- logging risks and issues and associated mitigating actions in the HSCIC Risks and Issues tracking database for the monitoring of corrective actions.

16 Change implementation plan

All consultant episodes that end on or after the 1 April 2016 must be coded to ICD-10 5th Edition. This requires national and local computer systems to be updated to accept the code changes. The early release of the ICD-10 5th Edition data files and file specifications are essential to enabling the NHS and NHS system suppliers to achieve the code changes as well as engagement with key stakeholders. This is followed by provision of clinical coding materials to help the clinical coding community and analysts to understand and apply the changes in readiness for use from 1 April 2016.

Implementation of the ICD-10 updates is supported by the well-established infrastructure put in place by the Clinical Classifications Service. The quality management system governing the provision of the Clinical Classifications Service is ISO 9001:2008 certified.

A high level release timeline is provided below.

ICD-10 5th Edition Release Products	Release date
Submission of Advance Notification (AN) to SCCI for approval and subsequent publication to the NHS and NHS system suppliers in April	April 2015
Provide Draft Summary of updates from ICD-10 4 th edition to ICD-10 5 ^h Edition	April 2015
Submission to SCCI to approve implementation of updates and consequent release of Information Standards Notice (ISN) and supporting documentation	26 August 2015
Information Standards Notice Publication	18 September 2015
Publish final Summary of Changes ICD-10 4 th Edition to 5 th Edition	September 2015
Release of ICD-10 Codes and Titles and Metadata file and Table of Coding Equivalence between versions for HSCIC, NHS and NHS system suppliers via TRUD	02 November 2015
Two trainer Forums (Changes to training materials as a result of ICD-10 5th Edition included in the agenda)	January 2016
Release Key Learning Points	January 2016
ICD-10 Volumes 1-3 subject to WHO publication schedule	January/February 2016
ICD-10 eVersion (Includes Installation Guidance and Release Note)	January/February 2016
National clinical Coding Standards ICD-10 5 th Edition reference book	January 2016

All associated training materials and guidance	January 2016
The Read Codes to ICD-10 Cross-maps	Mid-March 2016
SNOMED CT to ICD-10 Cross-maps	Mid-March 2016
Implementation of ICD-10 All consultant episodes that end on or after the 1 st April 2016 must be coded to ICD-10 5 th Edition.	1 st April 2016

17 Communications Plan

See ICD-10 5th Edition Communications plan. Available on request from the Information Standards Helpdesk. Email: information.standards@hscic.gov.uk

As well as the SCCI notifications to the NHS and NHS system suppliers the Clinical Classifications Service uses existing communication mechanisms to prepare users for the changes. Explanatory marketing collateral (website, leaflets where permissible) compliant with accessibility requirements (plain English) are provided. Primarily:

- Coding Clinic (technical journal) which is published on the website quarterly or more frequently depending on need
- Email bulletins to approved Clinical Coding Trainers, Clinical Coding Auditors
- Briefings to coding forums / events /training etc to raise awareness.

Information is provided at stakeholder meetings such as Clinical Coding Working Group (DH, Monitor, HSCIC), UK Terminology Centre Implementation Forum, Clinical Coding Academies, local coding forums, UK Coding Review Panel, NICE Interventional Programme collaborative meetings etc.

18 Contacts

The following table lists the contacts for the standard.

Developer	
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