

STANDARD OPERATING PROCEDURE RECORDING TREATMENT AND ASSESSMENT INTERVENTION SNOMED CLINICAL CODES IN LORENZO

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VALIDITY – All local SOPS should be accessed via the Trust intranet

CHANGE RECORD

Version	Date	Change details
1.0	April 2024	New SOP. Approved at Operational Delivery Group (22 April 2024).

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1. Introduction

It is an NHSE requirement that all Mental Health and Learning Disability treatments and procedures are recorded on the EPR (currently Lorenzo) with an appropriate SNoMED CT code which has been approved by NICE/NHSE.

SNoMED CT (**S**ystematised **N**omenclature of **M**edicine - **C**linical **T**erms) is a structured clinical vocabulary for use in an electronic health record, designed so that each item or event relating to a patient's care can be given a specific code.

To simplify the process of selecting and recording codes Lorenzo has been configured with a reduced list of codes to align with the NICE/NHSE approved codes (meaningful codes).

This list is intended to cover the most common interventions but may not currently cover all aspects of care, so is expected to evolve over time as feedback and data on the codes used are collected.

SNoMED codes used within mental health services look at how clinicians record what they have delivered to the service user and provide direction on interventions.

The aim is to provide a national consensus to ensure that all providers report key interventions in a uniform way. The interventions and outcome data mapped to relevant SNoMED codes will then go to NHS Digital as part of the Mental Health Services Data Set (MHSDS).

Ensuring that accurate data is submitted into MHSDS will support services and individuals by:

- enhancing the individual therapy experience of service users, by monitoring outcomes
- supporting the development of each practitioner's clinical skills and development
- supporting the development of teams/services in using effective interventions

Commissioners can use the data to:

- inform future needs assessments
- review service provision through benchmarking and level of service required
- inform priorities in terms of the most effective services inform the design of services that will provide the most effective use of resources to get the best outcomes
- manage contract performance
- receive service user feedback on service provision, which will enhance services

2. Scope

This document is for use by all clinical and administrative staff with patient contact recording responsibilities within Mental Health and Learning Disability services (currently via Lorenzo).

This document is designed to support with the following, in relation to SNoMED coding for treatments and procedures:

- Capture Points
- Recording a code in Lorenzo
- How to request a new code
- How to access reports on compliance
- Governance structure and process

Please note that SNoMED coding for diagnosis is not currently within the scope of this document.

Please note that SNoMED coding is an additional requirement when inputting clinical contacts. SNoMED coding should be inputted on the coding screen when recording treatment and assessment intervention care contacts.

3. Duties and Responsibilities

Chief Operating Officer – the Chief Operating Officer will ensure that this policy is acted upon by Divisions via a process of policy dissemination and implementation in collaboration with senior managers.

General Managers & Clinical Leads – responsible for the application of this SOP to ensure performance compliance is achieved. General Managers will provide assurance to the Chief Operating Officer via Performance and Productivity and Patient Care Performance Accountability meetings. The General Manager is jointly responsible with the Clinical Lead for ensuring a Divisional SNoMED Lead is in place.

Divisional SNoMED Lead – will provide advice and guidance regarding SNoMED coding and associated processes.

Service Managers – the Service Manager is the budget holder and is responsible for the service meeting their performance indicators. The Service Manager holds responsibility for the operation of the service, working closely with the Team Manager to facilitate and enable this including SNoMED recording. The Service Manager will report directly to the General Manager of the Division and provide compliance assurance via Divisional Performance meetings.

Team Managers, Clinical Leads – ensure that SNoMED coding is being used and compliance discussed in supervision to drive performance. Identify where appropriate SNoMED codes are not available and follow the process outlined in this SOP to request from NHSE as required.

Administration team – the Administration team provides administrative and clerical support to the clinical team as required.

Clinicians – accurate recording of patient events, including SNoMED coding via the EPR in line with Trust Policy. Identify where appropriate SNoMED codes are not available and follow the process outlined in this SOP to request from NHSE as required.

Business Intelligence Team – Develop and provide reporting to support services with ensuring compliance is achieved.

Business Intelligence Lead – oversee and facilitate requests for new SNoMED codes via NHSE. Oversee housekeeping process to ensure the EPR lists are aligned with the national data reference set.

Humber Digital team- To provide Training and guidance on system input of SNoMED codes

4. Procedures

4.1. SNoMED Coding Capture points

SNoMED coding should be entered at every direct clinical treatment, assessment, or intervention where a code exists in the national data reference set. The clinician or administrative staff member when tasked by the clinician should record the appropriate SNoMED code within 1 working day of the event having taken place. Please refer to Appendix 1 which contains a guide on how to input a SNoMED Code.

It is acknowledged that there are instances where appropriate SNoMED codes are not yet developed or available within the reference set. Please see section 4.2 to follow the Trust process where this is identified.

4.2. Requesting a New Code

Meaningful Codes – is a SNoMED code that is recognised by NHS England for reporting purposes and is included within the national data reference set.

Non-Meaningful Codes – is a SNoMED code that exists that has not been approved by NHS England for reporting purposes and therefore does not exist within the national data reference set.

You must only use the meaningful codes within Lorenzo using Trust approved drop down lists that are aligned with the national data reference set. Although it is possible to search for codes outside of the drop-down lists these must not be used, and monitoring is in place to support with this. See appendix 1 – recording a code.

Where it is identified that an appropriate SNoMED code does not exist within the national data reference set (Lorenzo drop down lists), the following process should be followed:

Step	Process	Who
1.	Contact the Divisional SNoMED Lead to discuss	Clinician / Clinical Lead
2.	Review full SNoMED browser to determine if an appropriate and reflective code exists	Clinician / Divisional SNoMED Lead
3.	Request agenda addition for Data and Digital Delivery Group meeting ensuring representation for the meeting	Clinician / Clinical lead
4.	Request approval from Data and Digital Delivery Group to request new code from NHSE	Divisional Representative
5.	BI lead will take forward the request if approved	BI Lead

Please see appendix 2 for full governance process.

If approved by the Data and Digital Group, a request will be made to NHSE by the BI Lead to include in the National Data Reference Set and will be added to the drop-down lists within the EPR once confirmation is received.

5. Implementation

General Managers for each Division will be responsible for addressing the implementation of this SOP within their service areas. Service Managers and Clinical Team Leads will ensure the SOP is embedded within their service areas.

6. Monitoring & Compliance

It is expected that all services will meet the following compliance trajectory:

24/25	Q1	Q2	Q3	Q4
% of interventions recorded with meaningful SNoMED Code	25%	50%	75%	80%

Compliance against this trajectory will be monitored by the following:

- Trust Performance and Accountability Meetings
- Performance and Productivity Meeting
- Divisional ODG/Divisional Performance and Accountability Meeting
- Service Level Performance Meetings
- Team Level Performance Meeting
- Supervision

Divisions/Services will use the Power BI SNoMED compliance report as an operational tool for identifying where SNoMED coding has not been recorded and ensuring this is addressed. This approach will support services with understanding training requirements and performance related issues.

The Power BI report can be access via the following link:

[Reporting & Analytics \(humber.nhs.uk\)](https://humber.nhs.uk)

The Mental Health Services Data Set (MHSDS) can also provide information regarding SNoMED recording compliance:

[Mental Health Services Data Set \(MHSDS\) - NHS Digital](https://humber.nhs.uk)

Training on how to access and use the Power BI report is available at:

[Reporting & Analytics \(humber.nhs.uk\)](https://humber.nhs.uk)

The [Humber Digital Team](https://humber.nhs.uk) can be contacted for any training required in relation to recording of SNoMED codes onto the EPR (please see appendix 1 – Recording a Code).

7. References

[Data Quality Policy F-021.pdf \(humber.nhs.uk\)](https://humber.nhs.uk)

[SNOMED CT - NHS Digital](https://humber.nhs.uk)

[Reporting & Analytics \(humber.nhs.uk\)](https://humber.nhs.uk)

[Mental Health Services Data Set \(MHSDS\) - NHS Digital](https://humber.nhs.uk)

[Coding from a contact using the Shared Favourites.pdf \(humber.nhs.uk\)](https://humber.nhs.uk)

These are the links for existing NHSE policy guidance with SNoMED code lists.

Area	Guidance	Publication
PT-SMHP	Psychological Therapies for people with Severe Mental Health Problems	October 2021
AED	Adult Eating Disorders	October 2021
EIP	Early Intervention in Psychosis	November 2022
Dementia	Dementia and memory clinics and Coding source for good care planning	2018
MHSTs	Mental Health School Teams	October 2021
CYP ED	Commissioning Guide Access and Waiting Time Standard for Children and Young People with an Eating Disorder (July 2015) and Guidance for reporting against access and waiting time standards: Children and Young People with an Eating Disorder (2016).	February 2016
Perinatal	Perinatal Mental Health Psychological Therapies	2022
CYP	Children and Young People's Waiting Times	December 2022

Appendix 1 – Recording a Code Guide

Creating a Single Contact from the Clinical Chart

- In the patient record go to Clinical Charts
- Select the menu button, scroll down to Care Events
- Select Create Single Contact



- Complete the contact details

The screenshot shows the 'Contact details' form. The form is divided into several sections: 'Care provider', 'Health organisation', 'Team', 'Patient', 'Contact details', 'Location details', and 'Referral'. The 'Care provider' section includes 'Latham Rebecca' and 'Specialty: ADULT MENTAL ILLNESS'. The 'Health organisation' section includes 'HUMBER NHS FOUNDATION TRUST' and 'Treatment function: ADULT MENTAL ILLNESS'. The 'Patient' section includes 'XXTESTPATIENTDHBD Csc-donotus'. The 'Contact details' section includes 'Purpose: Intervention', 'Contact type: Face To Face', 'Contact subject: Patient', 'Consultation medium: Face to face', 'Intervention type (CAMHS)', and 'Intervention status (CAMHS)'. The 'Location details' section includes 'Location Type: Patient/Service User's Home', 'Service Point', and 'Location: Humber Centre For Forensic Beverley Road, Willerby HU11, United Kingdom'. The 'Referral' section includes 'Referral Date: 01/02/2013 08:36:00', 'Referred by health organisation', 'Referred by care provider', 'Referral to health organisation: HUMBER NHS FOUNDATION TRUST', 'Referral to type: Team', 'Referral to name: XXTESTTEAMXX', 'Referral type: Mental health-Community', 'Referral source: Other', 'Episode: 01/02/2013 XXTESTTEAMXX', 'Create referral', 'Interpreter required', 'Interpreter Booked', and 'Preferred language'. The form has a blue header and a blue footer with buttons for 'Suspend', 'Reassign', 'Next', and 'Cancel'.

Referral

Referral Date

Referred by health organisation

Referred by care provider

Referral to health organisation

Referral to type

Referral to name

Referral type

Referral source

Episode

Create referral

Click on the Referral Search button to bring through the referral to link to the contact

- Click Next to go to the Scheduling page
- Check the date of the contact (**defaults to current date**), and input all relevant times, including the travel times

XXTESTPATIENTDHAO , Csc-donotuse (Mr) Male DOB: 26-Sep-1974 40 Yrs Patient ID: HFT0000004 NHS No: 999-033-8485
Allergies/ADRs - None Recorded (Not Checked On 08-Sep-2015)

» Contact details » **Scheduling** » Attendees » Outcome » Documents

Scheduling

Planned/Actual date/time

Care provider name: Latham Rebecca
 Planned/Actual date: 08/09/2015
 Outward journey start time: 08/09/2015 10:00 Hrs:Mins
 Outward journey duration: 00:00 Hrs : Mins
 Planned/Actual contact start time: 10:00 Hrs : Mins
 Planned/Actual contact duration: 01:00 Hrs : Mins

Planned/Actual contact end time: 08/09/2015 11:00
 Return journey duration: 00:00 Hrs : Mins
 Return journey end time: 08/09/2015 11:00
 Total duration: 01:00 Hrs:Mins
 Status: Actual

Other Care providers

Care provider: [...]

View diary	Care provider name	Team	Specialty	Status
There are no records to show				

Suspend Reassign Previous Next Cancel

- Click on the Outcome screen to complete the outcome (return appointment) then Finish Now at the bottom of the screen

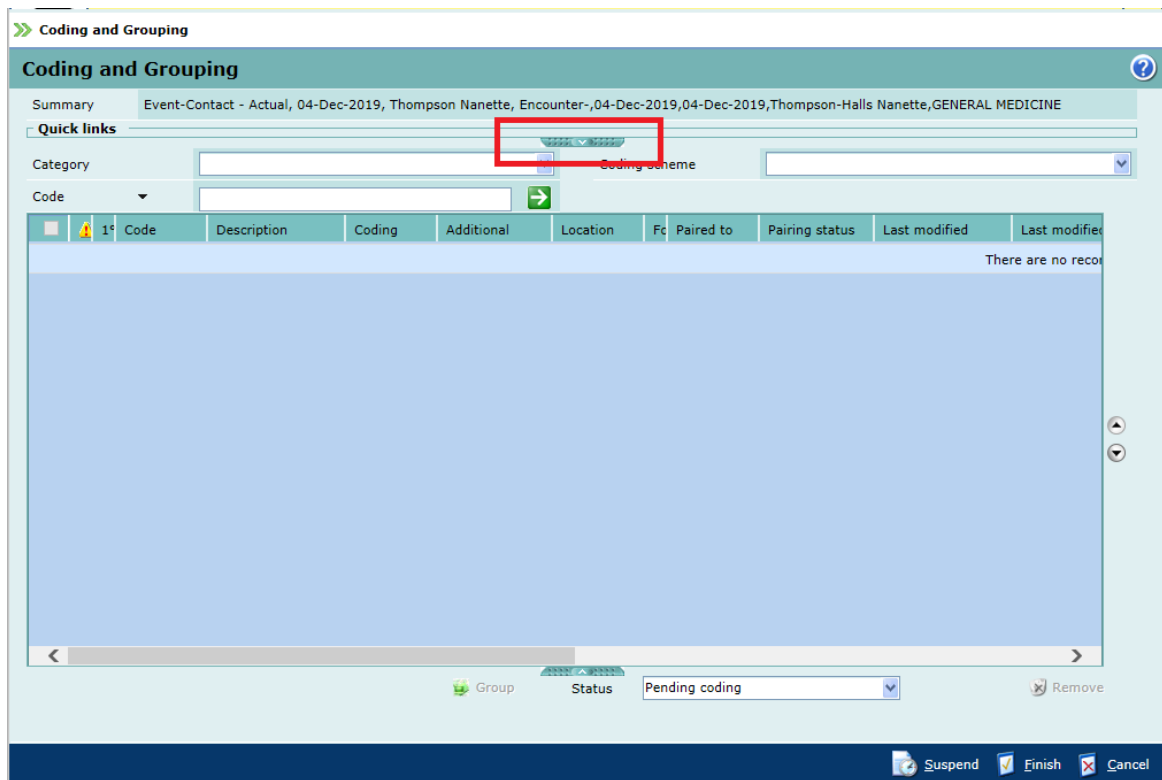
Coding the Contact

- Once you've recorded your contact click Finish Now on the above contact screen
- The below Care Activities screen will appear, select any of the care activity options to carry out a care activity. Once you have finished completing any care activities click Finish Now on the Care Activities screen

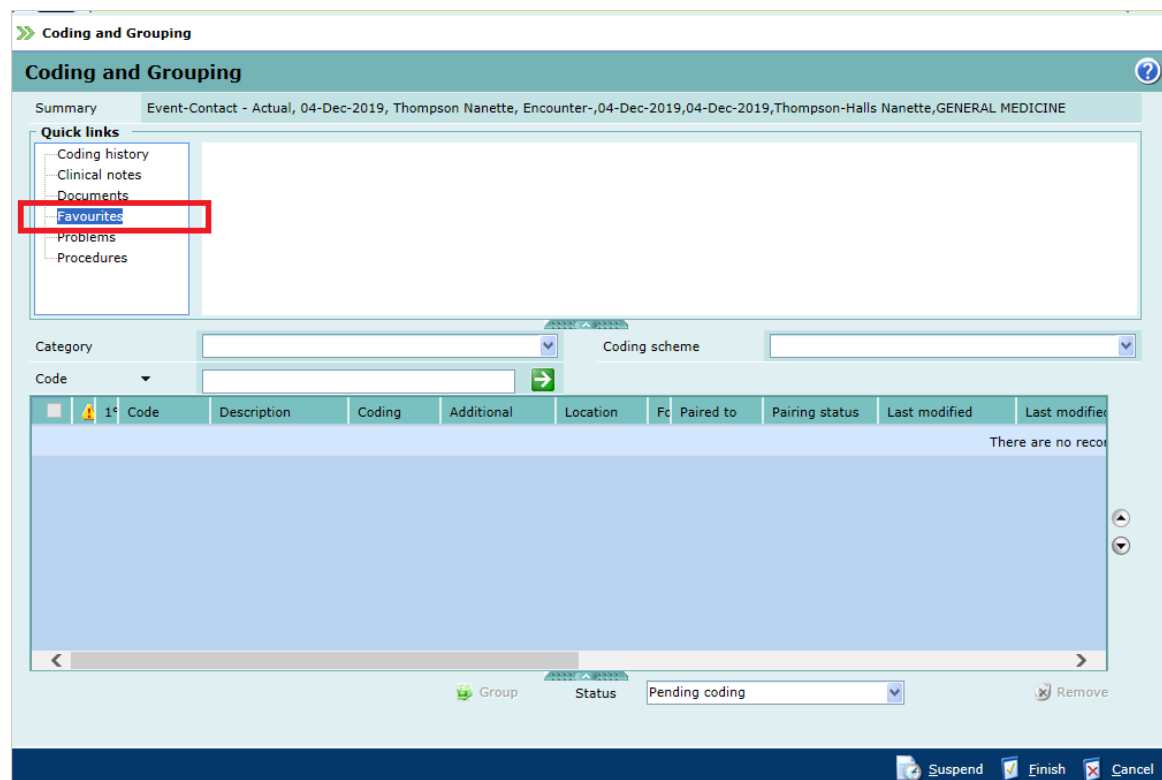
- In the Coding and Grouping screen, add in the following information:

Find a code through the Shared Favourites:

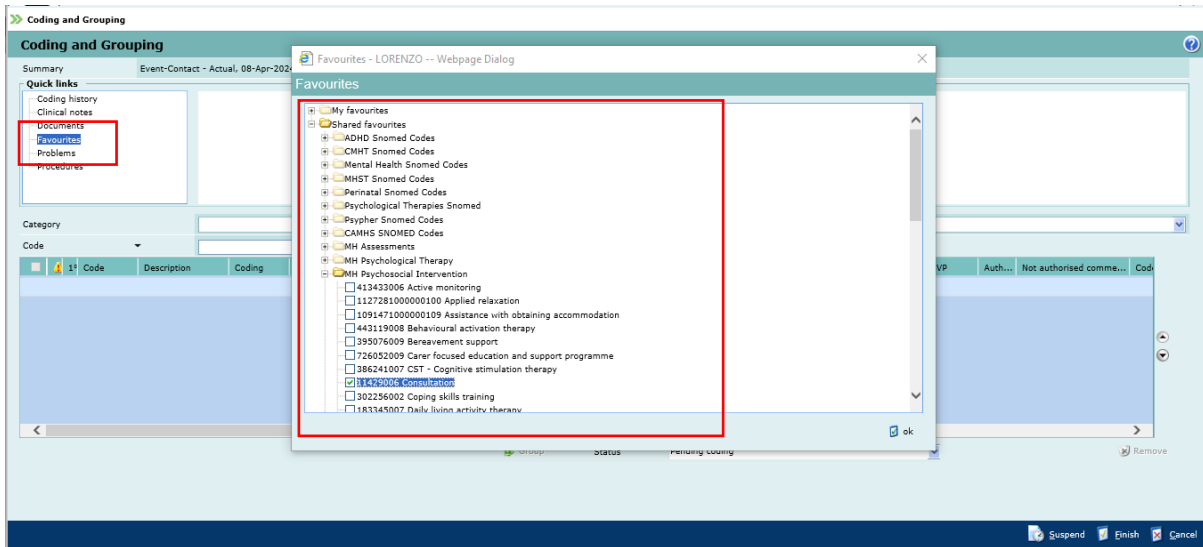
- The coding and grouping page will open after you have finished your contact and finished the care activity page for creating a note
- Click onto the green toggle button to display the quick links panel



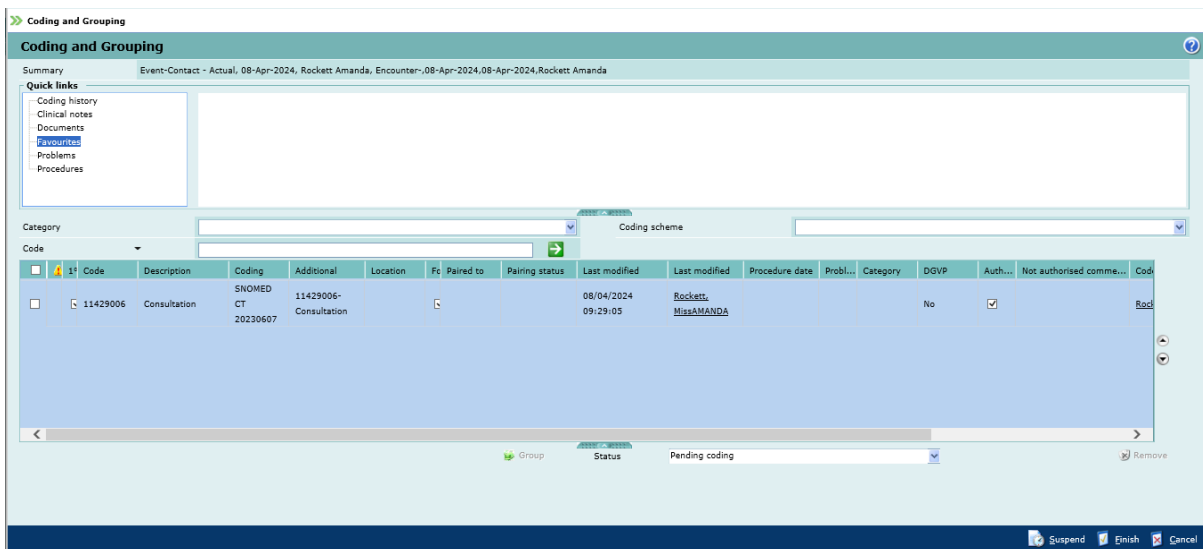
- Select Favourites from the quick links box



- Expand the nodes to view folders and contents
- Select the code from a folder

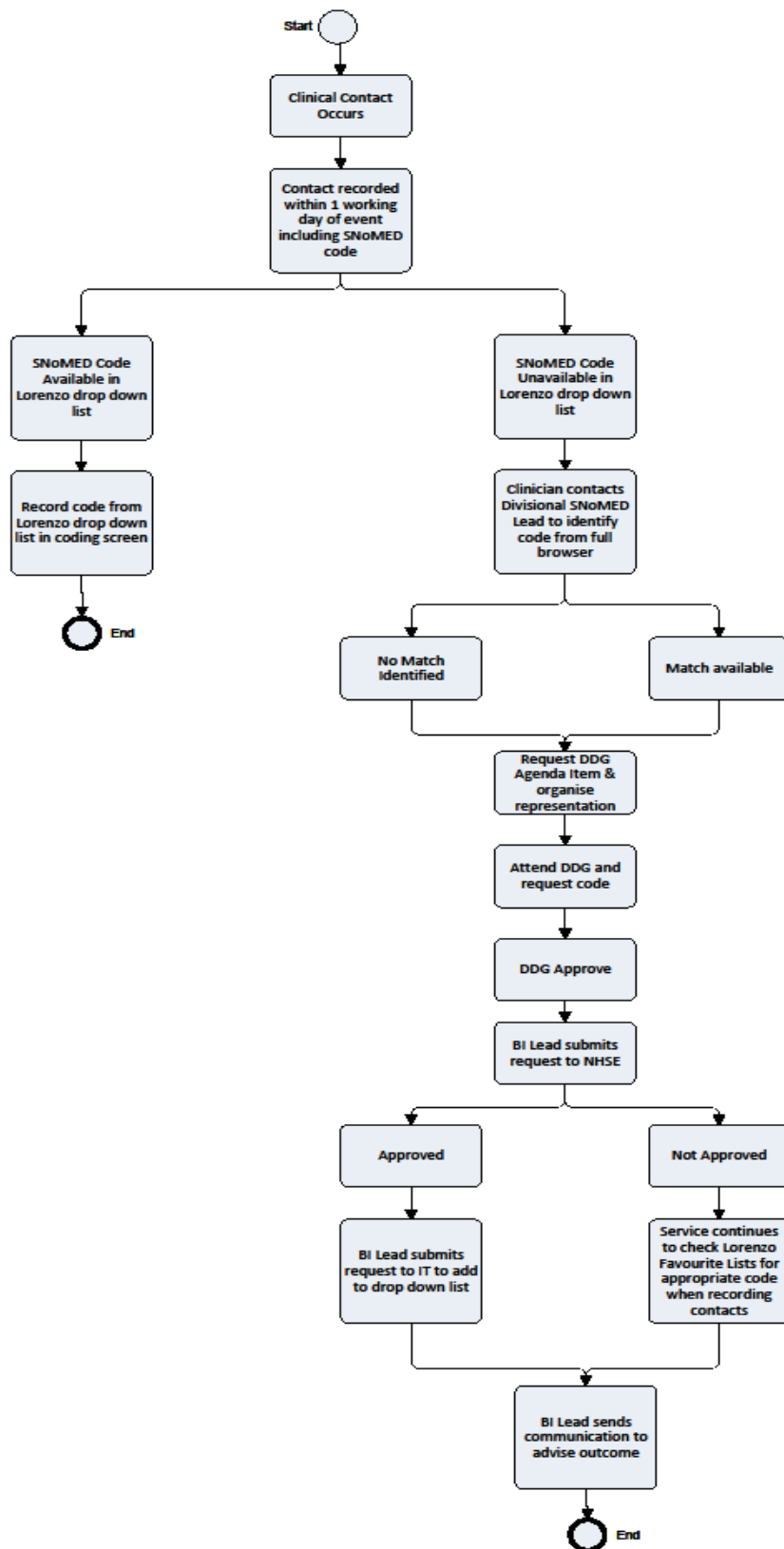


- Click OK
- The code will now appear in the grid



- Click Finish to save
- Click cancel on the documents screen

Appendix 2 – Process Flowchart



- BI Lead performs monthly checks against data reference set to ensure Lorenzo Favourite Lists Align.
- BI Lead will send communication when new codes are available
- Systems & Training Team will not amend Lorenzo Drop Down Lists without BI Lead confirmation