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Clinical coding follow-up review – **Betsi Cadwaladr University Health Board**

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The person who delivered the work was Sara Utley.

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The Health Board has improved its coding performance significantly, but has not yet realised the full potential of clinical coding and more work is needed to engage with clinicians and improve medical records.

Summary report

Introduction

1 Clinical coding involves the translation of written clinical information (such as a patient's diagnosis and treatment) into a code format. A clinical coder will analyse information about an episode of patient care and assign internationally recognised standardised codes[1].

2 Good quality clinically coded data plays a fundamental role in the management of hospitals and services. Coded data underpins much of the day to day management information used within the NHS and is used in many different systems and presented in different formats. It can be used to support healthcare planning, resource allocation, cost analysis, assessments of treatment effectiveness and can be an invaluable starting point for many clinical audits.

3 Coding departments within Welsh NHS bodies are required to satisfy standards set by the Welsh Government on completeness and accuracy of coded data. Performance against these standards form part of NHS bodies' annual data quality and information governance reporting.

4 During 2014-15 the Auditor General reviewed the clinical coding arrangements in all relevant NHS bodies in Wales. That work pointed to several areas for improvement such as the accuracy of coding, the quality of medical records and engagement between coders, clinicians and medical records staff.

5 We also found that NHS bodies routinely saw clinical coding as a back-office role, often with little recognition of the specialist staff knowledge and understanding needed. In addition, not all NHS bodies understood the importance of clinical coding to their day to day business.

6 In October 2014 we reported our findings for Betsi Cadwaladr University Health Board (the Health Board). The report concluded that 'whilst there had been a positive investment and focus on clinical coding within the Health Board, a lack of consistent coding processes, low clinical engagement and slow access to medical records could potentially affect the accuracy of clinical coded data'. More specifically we found that:

- although the Health Board recognised the importance of clinical coding, resources were insufficient and stronger links were needed to medical records and the board needed to focus more on the accuracy of clinical coded data in its reviews;
- the effectiveness of the coding process was being affected by low levels of clinical engagement, slow access to medical records and a lack of consistent coding processes; and

[1] For diagnoses, the International Classification of Diseases 10th edition (ICD-10), and for treatment, the OPCS Classification of Interventions and Procedures version 4 (OPCS)

- clinical coded data was used appropriately with good overall performance against Welsh Government standards, but there were areas for improvements related to consistency, standards and accuracy.

7 We made a number of recommendations, which focused on:

- raising the profile and awareness of clinical coding across the Health Board;
- developing a single coding policy and procedure to ensure consistent practices and processes;
- strengthening clinical engagement with medical staff; and
- improving the quality of medical records across the Health Board.

8 As part of the of the Auditor General's 2018 audit plan at Betsi Cadwaladr University Health Board, we have examined the progress made in addressing the recommendations set out in the 2014 Review of Clinical Coding and any resulting improvement in clinical coding performance.

9 In undertaking this work, we have:

- reviewed documentation, including reports to the board and committees;
- asked the Health Board to self-assess its progress so far;
- analysed clinical coding data sent to the Welsh Government;
- sought board member views[2] on their understanding of clinical coding; and
- interviewed staff to discuss progress, current issues and future challenges.

10 We summarise our findings in the following section. Appendix 1 provides specific commentary on progress against each of our previous recommendations.

Our findings

11 We conclude that the **Health Board has improved its coding performance significantly, but has not yet realised the full potential of clinical coding and more work is needed to engage with clinicians and improve medical records.**

The Health Board's clinical coding performance has improved significantly but is not yet above the Welsh Government target

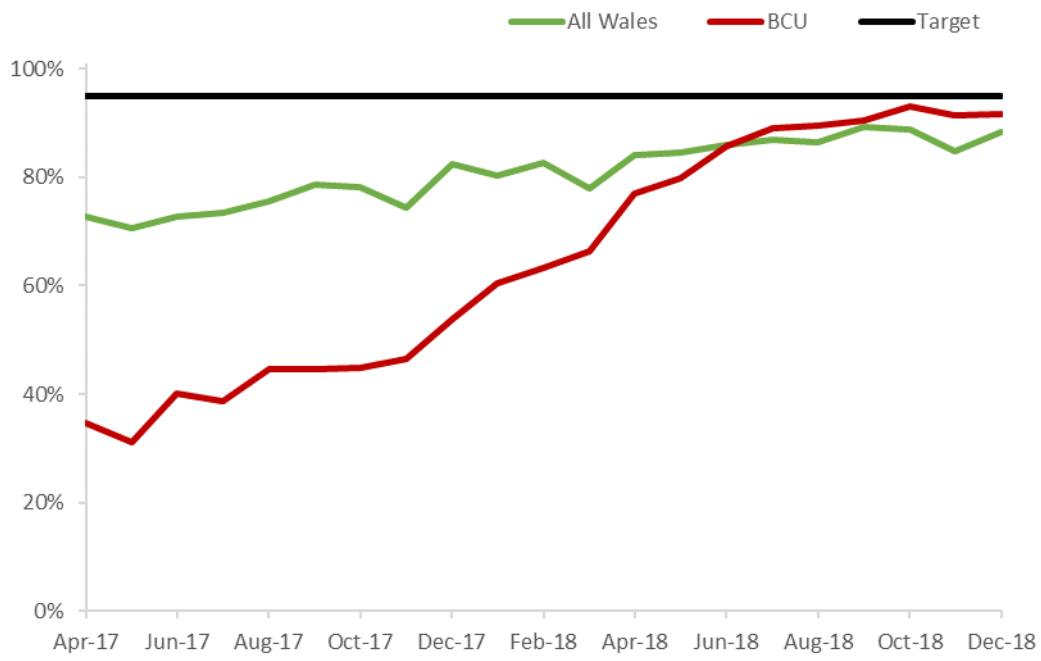
12 The Welsh Government has two coding related Tier 1 targets which NHS bodies are required to meet. These relate to completeness and accuracy.

13 Each year, NHS bodies send data to the Welsh Government showing their performance against the Tier 1 target for **completeness**. The target is that 95% of hospital episodes should have been coded within one month of the episode end date. NHS bodies need to meet this target monthly rather than at the end of each

[2] A number of questions relating to clinical coding were included in the board member survey which formed part of our 2018 Structured Assessment work. A total of eight responses out of a possible 22 responses were received.

financial year which was previously the case. Based on this data, Exhibit 1 shows that the Health Board's completeness has improved considerably over the past year and a half. However, they are yet to meet the Welsh Government target.

Exhibit 1: percentage coded within one month of the episode end date



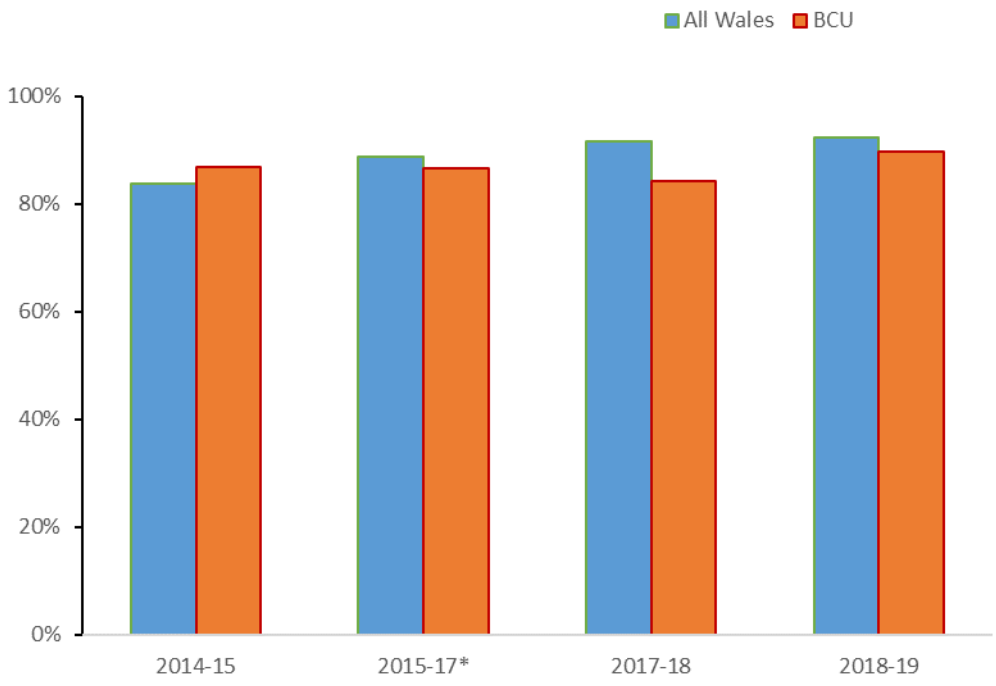
Source: Wales Audit Office analysis of clinical coding data reported by health bodies to the Welsh Government

14 As part of our fieldwork, we requested the year-end backlog position as at March 2018. The position at the end of 2017-18 was a backlog of 23,119 finished consultant episodes (FCE's) which was a considerable improvement on the previous year end position in 2016-17 of 70,000 FCEs. Work to address this backlog has been considerable and the team must be congratulated on their work to date in bringing the backlog down. However, this has meant that progress has not been made in other areas such as developing standard coding operating procedures and undertaking routine accuracy reviews due to pressures on staff capacity.

15 Each year, the NHS Wales Informatics Service (NWIS) Standards Team check the **accuracy** of clinical coding. They do this by reviewing a sample of coded episodes and checking the information against evidence within the patients' medical record to assess accuracy. NHS bodies are expected to show an annual improvement in their accuracy. Based on this review, Exhibit 2 shows that the Health Board's

accuracy has improved by 5.45% in their latest assessment. This is a positive result for the coding teams, especially against a background of significant backlog which has taken up considerable resources and time for the team to address. Accuracy levels however still fall short of the all-Wales comparison.

Exhibit 2: percentage of episodes coded accurately



Source: results of NWIS clinical coding accuracy reviews 2014-2019

* Note that due to capacity within the NWIS clinical coding team, a single accuracy review was undertaken during the period 2015-16 and 2016-17.

The Health Board has not yet started to use clinical coded data to its full potential to support improvement

16 Previously we found that not all NHS bodies understood the wider importance of clinical coding to their business and they were missing opportunities to use this information more extensively. For example, to plan and monitor services, where coding can be used to:

- assess volumes of patients following particular clinical pathways; and

- provide comparative activity data to evaluate productivity, quality and performance.

17 The coding portfolio remains with the office of the Medical Director reporting through the Informatics Department. Day-to-day management is by the Head of Clinical Coding who reports to the Head of Information who in turn reports to the Assistant Director of Informatics. Previously performance against the two key coding indictors; completeness and accuracy, was through the quarterly Integrated Quality Performance and Workforce Report. This report highlighted the backlog issues, as well as detailing the trajectory and actions being taken to remove the backlog. However, the information stopped short of explaining the implications of this backlog on the quality of the data and impact to the Health Board. The last of these reports was in September 2018 where the completeness performance was at 80%. However, following work by the executive to rationalise the performance report to a more manageable size, the focus on coding has been lost. A new sub group of the Board has been established called the Information Governance and Informatics Committee and it would seem sensible for coding performance to be reported at this group to maintain oversight of performance in terms of completeness and accuracy.

18 The Health Board is using coded data to inform some elements of service planning. However, this usage is ad hoc and not maximising the full potential of coded data. Since our previous work, the Health Board has expanded the activity which is coded. Following a request from clinicians within the clinical decision unit, this activity is now coded to accurately reflect the nature of their work and inform job planning. Some work has also been undertaken in speciality areas such as Urology to understand prevalence of particular illnesses. However, the benefits of coded data to clinicians have not yet been realised. These include supporting medical revalidation and being able to identify trends in diseases or prevalence within the population.

Some progress on implementing a number of recommendations has been made, but addressing the coding backlog has meant that a lot of actions still need to be completed fully

19 Exhibit 3 summarises the status of our 2014 recommendations.

Exhibit 3: Status of our 2014 recommendations

Total number of recommendations	Implemented	In progress	Overdue	Superseded
15	3	12	0	

Source: Wales Audit Office

20 Our follow-up work has found that the Health Board has made some progress against our 2014 recommendations, although the scale of progress has been limited due to capacity issues within the team.

21 Following our previous review, the Health Board delivered training for Board members on Clinical Coding. Since this training there has been a turnaround of Board Members. Also, five out of eight respondents to our Board member survey stated that they would find it helpful to have more information on clinical coding and the extent to which it affects the quality of performance information. The full board survey results are available in Appendix 2. The Health Board may need to revisit this training.

22 The Health Board has a coding policy and work is being undertaken to develop standard operational procedures to support consistent coding practice across the Health Board. Although there has not been any progress on internal coding audits, there are a range of validation checks in place. These are not as comprehensive as a full review but will highlight common mistakes. There remain however some variations in coding practices.

23 Positively there has been significant increase in staff levels amongst the teams since our last review. In our previous review we highlighted that filling vacancies and developing successions plans were vital for maintaining stability within the team. Our follow up has found that there has been a 32% increase in overall staffing numbers. Arrangements for succession planning have improved and currently the clinical coding department have 18 trainee coders, who are being supported to study towards their Accredited Clinical Coder qualification. This has been supported by additional monies allocated through the Health Boards informatics plan where it had been recognised that there were cost pressures within coding, and the need to reduce risks posed by over reliance on temporary staff.

24 Clinical engagement remains an area of focus for the teams. Engagement with clinicians on coding has remained the same with only a handful of individual conversations being held with consultants being identified. The coding team feel issues with capacity because they have been focussed on clearing the backlog has affected their ability to undertake awareness raising and clinician engagement activities and hope to focus on this in future. There is scope to improve the Health Board's arrangements for medical staff induction on clinical coding. The materials being used could be updated to provide a more holistic overview of the coding arrangements within the Health Board. It is clear to see that materials have not been updated for some time and would benefit from being refreshed. A positive development within the Health Board is the Medical Information Officer. This is a new role which reports to the Chief Medical Information Officer. Each hospital has a Medical Information Officer in post. Their role is to support the Chief Medical Information Officer with the development of a clinically-oriented Digital Strategy for the Health Board. They also have a positive influence from a coding perspective as they will lead on improving clinical engagement with clinical coding, as well as

supporting in promoting the work of the clinical coding service and the need for good record keeping amongst peers.

25 Since our last review there is better engagement between health records and coding. Previously there were informal working relationships in place between the two departments, and there was no formal engagement on the Health Records Group. The Health Records Group has subsequently been renamed the Patient Record Group, and coding staff are now attending this group. The group is chaired by a consultant, and there are representatives from various areas of the Health Board. This includes the Head of Digital Records which is an important link for coding as they will be a key user of the digital systems implemented by the Health Board. However, although attendance at this group is positive, the group appear to meet infrequently, which raises concerns about its effectiveness.

26 Improvements have been made to casenote tracking with the Health Board investing in a Radio Frequency Identification (RFID) file tracking system to track casenotes through the main hospital sites. This helps support coders trying to locate notes quickly to code them as they are automatically tracked through a series of scanners. However, there are still issues with the quality of casenotes. The latest NWIS accuracy report advised that an immediate effort should be made to ensure that all staff within the Health Board who have any responsibility for clinical case notes are reminded of the need for good practice regarding their use. Through our focus groups the issue of poor condition of records was highlighted with an emphasis on the lack of focus on ensuring the notes for deceased patients are filed correctly to ensure a complete record. This is of concern as this could potentially affect the mortality review process.

Recommendations still outstanding

27 In undertaking this work, we have made some additional recommendations. These are set out in Exhibit 4. The Health Board also needs to continue to make progress in addressing our previous recommendations. The outstanding recommendations are set out in Exhibit 5.

Exhibit 4: new recommendations

2019 Recommendations	
Board Awareness	
R1	Ensure that performance on coding is reporting into the newly formed information governance informatics committee to ensure that monitoring performance against the Welsh Government target is maintained.
Clinical engagement	
R2	Revisit training materials and standardise across the Health Board, ensuring that the materials reflect the totality of the Health Boards coding not just site based.

28 The outstanding recommendations are set out in Exhibit 5.

Exhibit 5: recommendations still outstanding

2014 recommendations not yet complete
Clinical Coding Policy and Procedures R2 Introduce a single coding policy and procedure across the heath board which brings together all practices and processes to ensure consistency. The policy and procedure should include: a) ensuring coding practices are well described; b) providing guidance and feedback to staff to enable consistent practices across the health board; d) address variations in practices across the three sites; and e) strengthen internal coding audits.
Clinical Engagement R3 Strengthen engagement with medical staff to ensure that the positive role that doctors have within the coding process is recognised. This should include: a) embedding a consistent approach to clinical coding training for medical staff across the health board; b) ensuring a consistent approach to medical staff induction across the health board; c) encourage the use of coding information for uses other than mortality statistics; and d) improve clinical engagement in the validation of coded data to drive improvements in quality and awareness of potential use of information.
Medical Records R4 Improve the arrangements surrounding medical records, to ensure that accurate and timely coding can take place. This should include quality of medical records across the Health Board. This should include: a) improving engagement between the clinical coding department and medical records; c) addressing the size of casenotes by clarifying roles and responsibilities; and d) ensuring the availability of training on the importance of good quality medical records to all staff.

Source: Wales Audit Office

Appendix 1

Health Board progress against our 2014 recommendations

Exhibit 5: Assessment of progress

Recommendation	Status	Target date for implementation	Summary of progress
Board Awareness R1 Improve Board reports to include detailed information on accuracy as well as comparative data:			
a. provide more information on accuracy of coding as well as backlogs and the effect this has on RAMI figures	**In progress**	December 2014	Following our review, the Health Board received reports on accuracy of coding at Board level through the Integrated Quality and Performance Report. These reports highlighted issues with a significant coding backlog which meant the Health Board were not meeting the Welsh Government target of coding 95% of episodes within one month of the episode end date. However, the information stopped short of explaining the implications of this backlog on the quality of the data and impact to the Health Board. The last of these reports was in September 2018 where performance was at 70.90%. Performance against the target has not been reported through a committee since this date. We recognise the recent establishment of the Information Governance and Informatics Committee and recommend that coding performance is reported at this group. We also previously recommended that the Board received more detail on coding and the impact on the Risk Adjusted Mortality Index (RAMI). In 2014 RAMI was removed as an indicator following the Palmer Review therefore this element of the recommendation is no longer relevant.

Recommendation	Status	Target date for implementation	Summary of progress
b. undertake training with board members on clinical coding to raise awareness of implications of clinical coding accuracy	**Completed**	December 2014	Following our original review all Board members received training in January 2016. However, since that time, there has been Independent Member turnover. The Health Board may wish to consider revisiting this training due to the new Independent Members within the Health Board. The results from our Board member survey show that five of the eight respondents through it would be helpful to have more information on clinical coding and the extent to which it affects the quality of key performance information.
Clinical Coding Policy and Procedures R2 Introduce a single coding policy and procedure across the health board which brings together all practices and processes to ensure consistency. The policy and procedure should:			
a. ensure coding practices are well described	**In progress**	January 2015	At our last review we found that the Health Board did not have a clinical coding policy which covered all sites and activities. There were historical policies in place for Wrexham Maelor and Glan Clwyd, with no policy in place in Ysbyty Gwynedd. The Health Board recognised the need for a single policy to address potential inconsistencies in practice and to provide more clarity for staff as to what is expected of them. A single coding policy is now in place, however there is further work to be done to fully complete implementation of this. Through our interviews, awareness of the policy was low amongst coding staff. Additionally, there are some elements that need to be changed to reflect the changes in the Welsh Government targets. The coding manager is currently developing standard operational procedures (SOP) to support the clinical coding procedure. This is positive and will provide additional information to support the coding policy and should address inconsistencies as well as clearly identify the routine validation checks which have been introduced.

Recommendation	Status	Target date for implementation	Summary of progress
b. provide guidance and feedback to staff to enable consistent practices across the Health Board	**In progress**	January 2015	The Health Board uses the PDP process and at the time of our review, the coding department were near 100% compliance with only one member of staff waiting for their review. Arrangements are in place for routine validation checks and if issues are identified these are fed back to the individuals. However, there could be more consistency in feeding back issues to the whole team across sites.
c. ensure plans are put in place to fill current vacancies and ensure effective succession planning	**Completed**	January 2015	Vacancies and succession planning are not detailed within the policy; however, the team have a workforce plan for the department. Positively there has been a significant change in staffing numbers since we last did the review. Overall staffing levels are up by 32% and the coding manager feels they are fully staffed. This has been supported by additional monies allocated through the Health Board's informatics plan where it had been recognised that there were cost pressures within coding, and the need to reduce the risks posed by over reliance on temporary staff. Arrangements for succession planning have also been improved since 2014. During our last review a third of the staff within the department were aged 56 and over and likely to retire in the next five years. Currently the clinical coding department have 18 trainee coders, who are being supported to study towards their Accredited Clinical Coder national clinical coding qualification. This increase in staff will have provided stability for the department.

Recommendation	Status	Target date for implementation	Summary of progress
d. address variations in practices across the three sites	**In progress**	January 2015	Work is ongoing to address any variations in practices across sites, and the coding management team meet to discuss any issues highlighted through routine validation checks. However due to pressures of work local team meetings do not always happen, and opportunities for the coding team to get together as a whole group are difficult to organise. Currently standard operational procedures are being developed by the coding manager, and these should help remove any variations in coding practices by providing more detailed instructions. In our last review we found variations in policies between the three DGH sites relating to mental health and community hospital coding. At Ysbyty Gwynedd coders within the team were coding activity relating to mental health and community hospital, whereas in Wrexham Maelor coding staff did not code mental health but did code community provision. At Ysbyty Glan Clwyd, they did not code either mental health or community. Positively all mental health activity across the Health Board is now coded by the coding departments, following changes in April 2015. However, there are still differences in approach in relation to coding community activity as previously found. There are also still different systems within the Health Board. Coding is carried out using the Welsh Patient Administration System (PAS) and 3ms Clinical Encoder in Wrexham Maelor and Ysbyty Glan Clwyd, but the Patient Information Management System (PIMS) is still used in Ysbyty Gwynedd.

Recommendation	Status	Target date for implementation	Summary of progress
e. strengthen internal coding audits	**In Progress**	January 2015	In our last review we highlighted that ensuring the consistent application of coding rules across the Health Board was a challenge, and one recognised by the Head of Coding. We recommended that the Health Board strengthen their own internal coding audits. The Health Board has two accredited clinical coding auditors; however, their qualification has now lapsed. There are no plans in place to renew their qualifications although they are aware of the audit methodology. The Health Board places reliance on the external audit conducted by NWIS at each of the three sites every other year as part of the National Audit Programme. They note that additional external audit may be commissioned additionally if required. The results from the NWIS accuracy audits are positive, and the Health Board are showing improvements. The Health Board has recently recruited a staff member who can undertake audit work, however they were not employed for this purpose, so it is unclear if they will undertake this role going forward. The Health Board recognises this position but reflects that the coding audits are very time consuming. A range of validation checks have been put in place which automatically look for common coding errors. These are positive but would not give the depth of information a formal review back to casenotes would.

Recommendation		Status	Target date for implementation	Summary of progress
Clinical Engagement				
R3	Strengthen engagement with medical staff to ensure that the positive role that doctors have within the coding process is recognised:			
	a. embedding a consistent approach to clinical coding training for medical staff across the health board	**In Progress**	August 2014	There is a recognition from coding staff that this work will never be completed, and that clinical engagement remains an ongoing challenge. During our last review we found that clinical coding positively featured as part of the induction for junior doctors. These arrangements have continued, and coders continue to attend the junior doctors' inductions with the last ones being in September 2018. Further work in this area has been affected by capacity within the team. Although there is recognition by the team they want to do more.
	b. ensuring a consistent approach to medical staff induction across the health board	**In Progress**	January 2015	We noted in our previous report that there were different approaches to medical staff induction at different sites. This has continued. There is evidence of clinical engagement events being undertaken, such as meeting junior doctors in Wrexham Maelor and providing information on the importance of coding and data quality. However, the approaches remain inconsistent across the Health Board, and the presentation shared with us for this review could helpfully be updated as it appears not to have been reviewed for some time. The training slides do not give an overview of the Health Board coding function, which would be helpful.

Recommendation	Status	Target date for implementation	Summary of progress
c. encourage the use of coding information for uses other than mortality statistics	**In Progress**	January 2015	In our last review we highlighted the potential for the data produced through coding to be used for other purposes such as service transformation and planning. There have been some examples of this however its usage remains adhoc. Since our previous work, the Health Board has expanded the activity which is coded. Following a request from clinicians within the clinical decision unit, this activity is now coded to accurately reflect the nature of their work and inform job planning. Some work has also been undertaken in speciality areas such as Urology to understand prevalence of particular illnesses. One positive aspect that could improve this is the new Medical Information Officer roles which have been appointed across the organisation. This role supports the work of the Chief Medical Information Officer, and engagement with coding is part of their role with a responsibility for improving clinical engagement for clinical coding.
d. improve clinical engagement in the validation of coded data to drive improvements in quality and awareness of potential use of information	**In progress**	January 2015	The Health Board recognises the need to improve clinical engagement and the Coding Manager is confident that this can improve now they have tackled the coding backlog. The clinical coding department at Wrexham Maelor has run ten clinical engagement events over the past 12 months. Since our last review the staff at Ysbyty Gwynedd have moved to a larger space to place all the staff and the additional staff in one location. This is positive. However, the relocation of staff at Ysbyty Glan Clwyd to outside of the main hospital building is felt by the team to have impacted on their ability for the coding staff to engage with clinical staff.

Recommendation	Status	Target date for implementation	Summary of progress
			The role of the Medical Information Officer is also seen as a key enabler of this recommendation. From their role description there is a clear commitment for them to focus on improving clinical engagement with clinical coding and promoting the clinical coding services.
Medical Records R4 Improve the arrangements surrounding medical records, to ensure that accurate and timely clinical coding can take place. This should include:			
a. improving engagement between the clinical coding department and medical records	**In Progress**	September 2014	Our last review highlighted there was no formal coding engagement on the Health Records Group. This has now been addressed. The group has changed name to the Patient Record Group and there is regular attendance from the Head of Coding or his deputy. A review of minutes for this group show good attendance and issues with casenotes being discussed. However, these meetings appear infrequent. A review of minutes for this group show good attendance and issues with casenotes being discussed. However, these meetings appear infrequent.
b. ensuring quicker access to records for coding staff	**Completed**	September 2015	Work has been undertaken to help ensure quicker access to medical records. Staff we spoke to as part of the focus group did not report any issues with accessing records. The Coding Manager is confident that any issues with access would be raised at the Health Records Group, however we are mindful that the meeting of this group is infrequent. Improvements have been made to casenote tracking with the Health Board investing in a Radio Frequency Identification (RFID) file tracking system to track casenotes through the main hospital sites. This helps support coders trying to locate notes quickly to code them as they are automatically tracked through a series of scanners.

Recommendation	Status	Target date for implementation	Summary of progress
c. addressing the size of casenotes by clarifying roles and responsibilities	**In progress**	Long Term Project	Issues with medical records remain. The medical records team have responsibility to setting up the record and ensuring that it is stored appropriately. However, the responsibility for filing information and the quality of information recorded in the medical records rest with other staff. One area in our last review was regarding results slips and this is a topic on the Health Records Group which they are trying to address. The Health Records department remain responsible for the policy entitled 'Health Records Management procedure'. The procedure outlines the definition of a health record as well as responsibilities. There are also standards of record keeping and good record keeping principles, which although are not the Royal College of Physicians standards, they are similar in their nature. There is no evidence of any additional work on casenotes to tackle their size. Staff within the focus groups at Wrexham Maelor and Ysbyty Glan Clwyd raised concerns around the poor quality of casenotes. As well as that, deceased patient records are not being filed correctly and there was not enough effort to ensure the files were a complete record.
d. ensuring the availability of training on the importance of good quality medical records to all staff	**In progress**	Long Term Project	There is a policy in place in relation to health records, and staff receive induction on this. Processes are in place for the Health Board to regularly audit records management systems, and as a minimum there must be an annual record keeping audit. Through mortality reviews, issues with record keeping are identified as well and fed back to staff. Arrangements are in place through the new Medical Information Officer role to support improvements in medical records. Part of the role description is to work with health records and promote the need for good record keeping.

Source: Wales Audit Office

Appendix 2

Results of the board member survey

Responses were received from eight of the board members in the Health Board. The breakdown of responses is set out below.

Exhibit 6: rate of satisfaction with aspects of coding

	How satisfied are you with the information you receive on the robustness of clinical coding arrangements in your organisation?		How satisfied are you that your organisation is doing enough to make sure that clinical coding arrangements are robust?	
	This Health Board	**All Wales**	**This Health Board**	**All Wales**
Completely satisfied	-	6	2	5
Satisfied	4	34	3	40
Neither satisfied nor dissatisfied	2	46	2	46
Dissatisfied	2	10	1	4
Completely dissatisfied	-	-	-	1
Total	**8**	**96**	**8**	**96**

Exhibit 7: rate of awareness of factors affecting the robustness of clinical coding

	How aware are you of the factors which can affect the robustness of clinical coding arrangements in your organisation?	
	This Health Board	**All Wales**
Full awareness	4	26
Some awareness	3	50
Limited awareness	1	17
No awareness	-	3
Total	**8**	**96**

Exhibit 8: level of concern and helpfulness of training

	Are you concerned that your organisation too readily attributes under performance against key indicators to problems with clinical coding?		Would you find it helpful to have more information on clinical coding and the extent to which it affects the quality of key performance information?	
	This Health Board	**All Wales**	**This Health Board**	**All Wales**
Yes	2	8	5	77
No	6	84	3	19
Total	**8**	**92**	**8**	**96**

Exhibit 9: additional comments provided by respondents from the Health Board

- Have an understanding of the importance of coding but no real knowledge of the process and I believe more knowledge would improve my ability to gain assurance.
- There have been historical problems in coding, but it seems as though they are being tackled, partly by increasing the energy devoted to targeting coding problems.

Appendix 3

Management response

Exhibit 10: management response

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
R1	**Board Awareness** Ensure that performance on coding is reporting into the newly formed information governance informatics committee to ensure that monitoring performance against the Welsh Government target is maintained.	To ensure that coding performance has a profile within the Health Board and performance against the Welsh Government targets is monitored.	Yes	Yes	In May 2019 the IGIC agenda items will include an Informatics Quarterly Assurance Report this report includes a summary of this audit and its action along with coding performance against Welsh Government targets. Coding completeness will be recorded quarterly via the mechanism.	Quarter 1 of 2019/20	Head of Clinical Coding
R2	**Clinical engagement** Revisit training materials and standardise across the Health Board, ensuring that the materials reflect the totality of	Ensure consistency of training across the Health Board and also to raise awareness of the	Yes	Yes	Clinical Coding training materials are currently being updated to assist with engagement and	Quarter 1 of 2019/20	Head of Clinical Coding

Ref	Recommendation	Intended outcome/ benefit	High priority (yes/no)	Accepted (yes/no)	Management response	Completion date	Responsible officer
	the Health Boards coding not just site based.	benefits and opportunities of coded data to clinicians			knowledge, once completed these will be released as part of a wider engagement strategy.		

Wales Audit Office
24 Cathedral Road
Cardiff CF11 9LJ

Tel: 029 2032 0500
Fax: 029 2032 0600
Textphone: 029 2032 0660

E-mail: info@audit.wales
Website: www.audit.wales

Swyddfa Archwilio Cymru
24 Heol y Gadeirlan
Caerdydd CF11 9LJ

Ffôn: 029 2032 0500
Ffacs: 029 2032 0600
Ffôn testun: 029 2032 0660

E-bost: post@archwilio.cymru
Gwefan: www.archwilio.cymru