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Clinical coding follow-up review – **Hywel Dda University Health Board**

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Contents

Coding continues to be a low priority for the Health Board and non-compliance with the completeness target is impacting on overall improvement in accuracy and staff morale. The use of coding data as business intelligence remains underdeveloped and there is still considerable room for progress against our previous recommendations.

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 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 health bodies understood the importance of clinical coding to their day to day business.

6 In April 2014 we reported our findings for Hywel Dda University Health Board (the Health Board) and concluded that 'the Health Board gives clinical coding a high profile, supporting it with a good level of investment, and is focused on improving the quality of management information although further improvements to local practices are required'. More specifically, we found that:

- the importance of clinical coding to support the effective operation of its business was recognised in the health board although more needed to be done to raise the profile of medical records and focus on accuracy;
- many aspects of the clinical coding process were sound but clinical engagement was sometimes lacking, medical records were often poor, and some records took a long time to be coded; and
- clinical coded data was used appropriately and met the Welsh Government standards for timeliness and completeness, but some coding was inaccurate, and the Board were not aware of the inaccuracies or its implications.

[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)

7 We made several recommendations, which focused on the need to:

- improve the management of medical records;
- strengthen clinical coding resources;
- further build Board engagement and resources; and
- strengthen engagement with medical staff.

8 As part of the Auditor General's 2018 Audit Plan for the 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 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 coding continues to be a low priority for the Health Board and non-compliance with the completeness target is impacting on overall improvement in accuracy and staff morale. The use of coding data as business intelligence remains underdeveloped and there is still considerable room for progress against our previous recommendations.

The proportion of episodes coded within a month of completion is below target and there is evidence that pressure to clear the backlog is affecting overall improvement in accuracy and reducing staff morale

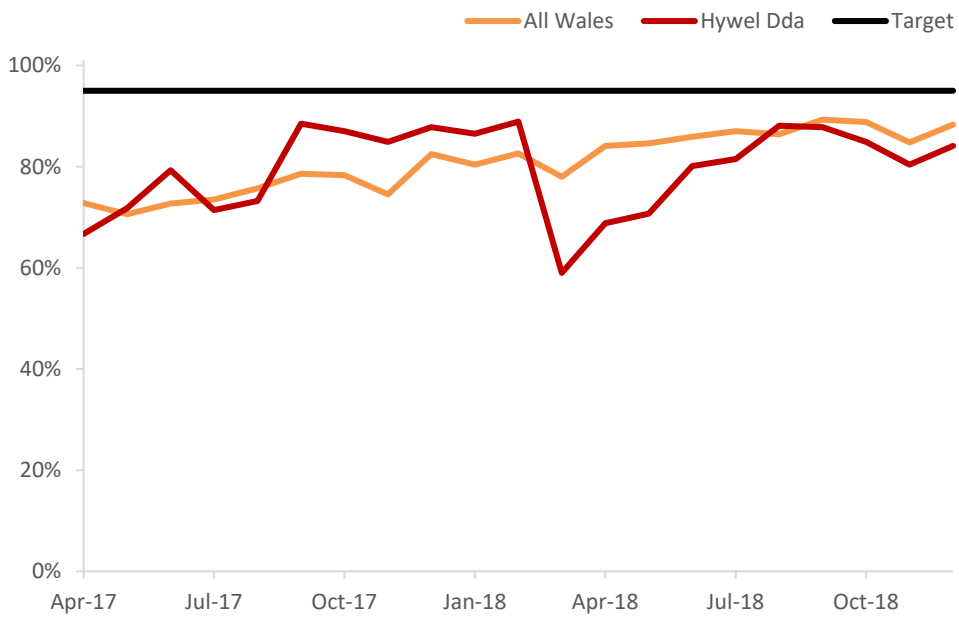
12 The Welsh Government has two coding related Tier 1 targets which NHS bodies are required to meet. These relate to completeness and accuracy.

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 20 responses out of a possible 30 responses were received.

financial year which was previously the case. Based on this data, Exhibit 1 shows that the Health Board's performance has been consistently below the 95% completeness target and has been highly variable (ranging between 66.7% in February 2017 to 84.1% in December 2018). The main cause of variability is linked to a reduction in the number of whole-time-equivalent Band 3 and 4 coders and a predominantly year-on-year increase in finished consultant episodes (FCEs).

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



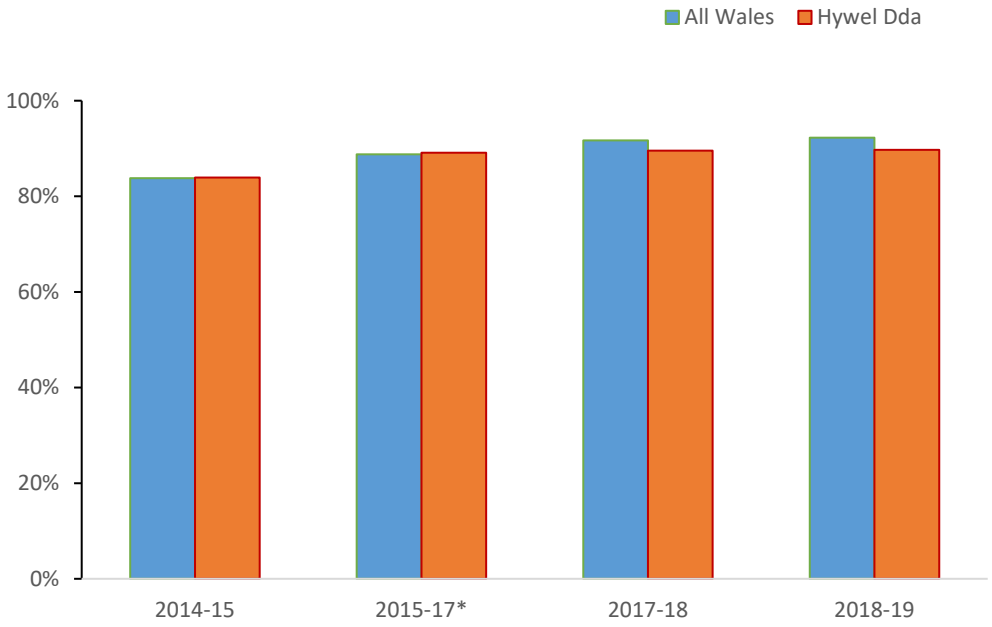
Source: Wales Audit Office analysis of data sent to Welsh Government

14 As part of our fieldwork, we requested the backlog position as at March 2018. The Health Board reported a significant backlog of 6.25% (8,469) of the FCEs. The backlog has continued to grow over the last three years. The Health Board is currently third highest in terms of coding backlog amongst Welsh health bodies (behind Betsi Cadwaladr University Health Board and Aneurin Bevan University Health Board).

15 Each year, the NHS Wales Informatics Service (NWIS) Standards Team checks 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 improvement in their accuracy year-on-year. Exhibit 2 shows that accuracy has improved (89.7% of episodes samples were coded correctly in 2018-19 compared to 83.7% in 2014-15). However, the improvement at the Health Board has not been

as great as in Wales as a whole: in 2017-18 (92.3% of episodes sampled were coded correctly in 2018-19). NWIS note that the 'overall results of the audit confirm that the clinical coding staff at the Health Board achieved above the recommended accuracy for secondary diagnosis, primary procedure and secondary procedure coding, but failed to achieve the recommended accuracy for primary diagnosis coding.'

Exhibit 2: percentage of episodes coded accurately



Source: Results of NWIS clinical coding accuracy reviews 2014-19
* 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.

16 NWIS also notes that 'to achieve Welsh Government completion targets there continues to be a drive to assign classification codes as soon as possible post discharge', and 'without reference to the full medical record and /or without a complete accurate discharge summary'. Furthermore 'the number and type of errors identified in [the] audit indicates that the clinical coders at Hywel Dda are rushing the clinical coding process', which leads to errors despite the correct information being available in the medical record.

17 Coding staff told us that the ongoing pressure to clear the backlog and the negative impact this has on other aspects of coding, is having a significant effect on staff morale.

Despite widespread awareness of the issues associated with clinical coding performance, it is still a low priority and the use of coded data for business intelligence remains under-developed

18 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.

19 We found that while clinical coding in the Health Board now has a significantly higher profile in terms of awareness, it is still a low priority. Several board members said that while they recognise that it needs more investment, clinical coding is in heavy competition with other priorities.

20 Clinical coding issues are raised regularly and in a comprehensive way at senior level forums, including:

- Executive Team meetings, for example, an update report on clinical coding was presented in January 2018;
- Board meetings, with performance reports including the percentage of clinical coding accuracy attained in the NWIS national clinical coding accuracy audit programme;
- Business, Planning & Performance Assurance Committee (BP&PAC) meetings, with the Tier 1 target for clinical coding completion included in the Integrated Performance Assurance Report (IPAR) alongside an explanation of the current situation and challenges; what is being done; when and how much improvement can be expected; and how this will impact on patients and finances; and
- Information Governance Sub-Committee (IGSC) meetings, with this bi-monthly sub-committee a key forum for assurance around coding issues through regular clinical coding reports and updates.

21 The management structure and professional accountability for clinical coding has been strengthened since our previous review. The Director of Planning, Performance and Commissioning is responsible for the coding function and has highlighted that one of the fundamental challenges for clinical coding at the Health Board is the level of under-staffing in relation to activity. The Health Board estimates that it is short of between five and six clinical coders. This is based on its existing staff compliment, activity levels which have increased by approximately 36,000 FCEs since previous estimates were made, and professional norms for clinical coder productivity. The Health Board has opted not to invest in the function because of financial constraints and other competing priorities. In addition, supervisory capacity is diminished due to long term sickness. Managers and

clinical coding teams have considered and implemented more efficient ways of working. However, the backlog has continued to grow over time and the resulting pressure to address it is affecting the quality of coding.

22 While awareness of issues associated with clinical coding is much higher, the use of coded data for business intelligence remains under–developed. There is ongoing debate in the Health Board about the nature and extent of investment in digital solutions for clinical coding but no clear consensus about how this can be progressed. Nonetheless, several board members recognise that there needs to be investment in technological solutions in this area.

23 Digital solutions for clinical coding can provide significant benefits in a number of areas. For example, as part of their digital strategy, Abertawe Bro Morgannwg University Health Board has secured investment for the modernisation of case note tracking with Radio-Frequency Identification (RFID). The project will implement a RFID solution with the objective of improving the clinical and logistical problems of a paper-based health record whilst also modernising and improving the service the Health Records department provides. The solution will provide RFID tagging of acute records and Location Based Filing using barcode scanning and identification of a records location via fixed sensors. This will enable records to be easily tracked, located and made available when required.

24 Hywel Dda University Health Board is at the very early stages of adopting value-based healthcare. A paper submitted to the Welsh Government to develop a joint infrastructure with Abertawe Bro Morgannwg University Health Board and Swansea University has been agreed and will be funded for two-years. The Health Board is already leading value-based healthcare in relation to the lung pathway but recognises that it currently lacks both outcome and cost data, the latter being linked to clinical coding. This information is needed to take value-based healthcare forward across other specialties and pathways.

The Health Board has made limited progress against previous audit recommendations and several issues require considerable attention

25 Exhibit 3 summarises the status of our 2014 recommendations.

Exhibit 3: progress status of our 2014 recommendations

Total number of recommendations	Implemented	In progress	Overdue	Superseded
15	4	6	5	-

Source: Wales Audit Office

26 Our follow-up work has found that the Health Board has made some progress against our 2014 recommendations, but many recommendations remain outstanding or are overdue.

27 The relationship between the clinical coding teams and medical records staff has improved. However, the standard of case notes has deteriorated since our previous work. The clinical coding team play an essential role in highlighting this issue. There is little ownership of medical records and folders at ward level and tracking of medical records remains an issue. There is greater movement of patients around the Health Board because of increased clinical specialisation, as well as shorter lengths of stay. This adds to the challenge of maintaining notes in line with professional standards, and of making them available when needed. The use of temporary files continues to be problematic. The Health Records Group has been tasked with addressing these issues, which are also subject to recommendations from other internal reviews.

28 The clinical coding management structure was strengthened following our previous report. This included the appointment of a Clinical Coding Manager with responsibility for all coding teams and two coding team supervisors. However, arrangements have been compromised by the prolonged sickness absence of one of the supervisors, and despite the introduction of mitigating arrangements.

29 There is no evidence of training for board members to raise their awareness of the importance of clinical coding. However, the Board regularly receives information about coding performance as part of the Integrated Performance Assurance Report. The Board has previously received a copy of the NWIS clinical coding accuracy report. Information on coding accuracy is also provided on a regular basis to the Information Governance Sub-Committee.

30 Medical staff do not have a structured programme of training in relation to clinical coding. Awareness sessions are held with specialty teams on an ad hoc basis. Senior Health Board staff recognise the importance of clinical coding training for medical staff and acknowledge that the resources currently available are inadequate. An introduction to clinical coding was previously included in the induction process for new medical staff, but it is unclear whether this is still the case.

31 A clinical coding PowerPoint presentation was due to be emailed to all consultants at the time of our fieldwork. This was to include the ‘Royal College of Physicians Top ten tips for coding – a guide for clinical staff’. This was a one-off occurrence and there are no ongoing activities to promote standards. Coders said that medical staff are generally poor at fulfilling clinical coding requirements and the quality of discharge summaries is particularly poor. In addition, there is no evidence of routine involvement of clinicians in the validation of the use of clinical codes.

Recommendations still outstanding

32 In undertaking this work, we have made no additional recommendations. The Health Board needs to continue to make progress in addressing our previous recommendations. The outstanding recommendations are set out in Exhibit 4.

Exhibit 4: recommendations still outstanding or overdue

2014 recommendations not yet complete
Management of Medical Records R1 Improve the management of medical records to ensure that the quality of, and access to, medical records effectively supports the clinical coding process. This should include: a) improving engagement between the medical records and clinical coding teams. b) removing the use of temporary records, including poly-pockets and ensure files are merged into the master patient record. c) reinforcing the Royal College of Physician standards across the health board. d) providing training for ward clerks and other staff in relation to their responsibilities for medical records. e) improving compliance with the medical records tracker tool within the Myrddin Patient Administration System.
Clinical Coding Resources R2 Strengthen the management of the clinical coding teams to ensure that good quality clinical coding data is produced. This should include: b) extending the range of clinical information systems that coders have access to, including the operating theatres system. c) ensuring all staff receive consistent feedback on issues raised through validation and audit from all sites.

2014 recommendations not yet complete
Board Engagement R3 Build on the good engagement that already exists with the Board to ensure that the implications of clinical coding on performance management, and the wider management processes in the NHS, are fully understood. This should include: b) providing training for board members to raise their awareness of clinical coding and the extent to which it affects the quality of key performance information, other than mortality data.
Engagement with medical staff R4 Strengthen engagement with medical staff to ensure that the positive role that doctors have within the clinical coding process is recognised. This should include: a) embedding a consistent approach to clinical coding training for medical staff across the health board. b) reinforcing the importance of completing timely discharge summaries. c) improving clinical engagement with the validation of clinical coded data.

Source: Wales Audit Office

Appendix 1

Health Board progress against our 2014 recommendations

Exhibit 5: assessment of progress

Recommendation	Target date for implementation	Status	Summary of progress
Management of Medical Records **R1 Improve the management of medical records to ensure that the quality of, and access to, medical records effectively supports the clinical coding process. This should include:**			
a) improving engagement between the medical records and clinical coding teams.	Included in a wider action plan for Health Records	In progress	Clinical coding staff reported good relationships with health records staff across the Health Board. The Clinical Coding Manager recently met with the Health Records Manager for Carmarthenshire to discuss the processes in place between health records and clinical coding. They were satisfied that they were working well. Clinical coding staff pull the majority of case notes from the filing libraries at Glangwili Hospital, Prince Philip Hospital, and Bronglais Hospital. Coding staff at Withybush Hospital can ask health records staff at Prince Philip Hospital to pull notes to be sent to the relevant site for coding. Access to the health records library at Withybush Hospital has been restricted through the introduction of locks. Clinical coders do have access although they must ring to gain entry. This slows down retrieval of case notes. The Director of Business, Planning and Performance intends to strengthen the Health Records Group to provide a focus for issues associated with effective health records management.

Recommendation	Target date for implementation	Status	Summary of progress
b) removing the use of temporary records, including poly-pockets and ensure files are merged into the master patient record.	Included in a wider action plan for Health Records	Overdue	Temporary notes and poly-pockets are still in use across the organisation. The Health Board's self-assessment response indicated that the numbers received into coding offices are not high. However, clinical coders across the Health Board told us that the situation had deteriorated over the period since our last review. There has been a decline in the organisation, maintenance and condition of individual patient case note folders because of greater movement of patients around the Health Board and shorter lengths of stay. Both factors add to the challenge of ensuring the notes are maintained in line with standards, and available when needed by clinical coding teams as well as clinicians. A note is entered in Medicode whenever a poly-pocket is used as the source for coding. If an audit of the full case note is subsequently carried out, there will then be a flag to indicate that it was not available at the time of coding.
c) reinforcing the Royal College of Physician standards across the health board.	Included in a wider action plan for Health Records	In progress	A clinical coding PowerPoint presentation was due to be emailed to all consultants at the time of our fieldwork. This was to include the 'Royal College of Physicians Top ten tips for coding – a guide for clinical staff'. It is a one-off occurrence. We are not aware of ongoing activities to ensure that the standards are promoted.
d) providing training for ward clerks and other staff in relation to their responsibilities for medical records.	Included in a wider action plan for Health Records	Overdue	There is no ongoing programme of training to ensure that ward clerks maintain records in line with professional standards. Coding staff said that the standard of practice amongst ward clerks is highly variable, and there is no real ownership of the notes in some wards. Ward clerks are managed by individual specialties and wards. This increases the need for ongoing communication (with ward staff in

Recommendation	Target date for implementation	Status	Summary of progress
			general as well as with ward clerks) about the importance of maintaining standards of practice and for the provision of training.
e) improving compliance with the medical records tracker tool within the Myrddin Patient Administration System.	Included in a wider action plan for Health Records	Overdue	All the clinical coding teams are asked to track case notes correctly using the Myrddin Patient Administration System. The Health Board's self-assessment indicated that this always happens, except for when case notes are collected from a ward in the morning and returned that afternoon. However, coding staff indicated that case note tracking is generally poor, except at Withybush Hospital.
f) putting steps in place to ensure that coders have early access to medical records for patients transferring to South Pembrokeshire Hospital prior to transfer.	Included in a wider action plan for Health Records	Implemented	An internal process has been established to inform the coding department about patients who are to be transferred to South Pembrokeshire Hospital (SPH). The relevant case notes are then coded before the patient leaves the site. A coder visits SPH once a month to code any episodes which have been missed.
Clinical Coding Resources **R2 Strengthen the management of the clinical coding teams to ensure that good quality clinical coding data is produced. This should include:**			
a) reviewing the supervisory arrangements for Prince Philip Hospital to ensure that staff do not feel isolated.	October 2014	Implemented	Clinical coding management team arrangements have been strengthened since our previous audit. This includes the appointment of a Clinical Coding Manager with responsibility for all coding teams and two coding team supervisors, one at Withybush Hospital and the other who supervises at Bronglais, Glangwili and Prince Philip hospital. However, arrangements have been significantly compromised by prolonged sickness absence of the supervisor covering three sites, and despite the introduction of mitigating interim arrangements. While staff at Prince Philip Hospital commended the Clinical Coding Manager for the cover he has personally provided, the situation has

Recommendation	Target date for implementation	Status	Summary of progress
			affected their morale. In addition, consultants do not appear to be interested in the work that they do.
b) extending the range of clinical information systems that coders have access to, including the operating theatres system.	March 2015	In progress	The clinical coding team have access to the operating theatres module of the National Patient Administration System. However, there is inconsistent clinical practice in the use of the theatres module, NPAS functions in general, and other key systems that support the coding process like ChemoCare[3] and the Welsh Clinical Portal. Work had recently commenced to examine whether there are additional systems which could be utilised by the coding team to assist in the coding process. It was too early for any findings to be made available. Second computer screens are gradually being made available to individual clinical coders to assist and expedite the coding process.
c) ensuring all staff receive consistent feedback on issues raised through validation and audit from all sites.	Ongoing	In progress	None of the coders are currently qualified to audit coding work. In 2017-18 it was decided to have a supervisor and a coder carry out an audit of 30 case notes each month and to feedback the results directly to individual coders. The arrangement was suspended so that all coding team resources could be directed towards clearing the coding backlog. At the time of our fieldwork the situation had not changed.

[3] ChemoCare is an expert chemotherapy electronic prescribing system with integrated appointment scheduling, which, using a single patient record, provides the medication record, clinical information and appointment schedule required for the safe management of cancer patients receiving chemotherapy.

Recommendation	Target date for implementation	Status	Summary of progress
			The Coding Manager carries out data quality checks when time allows. However, his time has been heavily committed to providing a presence on each site to mitigate for the long-term sickness absence of one of the two coding team supervisors.
d) reconsidering the responsibility for typing discharge letters at Withybush to ensure that this duty does not impact on the clinical coding process and the use of coding resources.	March 2015	Implemented	Discharge letters are no longer typed by the clinical coding team at Withybush Hospital. Coders time is now entirely spent on coding episodes.
Board Engagement/Resources **R3 Build on the good engagement that already exists with the Board to ensure that the implications of clinical coding on performance management, and the wider management processes in the NHS, are fully understood. This should include:**			
a) providing training for board members to raise their awareness of clinical coding and the extent to which it affects the quality of key performance information, other than mortality data.	March 2015	Overdue	There is no evidence of training for board members to raise their awareness of the importance of clinical coding.
b) improving information to board on the accuracy of clinical coding.	March 2015	Implemented	The Board regularly receives information about coding performance (see also paragraph 21) as part of the Integrated Performance Assurance Report. It has previously received a copy of the NWIS clinical coding accuracy report. Information on coding accuracy is also provided on a regular basis to the Information Governance Sub-Committee.

Recommendation	Target date for implementation	Status	Summary of progress
Engagement with medical staff **R4 Strengthen engagement with medical staff to ensure that the positive role that doctors have within the clinical coding process is recognised. This should include:**			
a) embedding a consistent approach to clinical coding training for medical staff across the health board;	March 2015	Overdue	Medical staff do not receive training in relation to clinical coding. An introduction to clinical coding was previously included in the induction process for new junior medical staff, but it is unclear whether this is still the case. In the months prior to our review the Clinical Coding Manager had sent a PowerPoint presentation on clinical coding to the Medical Director and the four hospital clinical leads with a request for feedback, with varying responses. The presentation is to be emailed to all consultants and service delivery managers for information and further feedback. A Chief Clinical Information Officer (a respiratory consultant) had been in post for eight months and has two sessions per week to devote to clinical information issues. He would like to establish sufficient resource amongst clinicians across the Health Board to advocate and promote good practice in relation to clinical coding. His intention is to strengthen clinical representation on the Clinical Informatics Group to help focus on problematic areas. One example is endoscopy, where there is a high volume of patients and low quality of notes. The Health Board recently approved a post of Chief Nurse Information Officer and planned to make an appointment to the post later in 2018. This will help to focus on note taking which will in turn support better coding.

Recommendation	Target date for implementation	Status	Summary of progress
b) reinforcing the importance of completing timely discharge summaries	March 2015	In progress	The Health Board has been slowly rolling out electronic patient discharge arrangements, although it is still only available in a limited number of areas. Coding teams said that where this is in place, the quality of information entered in to the system is generally poor. There is a cyclical issue which arises because of junior doctor intakes, which means that expected standards must be learned each time. Coding staff also indicated that electronic system updates can be problematic. Coding staff said that the timeliness and quality of written discharges is variable and has deteriorated over time. For example, they are often illegible or blank.
c) improving clinical engagement with the validation of clinical coded data	March 2015	In progress	There was little specific evidence of clinical engagement with the validation of clinical coded data.

Source: Wales Audit Office

Appendix 2

Results of the board member survey

Responses were received from 20 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	-	5
Satisfied	5	34	3	40
Neither satisfied nor dissatisfied	12	46	16	46
Dissatisfied	3	10	1	4
Completely dissatisfied	-	-	-	1
Total	20	96	20	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	5	26
Some awareness	13	50
Limited awareness	1	17
No awareness	1	3
Total	20	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	3	8	18	77
No	15	84	2	19
Total	18	92	20	96

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

- Our clinical coding is not as timely as it has been previously, and the coding department appears stretched. Without timely, accurate coding with sufficient depth of coding it is difficult to interpret real time information, particularly benchmarked information.
- Needs a higher profile and ownership within the organisation.
- I understand that across Wales our approach to coding is in a different place to where it is in England. As I understand it this is partly at least attributable to the fact that in England coding plays a much greater role in driving the income of trusts. Consequently, there may have been a much greater investment in coding including technology to speed up coding than is the case in Wales. We may be in something of a vicious circle in that coding is usually suffering a backlog which greatly reduces its effectiveness and usefulness for clinicians so less attention is paid to the coding information produced. It's akin to you only weigh what you value.
- I do not recall clinical coding being addressed in any meeting. Obviously, it underpins all performance reporting, so it is implicit, but I don't believe it has been discussed so I am unable to answer most of these questions.
- As per latest IGSC report to BPPAC we know exactly where we are in terms of clinical coding and quality and with the volume of workload, we need more investment – in the front end to train our clinicians to code at source and at the back-end because good quality and timely coding saves lives, and that latter point is not an exaggeration.
- We have recently considered the need for further investment in clinical coding, however given the financial challenges the choices regarding investment make it difficult to prioritise clinical coding v clinical service delivery.
- Clinical coding requires investment in technology to maximise its productivity.
- There is clearly an issue with clinical coding capacity for us to be fully up to date all the time. I think the big issue for the Board is how we prioritise what investment we can make against all our priorities when in the financial position we are in. My assessment is that we are 'good enough' on the coding front, especially when looking at the position across Wales, but as with all things, there is always room for improvement.

- In an ideal world we would invest more in clinical coding than we do currently however we are overwhelmed with challenges as we have seen in the TCS Case for Change and this priority will be in competition with many others. However, improvements must feature in our clinical strategy moving forwards.

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